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

For sworn police officers below the rank of sergeant and represented by the Fraternal Order of Police

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

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

1. **Three-Tiered PPO**: Providers will be classified as "Tier 1," "Tier 2" or "Tier 3." The concept of "tiers" generally is used to indicate the level of Plan benefits available with respect to a particular Provider, as set forth in the Schedule of Benefits. Some PPO Providers are treated as "Tier 1" Providers, while other PPO Providers are in "Tier 2." The Tier 1 PPO network is a subset of the broader PPO network. Non-PPO Providers are referred to as "Tier 3" Providers. Participants may see any Provider, but the Deductibles, Coinsurance, and Out-of-Pocket Limits are lowest when a Participant sees a PPO Provider in the Tier 1 network.

- Generally, the Plan pays 90% of the Allowable Charge with respect to Tier 1 Providers, 75% with respect to Tier 2 Providers, and 60% with respect to Tier 3 Providers; some exceptions apply.
- The Deductible is $300 individual/$900 family for Tier 1 Providers, $350/$1,050 for Tier 2 Providers, and $1,500/$3,000 for Tier 3 Providers, and the Out-of-Pocket Limit is $1,000 individual/$2,000 family for Tier 1, $1,500/$3,000 for Tier 2, and $3,500/$7,000 for Tier 3.
- Copayments are $0 and the Deductible does not apply to recommended preventive services, such as routine check-ups and lab work including well baby and well woman care, hearing screenings, and colonoscopies, when received from a PPO Provider (Tier 1 or Tier 2), to the extent required to be covered under the Affordable Care Act of 2010 and subject to the frequency, gender and age guidelines established under the Affordable Care Act. The Plan does not cover preventive services provided by Non-PPO Providers or not required to be covered by the Affordable Care Act.
- Copayments for all other PPO office visits are $20 for Primary Care Providers and $30 for Specialists in Tier 1, $25 for Primary Care Provider and $35 for Specialists in Tier 2; the Deductible does not apply.

- Non-PPO Provider office visits are covered at 60% of the Allowable Charge after the Deductible is met.
- The Emergency Room Copayment is $150 regardless of tier and is waived if the individual is admitted as an in-patient. The Emergency Room Copayment does not apply toward the Deductible or Non-PPO Provider Out-of-Pocket Limit, but it does apply toward the PPO Provider Out-of-Pocket Limit for Tier 1 and Tier 2.

2. **Certification Requirements for Diagnostic Imaging:** Certification by the Medical Advisor is required with respect to Magnetic Resonance Imaging (MRI) scans, Positron Emission Tomography (PET) scans, and Computed Axial Tomography (CAT/CT) scans. Benefits will not be paid if the Medical Advisor does not approve the services as Medically Necessary.

3. **MRI, PET and CAT Scans Incentive Program.** If MRI, PET, and CAT scans are performed outside of the Hospital at a designated PPO Provider free-standing facility, the Plan will pay 100% of the expense for the scans. If the scans are performed at a Hospital Outpatient department or a Non-PPO Provider, the applicable Deductible and Coinsurance will apply. Any scans billed by a Hospital or Hospital-owned Outpatient facility will not be eligible for the incentive program and will be paid at the percentage set forth in the PPO Plan Schedule of Benefits. The Medical Advisor can help Participants locate nearby facilities that qualify for the Incentive Program.

4. **Diagnostic Testing/Independent Lab Incentive Program.** If diagnostic testing is performed outside of the Hospital at an independent PPO Provider location not affiliated with a Hospital, the Plan will pay 100% of the expense for the lab tests. If the testing is performed at the Hospital Outpatient department or a Non-PPO Provider, the applicable Deductible and Coinsurance will apply. Any lab tests billed by a Hospital will not be eligible for this improved benefit. The PPO Plan Claims Administrator can help Participants locate nearby facilities where they can obtain lab tests at no cost.

5. **Emergency Room Copayment:** The Emergency Room Copayment is $150.

6. **Mandatory Use of Blue Distinction Transplant Centers:** In order to receive coverage under the Plan for the following transplants, a Participant must receive treatment at a Blue Distinction transplant center specializing in the particular transplant procedure: Heart, Lung, Heart/Lung, Liver, Simultaneous Pancreas/Kidney (SPK), Pancreas (PAK) and Bone Marrow/Stem Cell. There will be no coverage for transplants performed elsewhere.

7. **Formulary:** The amount that a Participant must pay for drugs depends on whether the drugs are generic, formulary brand name drugs, non-formulary brand name drugs, or excluded drugs (for which there is no coverage). What category a drug falls into is determined by the Pharmacy Benefits Manager.

8. **Retail Maintenance Medication Refills.** If a Participant obtains more than three fills (an initial fill plus two refills) of a generic Maintenance Medication at a retail pharmacy, the Copayment will be $20 (as opposed to $10 for the first three fills). Likewise, if a Participant obtains more than three fills of a formulary brand name drug or a non-formulary brand name drug at a retail pharmacy, the Copayments will be $60 (as opposed to $30) and $90 (as opposed to $45), respectively.

9. **Allowable Charge:** Effective December 1, 2017, the first paragraph of Section A 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 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 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.

10. 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. The patient 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.).

11. A new definition of **Schedule of Maximum Allowances** is added as follows:

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.