AMENDMENT TO THE
CITY OF CHICAGO MEDICAL PPO PLAN
(EFFECTIVE JANUARY 1, 2017 OR AS OTHERWISE SPECIFIED HEREIN)

For non-represented Employees, and for Employees covered under the City's collective bargaining agreements with AFSCME Council 31, Coalition of Unionized Public Employees (Chicago Building Trades Coalition), Illinois Nurses Association, Public Safety Employees Unit II, Police Captains Association, Police Lieutenants Association, Police Sergeants represented by the Policemen's Benevolent & Protective Association of Illinois (PB&PA), Supervising Police Communications Operators represented by Teamsters Local 700; Aviation Security Sergeants represented by the Illinois Council of Police; Public Health Nurse III's and IV's represented by Teamsters Local 743, Uniformed Firefighters and Paramedics represented by the Chicago Fire Fighters Union, Local No. 2 and the Shift Supervisors of Security Communications Center represented by Teamsters Local 700 (the "Plan")

(As amended and restated effective as of October 1, 2015)

This Amendment to the Plan, as amended and restated effective as of October 1, 2015, (herein the "Plan") is adopted effective January 1, 2017 unless another date is specified below. Except as amended, the Plan shall continue in full force and effect in accordance with its terms.

1. **Physical Therapy:** Certification by the Medical Advisor is required with respect to all physical therapy visits in excess of seven visits per year; if Certification by the Medical Advisor is not received, any visits in excess of seven will not be covered by the Plan.

2. **Second Surgical Opinion Pilot Program:** Effective April 1, 2017, through December 31, 2019, Certification by the Medical Advisor is required prior to surgery on the knee, shoulder, hip, neck, back, gall bladder, vagina, cervix or uterus. If Certification by the Medical Advisor is not received, such surgery will not be covered. Additionally, with respect to these surgeries as well as bariatric surgery, the Medical Advisor will decide whether an outside second opinion is required based on the procedure code. If the Medical Advisor determines that a second opinion is required, the Participant must cooperate with the process of obtaining a second surgical opinion. If a second opinion is needed based on the procedure code and the Participant does not obtain a second opinion prior to the surgery, there will be no coverage for the surgery (or any related hospitalization). However, if the second opinion recommends against the surgery, the Participant may still choose to have the surgery, in which case, the surgery will be covered as set forth in the Schedule of Benefits. This second opinion requirement does not apply if the Participant is admitted to the Hospital for surgery from the emergency room.

3. **Telemedicine Pilot Program:** Effective January 1, 2017, through December 31, 2019, the Plan offers "virtual visits" through its Telemedicine Pilot Program. The Program includes remote consultations with designated Providers for many non-Emergency conditions via interactive mobile app, online video, cell phone video, telephone, or similar technology, where available, 24 hours per day, 365 days per year. Note: virtual visits are not available for services received from Behavioral

Health Specialists. As needed, Providers may give advice, write and send prescriptions to a nearby pharmacy, and/or recommend follow-up care. The cost to a Participant of a fifteen-minute consultation is a $20 Co-payment, which does not count towards the Deductible but will count towards the Out-of-Pocket Limit.

4. **Wellness Program:** Covered Employees and their covered Spouse, Same Sex Domestic Partner, or Civil Union Spouse are given the opportunity to participate in the Chicago Lives Healthy Wellness Program.

With respect to the 2017 Plan Year, these individuals are required to complete a written or electronic "well-being assessment" and a "health advisor call" to review the results of the well-being assessment and the latest biometric screening results on file. Participants receive a customized report that summarizes their individual results and offers suggestions for health improvement during the coming year.

Covered Employees and covered Spouses, Same Sex Domestic Partners, and Civil Union Spouses whose coverage is associated with a new hire or who do not have biometric screening results on file with the program from 2015 or 2016 also must complete a biometric screening.

Based on biometric screening results already on file as well as PPO Claim data, participants in the program will be assigned to one of two courses of action -- "participation paths" -- that must be followed in order to continue to qualify to avoid paying a higher premium. Written notice of the assignment will be provided. Those two paths are as follows:

Optional ongoing participation

A participant assigned to this path may continue to use the program portal (the "Well-Being Connect (WBC)" portal), participate in on-site education sessions, speak with a health coach, or participate in a disease or care management program offered through the Plan. However, participants assigned to this path no longer will be required to earn quarterly "participation points."

Required ongoing participation by engaging in a Health Improvement Program (HIP).

The Wellness Program will assign participants to this path based on them having certain risk factors such that participation in disease/care management programs would be expected to help prevent worsening of chronic conditions that can lead to other health problems. A participant assigned to this path will receive written communication offering the participant the opportunity to participate in a coaching program or disease/care management program. While the program no longer will require a participant to earn quarterly participation points, the participant following this path will be required to actively participate in the designated program. The participation requirements will differ by program, but generally will include an enrollment session and then individualized coaching sessions during each Calendar Year quarter. None of the programs require that participants meet a performance goal such as reduction in blood pressure, weight, or cholesterol readings.

If an Employee or the Employee's Spouse, Same Sex Domestic Partner or Civil Union

Spouse are unable to complete these steps, the individual might qualify for a waiver. More information is available from the Chicago Benefits Office.

Covered Employees and their covered Spouse, Same Sex Domestic Partner, or Civil Union Spouse who choose not to participate in the Chicago Lives Healthy Wellness Program or participate but do not complete the required program steps will incur an additional $50 per non-participant increase in their monthly employee contribution.

Confidentiality of Information Collected

The information collected on behalf of the City by the Wellness Program Administrator as part of the Chicago Lives Healthy Wellness Program is subject to HIPAA and is treated as confidential. The Wellness Program Administrator advises the Chicago Benefits Office as to whether you have completed the required program steps in order to avoid the imposition of the $50 extra employee contribution but does not share any other information with the Chicago Benefits Office or other City personnel.

5. **Allowable Charge:** Effective December 1, 2017, the section of the definition of Allowable Charge that relates to the Allowable Charge with respect Providers who are not Professional Providers is amended at the direction of the Claims Administrator to read as follows:

> For PPO and other Contracted Providers who are not Professional Providers (for example, Hospitals), the Allowable Charge will continue to be the amount determined by the Claims Administrator that the PPO or other Contracted Provider has agreed to accept as payment in full for a particular covered service as of the date of service pursuant to its contract with the Claims Administrator.
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> For Non-PPO Providers and other non-contracted Providers who are not Professional Providers, the Allowable Charge will continue to be the lesser of the Provider's billed charges or an amount determined by the Claims Administrator as of the date of service, which currently is developed from the rate of base Medicare reimbursements and represents approximately 100% (in Illinois)/300% (outside Illinois) of the base Medicare rate and excludes any Medicare adjustment(s) based on information regarding the Claim. When a Medicare reimbursement rate is not available for a particular service or is unable to be determined based on the information submitted with respect to the Claim, the Allowable Charge will be the lesser of the Provider's billed charges or 150% of the Allowable Charge for a PPO Provider. However, if this too cannot be determined, then the Allowable Charge will be 50% of the Provider's billed charge, provided that the Claims Administrator may limit such amount to the lowest contracted rate that it has in place with any PPO Provider as of January 1 of the year that the services are rendered for the same or similar service based upon type of Provider and information submitted with respect to the Claim. For out of network services provided as part of a Coordinated Home Care Program, the Allowable Charge will be the amount set forth on the

Schedule of Maximum Allowances, and if there is no such amount, then a per diem rate (determined by the Claim Administrator), and, if none is available, then 50% of the billed charge.

6. A new definition of **Coordinated Home Care Program** is added as follows:

Coordinated Home Care Program is defined as an organized skilled patient care program inwhich care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. A Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require skilled nursing service on an intermittent basis under the direction of a Physician. This program includes skilled nursing service by a Nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for private duty nursing services or Custodial Care. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

7. A new definition of **Schedule of Maximum Allowances** is added as follows to reflect the use of this term in the updated definition of Allowable Charge set forth above:

Schedule of Maximum Allowances is defined as the applicable fee schedule, as revised from time to time, setting forth the maximum rate that a particular Professional Provider has agreed to accept as payment in full for services provided pursuant to his or her contract with the Claim Administrator.