CITY OF CHICAGO

SEASONAL EMPLOYEES

(WHO HAVE WORKED LESS THAN 365 DAYS)

MEDICAL CARE PLAN

Richard M. Daley, Mayor

Who is Eligible?

Seasonal Employees

You are eligible for coverage if you are a full-time employee working for the City of Chicago on a seasonal basis compensated at an hourly or daily rate and the number of days you work does not exceed 180 in any calendar year.

Eligible Dependents

Eligible Dependents who may be covered under the Seasonal Employees Medical Care Plan are:

- **Your spouse, unless your spouse is a City employee eligible to participate in a Medical Care Plan,**
- **Unmarried children under age 19,**
- **Unmarried children who are between the ages of 19 and 22 and enrolled in an accredited community college, college or university as a full-time undergraduate student in good standing, and**
- **Unmarried children of any age who are incapable of self-support due to mental retardation or physical handicap and dependent on you for support and maintenance, provided that proof of incapacitation is received and all other eligibility requirements are met.**

The term “children” includes:

- **Natural children,**
- **Stepchildren,**
- **Children placed in your home for adoption,**
- **Legally adopted children.**

A child of an eligible seasonal employee shall not be eligible if a divorce decree or other valid judgment imposes upon a person other than the eligible seasonal employee or his/her spouse the responsibility to provide medical care for such child.

No Dual Coverage

You may be covered under the Seasonal Employees Medical Care Plan as either an employee or a spouse; you may not be covered as both. If you and your spouse are covered under the plan as seasonal employees, only one of you can cover your children. A dependent of a seasonal employee can be covered as a dependent of only one City employee.

If your spouse is also eligible for coverage as a regular City employee, your spouse can only be covered under the City of Chicago Medical Care Plan for employees and cannot be covered under the Seasonal Employees Medical Care Plan. If a dependent is also eligible for coverage as a regular City employee, that dependent can only be covered under the City of Chicago Medical Care Plan for employees and cannot be covered under the Seasonal Employees Medical Care Plan.

Enrolling in the Plan

In order to enroll in the Seasonal Employees Medical Care Plan you must complete the Seasonal Employees Health Status Questionnaire and the Seasonal Employees Enrollment Form and return them to:

City of Chicago
Benefits Management Division
333 South State Street, Room 400
Chicago, Illinois 60604-3978

These forms must be received within 30 days of your date of hire. Your application will not be processed until both of these forms are received. If both forms are not received within 30 days of your date of hire, neither you nor your dependents will be able to enroll for the Seasonal Employees Medical Care Plan until the Next Open Enrollment period, if you are employed bye the City at that time.

The Seasonal Employees Health Status Questionnaire

The Seasonal Employees Medical Care Plan will not provide benefits for any Pre-existing Condition that you, your spouse or your dependents may have including pregnancy. You must complete the Seasonal employees Health Status Questionnaire to provide a health history and a statement of current health status for yourself and all dependents that you wish to enroll in the Seasonal Employees Medical Care Plan. Your Health Status Questionnaire must be submitted before the effective date of your coverage, but no later than 30 days from your date of hire.

If you are enrolling in coverage for yourself you must complete Parts 1 and 2 of the Seasonal Employees Health Status Questionnaire. You must sign and date the form on the reverse side.

If you are enrolling your spouse in the Seasonal Employees Medical Care Plan, you must complete Parts 1, 2 and 3 of the Seasonal Employees Health Status Questionnaire. You must sign and date the form on the reverse side.

If you are enrolling your eligible dependents, you must complete Parts 1, 2 and 3 of the Seasonal Employees Health Status Questionnaire and sign and date the form on the reverse side.

The Seasonal Employees Enrollment Form

You must complete and Enrollment Form indicating that you want coverage for yourself and your dependents. Your enrollment form must be submitted before the effective date of your coverage, but not later than 30 days from your hire date.

- **If you wish to enroll for coverage for yourself you must complete Part 1 of the Seasonal Employees Enrollment Form.**
- **If you wish to enroll your spouse in the Seasonal Employees Medical Care Plan you must complete Part 2.**
- **If you wish to enroll your children, you must complete Part 3.**

Proof of Dependency

Certain documents are required as proof of dependency if you wish to enroll your spouse or dependent children. You have 60 days from your date of hire to submit the necessary documentation to the Benefits Management Division. If you wait more than 60 days to provide proof of eligibility you dependents will not be eligible to participate in the Seasonal Employees Medical Care Plan until the next Open Enrollment Period. Along with an Enrollment Form and the Health Status Questionnaire you must provide one or more of the following documents as Proof of Dependency:

If you are enrolling your spouse:

- **Certified marriage certificate.**

If you are enrolling your children:

- **Certified birth certificate for each child you claim as a dependent, including a newborn child (the birth certificate must contain the names of the child and the parents),**
- **Certified marriage certificate,**
- **Certified divorce decree which shows that you are responsible for coverage, if you and your current spouse are not the two parents shown on the child's birth certificate,**
- **Adoption papers for legally adopted children,**
- **Court orders if you are required to provide coverage for other children,**
- **Proof of mental or physical incapacity for a disabled child,**
- **A statement of academic standing and a paid tuition receipt for children ages 19 – 22, enrolled full-time in an accredited community college, college or university; documentation must be submitted twice a year, in the spring and fall.**

When Coverage Begins

Coverage For You

The Seasonal Employees Medical Care Plan has been set up as part of an Internal Revenue Code Section 125 plan that allows you to pay for coverage with before-tax contributions. Because of this you must complete enrollment before your coverage is effective. Your coverage will be effective on the first day of the month following your date of hire if:

- **You have submitted the Enrollment Form and the Health Status Questionnaire by that date, and**
- **The City begins the required payroll deduction.**

For example, if you are hired on March 5, your coverage will begin on April 1, if you enroll by that date and your payroll deductions begin.

However, if you are confined to a hospital on the day that your coverage is scheduled to begin, coverage will begin when you are no longer confined.

If you do not submit the completed Enrollment Form for Seasonal Employees and/or the Health Status Questionnaire within 30 days of your date of hire, you will not be able to enroll in the Seasonal Employees Medical Care Plan until the next Open Enrollment period, if you are employed by the City at that time.

Your Spouse and Dependents

Your dependents are eligible for coverage at the same time you are, if you submit the Enrollment Form and the Health Status Questionnaire to the Benefits Management Division within 30 days of your date of hire. However, if your dependent is confined to a hospital on the day coverage is scheduled to begin, coverage will begin when your dependent is no longer confined.

You have 60 days from your date of hire to submit the Proof of Dependency document (s), as outlined on page 4. If you wait more than 60 days to submit The Proof of Dependency, your spouse and dependents will not be able to

enroll for coverage until the next Open Enrollment period, if you are employed by the City at that time.

Changing Your Coverage

Each year the Open Enrollment Period, you will be able to add or cancel coverage for yourself or dependents.

Limited Changes During the Year

You'll be able to change your level of coverage during the year only if you have a family status change, such as:

- **Your marriage or divorce,**
- **The birth or adoption of a child,**
- **The death or a covered spouse or dependent,**
- **A covered dependent reaching the limiting age, or**
- **A change in employment status for you or your spouse.**

You must notify the Benefits Management Division of a family status change and submit documentation to support the change with your request. This means you cannot add or drop dependents the year unless:

- **You experience a change in family status, and**
- **You notify the Benefits Management Division within 30 days of the change.**

To change you benefits as a result of a family status change, you must submit a completed enrollment form and provide proper documentation. Payroll deductions cannot be changed unless the Benefits Management Division is notified within 30 days of the event. The change in your payroll deduction will be consistent with your change in family status.

Enrollment Form – A new enrollment form must be completed for every family status change and submitted to the Benefits Management Division within 30 days of the event. You will also be required to submit proof of the change within 30 days of the event. If your enrollment form indicating your request for a change in coverage is not submitted within 30 days, you will not be able to make the change until the next Open Enrollment period (if you are employed by the City at that time).

Health Status Questionnaire – If you are adding a spouse or a dependent child a new Health Status Questionnaire must be completed for each person being added to your coverage. A Health Status Questionnaire is not required for newborns, when one or both of the parents is covered by the Seasonal Employees Medical Care Plan at the time of birth.

Proof of Change – Along with an Enrollment Form and Health Status Questionnaire, you must provide documentation to support the change in coverage. This documentation must be submitted within 60 days of the event for the change in coverage to be effective as of the date of the family status change. If you don't submit the documentation within 60 days of the event, you won't be able to make the change until the next Open Enrollment period (if you are employed by the City at that time).

Maternity Coverage and Coverage for Newborn Children

If the mother was pregnant before the Seasonal Employee's date of hire, she is not eligible for any pregnancy related benefits. <u>This is a pre-existing condition.</u> Only those covered services provided to the newborn will be eligible for payment as of the date of birth, if you submit the following to the Benefits Management Division.

- **An enrollment form within 30 days of the birth,**
- **A certified birth certificate within 180 days of the birth, and**
- **Proof of dependency.**

If You Don't Enroll

If you don't elect to enroll for coverage within the 30 days following your date of hire, you will not be able to enroll until the next Open Enrollment period (if you are employed by the City at that time).

Also, if you decline coverage, you and your eligible dependents will not be able to continue coverage under the Public Health Service Act if you leave the City or experience any other "qualifying event". See the section "Coverage After Termination" on page 34.

Plan Cost

The City pays a substantial portion of the cost of the Seasonal Employees Medical Care Plan. Your share of the cost may change each year.

If you enroll, your cost for coverage will be deducted on a before-tax basis. As a result, your taxable income will be reduced by the amount of your premiums. You won't pay any federal or state taxes (or Social Security or Medicare taxes if applicable) on your premiums. Since your taxable income will be lower, your taxes will be lower as well.

Your cost for medical coverage is based on your hourly wage and the level of coverage you select each time you are hired for seasonal work. (Example: Single, Employee plus one or Family Coverage).

What Your Seasonal Plan Does Not Cover

Pre-Existing Conditions

The Seasonal Plan will not provide benefit coverage for any pre-existing condition you or your dependent may have. A pre-existing condition is any condition for which the employee, spouse or eligible dependent has received treatment, or any condition for which expenses have been incurred during the 180 days immediately preceding the employee's date of hire.

Services That Can Be Avoided or Postponed

The Seasonal Plan will not provide benefit coverage for any medical condition where treatment can be avoided or postponed. Examples of this include:

- **Bunionectomy**
- **Mole Removal**
- **Laparoscopic Knee Surgery**
- **Laparoscopic Tubal Ligations**
- **Elective Surgery**

You or your dependent may be required to obtain an INDEPENDENT MEDICAL EXAMINATION/EVALUATION to confirm that the condition for which you are seeking treatment is not a pre-existing condition and is such that therapy or treatment cannot be avoided or postponed.

Dental Vision Coverage

Seasonal employees are not eligible for dental and vision coverage.

Other Services Not Covered

Other services not covered include those:

- **For treatment of bodily injuries arising from or in the course of any employment**

- **For treatment of sickness or disease for which any benefits are provided under any applicable Workers' Compensation Act or similar law**

- **For any services and supplies for which the employee or dependent is not charged**

- **For any operation on or treatment of the teeth or the supporting tissues of the teeth except:**

  1. **Removal of tumor(s)**
  2. **Treatment of malerupted impacted wisdom teeth**
  3. **Treatment of accidental injury to sound natural teeth (including their replacement) due to an accident occurring while covered under this Plan and**
  4. **Hospital charges for oral surgery while a registered bed patient if Medically Necessary**

- **For medical examinations, treatments or supplies not necessary for treatment of injury, illness, or mental or nervous condition**

- **For eye refractions, eye glasses or the fitting of eye glasses or contact lenses**

- **For cosmetic surgery, except operations necessary to repair disfigurement due to an accident occurring while covered under this Plan, and for Medically Necessary treatment of a congenital anomaly in a Dependent child covered by this Plan**

- **For treatment of injury, illness, or mental or nervous conditions which are occasioned by war, whether declared or undeclared, or in connection with intentionally self-inflicted injury or illness while sane or insane**

- **For services received while in the military service of any country**

- **For treatment considered experimental in terms of generally accepted medical practice**

- **For anything not ordered by a Physician, or not Medically Necessary for the individual's medical care**

- **Charges for In-Hospital Physician visits on days where hospital confinement is not Medically Necessary**

- **Charges in excess of Reasonable and Customary Charges**

- **Charges in excess of those usually made when there is no coverage or in excess of scheduled amounts for the services or supplies involved**

- **For services rendered or supplies obtained on or after the date the coverage of the Employee or Dependent is terminated**

- **For benefits payable to an Employee for Covered Expenses for a Dependent if the Dependent is entitled to Employee benefits as a City employee**

- **For hearing aids or hearing examinations**

- **For immunization and inoculations**

- **For treatment of foot conditions such as trimming or paring of corns and calluses, routine foot care and prescriptions of supportive foot devices**

- **For occupational therapy and speech therapy unless as an inpatient for restoration or correction of a physical impairment**

- **For whole blood or derivatives that are donated**

- **For personal convenience items or special medical equipment**

- **For routine physical examinations**

- **For expenses incurred on behalf of an Employee or Dependent who is enrolled in a Health Maintenance Organization sponsored by the Employer**

- **For medical services or supplies for any custodial care**

- **For charges for failure to keep an appointment or file claims in a specified time period**

- **For any charges incurred by the Employee because the Employee did not go through the Notification Process or incurred expenses that are not Medically Necessary**

- **For services in a nursing home and/or sanitarium other than a Skilled Nursing Facility**

- **For the services of a Registered Clinical Social Worker unless care is ordered or prescribed by a Physician and then only for treatment of mental or nervous conditions and payable under the psychiatric provisions of the Plan**

- **For the treatment of infertility**

How the Seasonal Plan Works

Notification Requirement

To receive full benefits from the Plan, you must contact The Encompass Medical Advisor before you or a covered dependent enters into any form of medical treatment. This includes medical treatment provided at a hospital (either inpatient or outpatient), a physician's office and all other forms of medical treatment, including prescription drugs.

The telephone number at Encompass is:

1-800-373-3727

Encompass Medical Advisors are available 24 hours a day, 7 days a week.

If you or a covered dependent receives outpatient emergency treatment for either a medical condition or an accidental injury, you or someone on your behalf, must contact an Encompass Advisor within 24 hours of when emergency treatment was received.

If you or your covered dependent is admitted to the hospital on an emergency basis, you or someone else on your behalf must call the Medical Advisor within two business days of the admission.

An emergency is defined on page 39. Only services that are certified as medically necessary by Encompass and not the result of a pre-existing condition will be paid. So, it's in your best interest to call as soon as possible after your emergency treatment but no later than two business days after receiving treatment.

Independent Medical Evaluation/Examination

You and your covered dependents may also be required to obtain an independent medical evaluation/examination that confirms that the treatment you are seeking cannot be avoided or postponed. The independent medical evaluation/examination will also confirm that the condition for which you are seeking treatment did not exist prior to your date of hire.

If you are asked to obtain an independent medical evaluation/examination, by Encompass, you will be given the name of physician who will conduct the evaluation/examination. You will be given a form to be completed by the physician. The completed form must be returned to the Encompass Medical Advisor. Also, if you or your dependent fail to notify Encompass, or fail to obtain an Independent Medical Evaluation/Examination when requested, the Seasonal Employees Medical Care Plan will not pay for any care you receive.

Participating Provider Option (PPO)

The Seasonal Employees' Medical Care Plan is the Participating Provider Option (PPO) for hospitals. The Seasonal Employees' Medical Care Plan Participating Provider Option (PPO) for doctors is effective as of August 1, 1994. If you choose doctors and hospitals that are part of the PPO network, the plan will pay a higher benefit than if you use the services of doctors and hospitals not belonging to the network. If you choose a PPO provider:

- **The plan will pay a higher percentage (90%) of many eligible doctor and hospital expenses and**
- **Your calendar year out-of-pocket limit will be lower.**

Refer to the directory of PPO network doctors and hospitals or visit www.bcbsil.com to locate Blue Cross Blue Shield of Illinois current PPO providers.

mind that providers may change from time to time. You should always verify that you are using a PPO physician and/or hospital before receiving services.

Reasonable and Customary Charges

The Plan pays benefits for reasonable hospital, surgical and other eligible medical expenses resulting from an illness or injury, for you and your covered dependents. Reasonable and customary charges are those that are the same as, or compare fairly with, charges made for similar services or supplies in the geographic area where expenses are incurred.

The Seasonal Employees Medical Care Plan does not cover charges above the reasonable and customary limit as initially determined by the claims administrator, subject to the appeals procedure. The plan will not pay:

- **Any amount incurred that exceeds what is reasonable and customary in the geographic location where the expenses are incurred,**
- **For a service or supply that is not generally accepted in medical practice, or not considered medically necessary or needed for the diagnosis or treatment of a condition, or**
- **For charges in excess of the PPO maximum allowable charge.**

If your expenses are more than the reasonable and customary amount, you will be responsible for the amount that is in excess. That amount cannot be applied toward your deductible (explained below); it will not be covered by the plan once the deductible is satisfied; and, it will not be applied toward your out-of-pocket limit (explained on page 16.)

Your Share of the Expenses

Deductible

All benefits are paid after the deductible has been met. The deductible is the portion of your medical expenses that you pay before the plan pays benefits. The annual deductible for seasonal employees is:

- **$150 for an individual, and**
- **$250 for a family.**

The expenses of all covered family members will be combined to meet the family deductible. However, at least one person in the family must meet the $150 individual deductible before expenses are combined to meet the family deductible.

Carryover Provision

If you do not meet your deductible before December 31 of any year, covered medical expenses that are incurred in October, November or December will be applied to the deductible for the following year if no benefits were paid by the plan during the year.

For example, if you incur $100 of eligible expenses between October and December and receive no benefit from the plan, you'll need only $50 of eligible expenses to meet the individual deductible for the next year.

Out-of Network Deductible

There is an additional $300 deductible for each admission to a hospital outside the PPO network. The maximum inpatient deductible amount each calendar year is two for a family. This $300 deductible is applied to the out-of-network, out-of-pocket limit.

Co-payment

After you've paid the calendar year deductible, the plan will pay a percentage of your eligible reasonable and customary expenses. You pay the remaining portion. This feature is called the co-payment. The amount of the co-payment depends on the type of expense and whether you use the PPO network.

Out-of-pocket limit

The plan places a limit on the amount of money you will have to pay for

eligible medical expenses each calendar year. Once your share of expenses (deductible and co-payment) reaches the out-of-pocket limit, the plan will pay 100% of eligible medical expenses for the rest of the calendar year. There is one exception. If you reach your out-of-pocket limit during your first inpatient hospital confinement for mental health or substance abuse treatment in a PPO or out-of-network (non-PPO) hospitals. And, it's possible that you can have separate out-of-pocket limits. For example, if you incur expenses for services both in an out of the PPO network, one out-of-pocket limit will apply to expenses incurred in the network and another out-of-pocket limit will apply to expenses incurred outside the network.

Out-of-Pocket Limit

	For Services Obtained In the PPO Network	For Services Obtained Outside the PPO Network
Individual	**$1,000**	**$3,500**
Family	**$2,000**	**$7,000**

However, the following expenses will never count toward the out-of-pocket limit:

- **Second and subsequent courses of in-network inpatient substance abuse treatment and**
- **All courses of out-of-network inpatient substance abuse treatment.**

See the Section on Mental Health and Substance Abuse Treatment on page 28 for more information.

Maximum Benefit

Each covered person can receive $1.5 million in benefits during his or her lifetime while enrolled in the plan. Any expenses paid by previous City of Chicago plans will be included in your lifetime maximum.

Mental Health and Substance Abuse Treatment Maximums

The combined maximum benefits for inpatient and outpatient mental health and substance abuse treatment are as follows:

Maximum Benefit For:	Maximum Covered Expense
Individual (annual)	**$ 37,500**
Individual (lifetime)	**$250,000**
Family (lifetime)	**$500,000**

These maximums count toward the overall plan maximum of $1.5 million. Keep in mind; co-payments for your first inpatient treatment for substance abuse received from an in-network hospital will count toward the out-of-pocket-limit.

The lifetime maximum for mental health and substance abuse treatment includes all expenses incurred from the date the plan amendment was implemented for your bargaining unit or employee group.

Filling Your Claims

To file a claim under this plan, all you need to do is show your identification card to the hospital, doctor or other provider when you receive services. If you assign benefits to the hospital or doctor they will file the claim for you and they will be reimbursed directly according to the plan provisions. However, it is your responsibility to ensure that the necessary claim information has been provided to the claims administrator.

If you pay for a service, you will have to file a claim directly with the claims administrator. To file your own claims, you must provide the claims administrator with the following information:

- **Copies of the itemized bills to be considered for benefits. The bills must include the following information:**

  1. **Provider's name and address.**
  2. **Patient's name,**
  3. **Diagnosis,**
  4. **Date and description of service, and**
  5. **Amount of charge.**

- **Your name, the plan code (found on your identification card) and your Social Security number, and**

- **The patient's name, date of birth, and sex.**

Mail the above-listed information to:

Blue Cross and Blue Shield
300 East Randolph
Chicago, Illinois 60601
ATTN: MAC Dept., 6th FLOOR

Claims must be submitted for processing within two years of the date service is received to be considered for benefits. No claims will be paid if the employee failed to get the necessary approval from the Encompass Medical Advisor or the treatment was received for a pre-existing condition.

Coordination of Benefits (COB)

Many individuals have medical coverage in addition to this plan. For example, you may be covered as a dependent under your spouse's plan or your parent's plan. The Seasonal Employees Medical Care Plan works with other group plans to reimburse up to 100% of allowable health care expenses for you or your dependents.

An allowable expense is any expense covered at least in part by this plan. The maximum amount payable by this plan is limited to the amount that would have been paid if there were no other plans involved.

The following types of plans will be coordinated with the Seasonal Employees Medical Care Plan:

- **No-fault automobile insurance plans,**
- **Other group health care plans or plans covering individuals or members of a group,**
- **Group hospital service prepayment plans, group medical service prepayment plans, group practice or other group prepayment coverage and**
- **Government programs (not including Medicare or Medicaid).**

How COB Works

Here's how other benefits are coordinated when a claim is made:

- **The primary plan pays its benefits first without regard to any other plan and**
- **The secondary plan adjusts its payments so that the total benefit paid will not be greater than your allowable expense.**

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision, here's how benefit payments will be determined:

- **The plan covering the patient directly, rather than as a dependent, will be the primary plan.**
- **If a child is covered under both parents' the plan covering the parent whose birthday comes first in a calendar year is the primary plan. If both parents have the same birthday, the plan of the parent**

who has been covered longer is the primary plan. If the other plan does not have this rule but has a rule based on the gender of the parent, then the rule of the other plan will determine the order of benefits.

- **If you are separated or divorced, the order will be as follows:**

  _If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is primary, then

  _The plan of the parent with the custody of the child, then

  _The plan of the step-parent married to the parent with custody of the child, then

  _The plan of the parent that does not have custody of the child.

- **The plan of the person who is not laid-off or retired will be primary over the plan of the person who is laid-off or retired.**

- **When a determination can't be made, the plan that has covered the person longest will be considered primary.**

The Seasonal Employees Medical Care Plan will pay the benefits explained in this handbook when this plan is the primary plan. When this plan is the secondary or later plan, it will usually pay the difference between benefits paid from the primary plan and the benefits provided by this plan. However, the total benefits paid will not be more than what would have been paid if this plan was primary.

If You Are Eligible For Medicare

If you are age 65 or over, you can elect this plan or Medicare as your primary coverage. If you elect this plan as your primary coverage, the benefits described in this booklet will apply to you. If you elect Medicare as your primary coverage, you will not be covered by this plan. If your covered spouse is age 65 or over and elects this plan as primary coverage,

the benefits described in this handbook will apply to him or her. If your spouse elects Medicare as primary coverage, he or she will not be covered by this plan.

The City will assume that this plan is primary unless you notify the Benefits Management Division that you or your spouse have elected Medicare as your primary coverage.

Reimbursement Provision

If you or your dependents are injured and benefits are paid by this plan:

- **You must immediately reimburse the plan for any money collected, whether by action at law, settlement or otherwise, to the extent that the plan has provided benefits to or on behalf of you or your dependents.**

- **The plan may have a lien, to the extent of benefits provided. A lien may be filed against the person whose act caused the injury, the person's agent, or with a court having jurisdiction in the matter.**

- **The plan requires that you provide information and assistance to execute documents or other instruments that the plan may require to enforce the plan's rights and that you take no action that will prejudice these rights. The plan reserves the right to withhold or delay payment of any benefits until all required documents have been received from you.**

If your Claim is Denied (Appeal Procedure)

If all or part of your claim is denied, you have the right to challenge the decision by sending a written request for review to the claims administrator, in care of:

Blue Cross and Blue Shield
300 East Randolph
Chicago, Illinois 60601
ATTN: MAC Dept., 6th FLOOR

If you are not satisfied with the decision of the claims administrator, you can then appeal the decision by sending a written request for review to the Benefits Manager. The Benefits Manager will review the claim and notify you of a denial within five business days after the denial of eligibility or a claim. You can appeal the denial by submitting a written request to the Benefits Committee no later than 30 calendar days after the notice of denial by the Benefits Management Office. Your written request must state why you think your claim should not have been denied. You must include all supporting medical or eligibility documentation.

The Committee members include the Budget Director, the City Comptroller, the Commissioner of personnel, the Benefits Manager and the Chairman of the Committee on Finance, or whomever they designate.

Correspondence with the Committee should be addressed to:

City of Chicago
Department of Finance
Benefits Management Division
333 South State, Room 400
Chicago, Illinois 60604-3978
ATTN: Benefits Committee

What the Seasonal Plan Will Cover

Covered Services and Supplies

The following schedule of benefits does not apply to Pre-existing Conditions or to treatments, which can be avoided or postponed.

No benefits will be paid to a seasonal employee, who fails to contact The Encompass Medical Advisor prior to beginning any medical treatment, except in the case of an emergency. In case of an emergency, you or someone else on your behalf, must contact an Encompass Medical Advisor with 24 hours of receiving emergency medical treatment for you or a covered dependent.

If you or your covered dependent is admitted to the hospital on an emergency basis, you or someone else on your behalf must call the Medical Advisor within two business days of the admission. Only the days that are certified by Encompass, as medically necessary and not the result of a pre-existing condition will be paid. So, it's in your best interest to call as soon as possible after your emergency admission.

All expenses are subject to reasonable and customary provisions and must be medically necessary. The level of reimbursement (50% to 90%) depends on whether services are provided in or out of the preferred provider network.

Doctor Visits

The PPO Physician Network includes doctors from virtually every medical specialty, as well as chiropractors and licensed clinical social workers (subject to Physician supervision). Eligible expenses for network doctors' services will be paid at 90%, after the deductible is met. Services obtained outside the PPO network will be reimbursed at 70% after the deductible.

Doctor's services for outpatient mental health or substance abuse treatment will be paid at 80% after the deductible. The network does not apply to these services.

The plan offers no coverage for routine annual exams, immunizations, inoculations, well-baby care or preventive care.

Durable Medical Equipment

Rental or purchase (if purchase is more cost effective) of durable medical equipment is covered at 90%, after the deductible is met, when approved by the Medical Advisor. Durable medical equipment includes wheelchairs, hospital-type beds, oxygen equipment or other medical supplies used exclusively for treatment of any injury or illness. Expenses to rent durable medical equipment will be applied against the purchase price if you later decide to buy the equipment. Rental and/or purchase costs paid by the plan will never be greater than the cost to purchase the equipment.

Emergency Services

Emergency accident and emergency medical care will be paid at 90%, after the deductible has met, whether or not you go to an in-network hospital. The hospital admission deductible does not apply to emergency care obtained outside the network.

In-network Benefits for Out-of-Network Care

In-network benefits will be paid for the following out-of-network care or services:

- **Emergencies defined as the sudden and unexpected onset of a medical condition with such severe symptoms that the lack of immediate medical attention could lead to serious and permanent medical consequences.**
- **Care ordered by a doctor which after review by the Medical Advisor, is:**
    - **Medically necessary,**
    - **Not for treatment of a pre-existing condition,**

- **Care which cannot be avoided or postponed, and**

- **Only available at an out-of-network hospital, or the proposed treatment is performed so infrequently in-network that receiving care at an out-of-work hospital is medically appropriate, or**

- **Available at an in-network hospital to which you can be safely transported if the cost of the transfer is paid by the plan (care at the out-of-network hospital would be covered by the plan only until you can be safely moved to an in-network hospital; arrangements to move to an in-network hospital should begin when the treatment plan begins),**

- **Care provided beyond a 50 mile distance (from any in-network hospital) if you are living away from home temporarily, or**

- **When doctor services are only available from an Out-of-Network doctor or the services are performed so infrequently In-Network that performance of the services by an Out-of-Network doctor is medically appropriate.**

Hospital Services

Inpatient Services

Once you satisfy the deductible, approved inpatient hospital services are covered at:

- **90%, if you go to a hospital that's part of the PPO network, or**
- **60%, if you go to a hospital outside the PPO network.**

Eligible Services include:

- **Semi-private room,**
- **Intensive care,**
- **Medical and surgical nursing care,**
- **Diagnostic tests,**
- **Supplies, and**
- **Medications.**

If your admission is for an emergency and hospital care is appropriate, and it is not for the treatment of a pre-existing condition, your hospital stay will be paid at 90% after the calendar year deductible is met.

Remember, there is an additional $300 deductible for each hospital admission if you obtain services outside the PPO network. The maximum out-of-network inpatient deductible amount is two deductibles for a family.

Outpatient Services

Generally, outpatient hospital services are covered at 90%, after the deductible (for treatment that cannot be avoided or postponed or that is not for a pre-existing condition), depending on whether you use a PPO network hospital. Eligible outpatient hospital services include:

- **Diagnostic tests**

- **Emergency room treatment and**
- **Outpatient surgery.**

Expenses for outpatient services received at a not-PPO-network hospital will be applied to the non-PPO-network out-of-pocket-limit.

Mental Health and Substance Abuse Treatment

Benefits for inpatient treatment of mental health will be paid at:

- **90%, after the deductible if you go to a PPO network provider and treatment is not for a pre-existing condition and cannot be avoided or postponed, or**
- **60% after the deductible if you go to a non-PPO network provider and treatment is not for a pre-existing condition and cannot be avoided or postponed.**

If you go to a non-PPO network provider, in addition to the calendar year deductible ($150 for an individual or $250 for a family), the inpatient out-of-network deductible ($300 for each admission will apply.)

Inpatient Substance Abuse Treatment

The plan will pay benefits for approved inpatient substance abuse treatment at the rates described in the chart below if the treatment is not for a pre-existing condition and cannot be avoided or postponed. A new course of treatment begins when 30 or more days have passed during which no treatment was received.

Course of Treatment	In-Network	Out-of-Network
First	90%	75%
Second	80%	60%
Subsequent	50%	0%

A course of treatment and the benefits that are paid are determined over a lifetime, not a calendar year. For example, let's assume you begin a course of treatment in October that lasts for two months. Then, you stop treatment for three months and you begin again in March. Since there was a period of more than 30 days that you did not have treatment, the treatment that begins in March is considered your second course of treatment.

As you can see the plan pays a greater benefit for treatment received in an in-network hospital rather than an out-of-network hospital. For example, if your first treatment is obtained through the PPO network, expenses would be paid at 90%. However, if the second treatment is received at a facility outside the PPO network, those services would be covered at only 60%, after the out-of-network deductible is met. Co-payments after the first in-network treatment will not count toward any out of pocket limit.

If the first course of treatment is received at a free-standing substance abuse facility it will be paid at 90%, after the deductible, if your stay was pre-approved by the medical advisor. This will be considered in-network treatment and your co-payment will count toward the out-of-pocket-limit.

Alternatives to Inpatient Treatment

There are certain alternatives to inpatient mental health and substance abuse treatments, such as:

- **Residential treatment**
- **Partial hospitalization**
- **Structured outpatient treatment**

If your alternative treatment for mental health is approved by the Encompass Medical Advisor and is not for treatment of a pre-existing condition and cannot be avoided or postponed, benefits will be paid as follows:

- **90%, after the deductible for in-network treatment, or**
- **60%, after the deductible for out-of-network treatment.**

If your alternative treatment for substance abuse is approved by the Encompass Medical Advisor and is not for treatment of a pre-existing condition and cannot be avoided or postponed, benefits will be paid according to the benefits schedule for substance abuse on page 29.

Outpatient Mental Health and Substance Abuse Treatment

Benefits for eligible outpatient mental health and substance abuse treatments which are not for treatment of a pre-existing condition and which cannot be avoided or postponed, will be paid at 80%, after the deductible, when approved by the Medical Advisor.

The maximum covered expense is $100 for each session. For example, if your bill for one session of treatment is $200, the most the plan will pay is 80% of $100 or $80. The maximum covered expense is $5000 per calendar year, per covered individual.

Benefits are only paid for a primary DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders-Third Edition, Revised) diagnosis or a diagnosis under a subsequent revision of the manual.

Prescription Drugs

The Seasonal Plan will not provide benefits coverage for any prescription drug, which is prescribed for the treatment of a pre-existing condition or one that can be avoided or postponed. If you are given a prescription by your doctor and you wish to be reimbursed for the cost, you must first call the Encompass Medical Advisor, even if you had contacted the Medical Advisor before seeking treatment. If the Medical Advisor approves the prescription, you will be eligible for reimbursement.

The cost of approved prescription drugs will be reimbursed at

- **90%, after the deductible, for generic drugs and for brand name drugs when no generic drug is available and**
- **90% of the generic cost if you get a brand name drug that has a generic equivalent.**

Non-Equivalent Generic Drugs

There are certain brand name drugs, which have generic equivalents that have not proven to be effective substitutions as determined by the State of Illinois. These brand name drugs will be paid as generic drugs.

Prosthetic Appliances

The Seasonal Plan will not provide benefit coverage for prosthetic appliances prescribed in the treatment of a pre-existing condition or one that can be avoided or postponed.

Approved prosthetic appliances, such as artificial limbs or other medically necessary prosthetic devices, are covered at 90%, after the deductible is met.

Certain replacement prosthetics are not covered. However, the plan will cover certain medically necessary prosthetic replacements inserted in the inner body, such as knee, hip, elbow and ankle replacements, heart valves and pacemakers.

Speech and Occupational Therapy

The Seasonal Plan will not provide benefit coverage for speech or occupational therapy prescribed in the treatment of a pre-existing condition or one that can be avoided or postponed.

Approved inpatient treatment by a qualified speech therapist to restore speech loss resulting from an injury or illness is covered at 90%, after the deductible. Also, inpatient occupational therapy by a physiotherapist is covered at 90%, after the deductible.

Outpatient speech and occupational therapy are not covered by the Seasonal Plan.

When Your Coverage Ends

Your coverage will end:

- **If the plan is discontinued,**
- **When you are no longer part of an employee group covered by this plan,**
- **When you leave City employment for any reason other than disability,**
- **On the date it is determined that you have knowingly presented bills for services that haven't been received or for a dependent who isn't eligible,**
- **After the fifth consecutive day that you are absent without pay (however, if you are an hourly employee in the Labor and Trades Coalition Bargaining Group and you make the required employee contribution, your coverage will continue through the last day of the month after the month in which the first day off without pay occurred),**
- **After the 31st day of a suspension lasting longer than 30 days,**
- **When you fail to make the required contributions,**
- **If you receive a lifetime award from the Industrial Commission,**
- **When you have completed 365 days of service as a seasonal employee, or**
- **When you die.**

Continuing Coverage

As an Active Employee

If you have completed 365 days of service as a seasonal employee, you are eligible to participate in the City of Chicago Medical Care Plan for Employees. In order to enroll you must first contact your department timekeeper to determine your continuous service date. You may then select any medical plan currently available to eligible full-time City of Chicago employees. You will not be eligible for Dental coverage.

As an Inactive Employee

The Benefits Management Division administers a direct pay program so that certain inactive employees can continue benefits. Benefits may be continued under the following circumstances:

- **If you are receiving Workers' Compensation benefits, other than a lifetime award from the Industrial Commission, you may continue coverage for yourself and your eligible dependents for the length of the benefits, if you make the required employee contributions.**
- **If you are receiving both Duty Disability benefits from an employer pension plan and a lifetime award from the Industrial Commission, you may continue coverage for your eligible dependents only for the length of the Duty Disability pension benefits, if you make the required employee contribution. You may not continue benefits for yourself.**
- **If you are receiving Duty Disability, you can continue coverage for the length of the Duty Disability benefits, if you make the required employee contributions.**
- **If you are suspended for more than 30 days, you may continue your coverage after the 30th day by paying the full cost of coverage for the length of the suspension.**

When Your Dependent's Coverage Ends

Coverage for your dependents ends at the same time your coverage ends (or earlier if your dependent no longer qualifies for coverage). However, your dependent can continue medical benefits under the following circumstances:

- **If you are killed in the line of duty, your dependent's coverage will continue at no cost to your spouse until the earlier of:**
  - **The date your spouse reaches age 65 or**
  - **He or she remarries.**

Coverage for your dependents will continue until they are no longer eligible dependents (as defined on page 1)

- **If you die under circumstances other than being killed in the line of duty, your dependent's coverage will continue at no cost for the lesser of 90 days or until they are no longer eligible dependents**

If your dependent is totally disabled benefits will continue, at no cost for expenses incurred for that continuing disability, only as follows:

- **For three months for hospital benefits,**
- **For the period of time your dependent was covered by the plan if 12 months or less, for non-hospital benefits, or**
- **Until the date he or she is covered under another plan that will pay expenses related to the disability for non-hospital benefits, if less than the above stated time frames.**

Coverage After Termination

In accordance with the Public Health Service Act, (PHSA) when coverage under the Seasonal Employees Medical Care Plan ends, you or your covered dependents may be eligible to continue your medical benefits at your own expense for a temporary period. To be eligible, a "qualifying even"

causing the loss of coverage must occur.

The benefits provided will be the same as those offered to eligible Seasonal employees who are covered under the Seasonal Employees Medical Care Plan. If the plan or cost for active seasonal employees changes, the plan or costs will also change for former seasonal employees and/or their dependents. The following chart shows who is eligible to continue under the plan and how long coverage may continue.

Qualifying Event (The reason coverage ended)	Who May Continue	Longest Period of Continuation
Your termination	**you, spouse and Dependents**	**18 months***
You die	**spouse and Dependents**	**36 months**
You drop out of The plan because You choose Medicare As primary coverage	**non-Medicare eligible spouse and dependents**	**36 months**
You Divorce or Legally separate	**spouse and dependents**	**36 months**
Your dependents are No longer eligible (because they reach the limiting age, get married or are no longer full-time students)	**dependents**	**36 months**

*If you or a dependent is disabled (as determined under the Social Security Act) at the time of the qualifying event, coverage may be continued for up to a total of 29 months.

The continuation coverage will stop before the maximum continuation period shown in the chart if one of the following events occurs:

- **Failure to pay the full cost for coverage on or before the due date**
- **Submitting a check for non-sufficient funds (NSF) as payment for your premium**
- **Coverage is started under another group health plan, unless coverage is delayed or denied because of a pre-existing condition, which was not considered pre-existing under the Seasonal Plan**
- **If you or your dependent (S) become entitled to Medicare**
- **The City discontinues medical coverage for its employees**

Multiple Qualifying Events

If coverage continues because of a qualifying event for which the continuation period is 18 months, this 18-month period may be extended under certain limited circumstances, for a longer period of time, but not longer than 36 months from your original qualifying event.

Coverage Cost

If you or your dependent (s) choose to continue coverage, you will have to pay the full cost of the coverage, plus 2% for administrative charges.

How To Apply for Continuing Coverage

All PHSA election enrollment forms and all monthly payments must be sent directly to the Health Care Service Corporation (HCSC), not the Benefits Management Division.

Please contact HSCS for further continuation of coverage information:

Health Care Service Corporation (HSCS)
21806 Network Place
Chicago, IL 60673-1218
1-888-541-7107

You will be notified of the opportunity to continue coverage for the following reasons:

- **You lose coverage because your employment ends,**

- **You die, or**

- **You notify the City that you have chosen Medicare as your primary coverage.**

You or your dependent (s) must elect, within 60 days of the date of the notice, whether or not to accept continuation coverage. If you decide to continue coverage you must return the full payment within 45 days of your election.

You or your dependents must notify the Continuation Coverage Administrator at the Benefits Management Division within 60 days of:

- **Your divorce,**

- **Your legal separation,**

- **Your losing dependent status, or**

- **Your death.**

Keep in mind that failure to provide the required notice will result in the loss of eligibility to continue benefits.

Converting Your Medical Coverage

If you leave City employment or when your continuation coverage ends, you can apply to Blue Cross and Blue Shield for an individual policy within 31 days after coverage ends. The benefits and provisions of the individual policy may differ from the City's plan. When a dependent's coverage ends, he or she can also convert to an individual policy within 31 days after coverage ends. It is your responsibility to obtain forms from Blue Cross and Blue Shield and to apply for coverage.

Definitions

Certain terms have a special meaning under the Seasonal Employees Medical Care Plan:

Accidental Injury – **A severe injury that requires immediate attention by a doctor.**

Benefits Committee – **Oversees the administration of the plan, interprets plan provisions and makes rulings on appeals.**

Before-tax Premiums – **Your cost for coverage will be automatically deducted on a before-tax basis. Your taxable income will be reduced by the amount of your premiums. You won't pay any federal or state taxes (or Social Security or Medicare, if applicable). Since your taxable income will be lower your taxes will be lower as well.**

Claims Administrator – **Care that is provided at a nursing facility or at home when a patient's condition is such that further progress is not expected and medical treatment is not provided, except that the patient is aided through supplies and services in normal daily life activities, such as walking, bathing, eating and reassign.**

Custodial care also includes care that could be provided safely and reasonably by a person who is not medically skilled.

Doctor (or Physician) – **A legally qualified practitioner of the healing arts acting within the scope of his or her license.**

Elective Treatment – **Treatment for a medical or psychiatric condition which if avoided or postponed would not result in jeopardy to the patient's life or cause serious harm to the patient's health.**

Emergency Accident Care – The initial outpatient treatment of an accidental injury, including related diagnostic service received with 72 hours of the accident.

Emergency Medical Care – The initial outpatient treatment, including related diagnostic service, of the sudden and unexpected onset of a medical condition, which has severe symptoms, and is received within 24 hours of the onset of symptoms. If immediate medical attention is not obtained, the symptoms could result in serious and permanent medical consequences. Examples of such symptoms are severe chest pains, convulsions or persistent, severe abdominal pains.

Family Status Change – Allows you to add or discontinue plan coverage for eligible dependents at a time other than the annual enrollment period. Such changes include:

- **A change in marital status (marriage, divorce or legal separation)**
- **The birth or adoption of a child**
- **The death of an eligible dependent**
- **A change in your or your spouse's employment status (such as a reduction in hours) which includes the loss of health insurance**
- **A dependent child reaching the age limit for the plan**

Home Health Care – A public or private agency or organization that provides skilled nursing and services in the home by registered nurses under a physician's or registered nurse's supervision. The agency must keep clinical records on all patients.

Hospice – An organization that provides a centrally administered program of palliative (relief from pain) and support services to the terminally ill and their families. Services are provided by a medically supervised team of professionals and volunteers.

Hospital – an institution that:

- **Is licensed as a hospital in the jurisdiction where it is located,**
- **Provides 24 hour a day skilled nursing services by registered nurses,**
- **Keeps a medical record of each patient,**
- **Keeps an ongoing quality assurance program with review by doctors,**
- **Charges for its services and supplies, and**
- **Although it provides medical or psychiatric treatment, it is not mainly:**

  - **A nursing home, convalescent, or extended care facility**
  - **A place for rest or the aged,**
  - **A place for drug addicts or alcoholics**
  - **A place that provides educational or behavior modification services in a residential setting for children or adolescents with behavioral or social problems, mental retardation or autism,**
  - **A place of career advice, job training or vocational rehabilitation, or**
  - **A place to reside, play or exercise.**

Independent Medical Evaluation/Examination – A consultive examination and evaluation by a licensed physician prior to beginning any course of medical treatment to confirm that the patient's condition is not pre-existing and that treatment cannot be avoided or postponed.

Medical Advisor Review Program – A health care function offered by the City to certify hospital confinements for you and your dependents, explain alternatives to hospital care and facilitate the early discharge of a hospital patient. Information shared with the medical advisor will be confidential medical information. This information may not be obtained by other employees, the City or any other individual or organization for any purpose unless the patient, or a person who the patient designates, authorizes the release of the information in writing.

Medical Care – Care and treatment by a doctor, including the professional services of a radiologist, pathologist or other specialist acting within the

scope of his or her license. The care or treatment must be for a service covered under the plan.

Medically Necessary – A service, supply or course of treatment that is customary for the treatment of an illness, injury or mental or nervous condition and is consistent with generally accepted medical standards. The service, supply or course of treatment must not involve the use of drugs, which are not approved by federal authorities. The eligible expense must be certified as medically necessary.

The claims administrator will initially determine if a service or supply is medically necessary. The plan will not pay for the cost of hospitalization or any other health care services or supplies that are not medically necessary. The judgment of the claims administrator relates only to benefits coverage under this plan. You should not use the availability of benefits coverage to determine what medical care or treatment you or your dependents decide to receive.

NOTE: Hospitalization, for purposes of your benefit coverage only, will be determined to be medically necessary when the medical services you receive require a hospital inpatient setting. If services could appropriately be provided in your doctor's office, the outpatient department of a hospital or some other setting without adversely affecting your condition, hospitalization will be considered not medically necessary.

Nursing Care – Medical care of an illness, injury or mental or nervous condition by a nurse:

- **Who is not a member of your or your dependent's immediate family, or**
- **Who does not live in your home or your dependent's home**

Nurse means a registered graduate nurse (RN) or a licensed practical nurse (LPN).

Notification – **An employee or dependent must contact The Encompass Medical Advisor prior to beginning any form of medical treatment. If you are admitted to the hospital for emergency care, you or someone else on your behalf must call the medical advisor within two business days of your admission. Benefits are not paid if the Medical Advisor is not notified.**

Pre-existing Condition – **Any condition for which an employee, employee's eligible spouse or eligible dependent has received treatment or incurred expenses for the treatment of, during the 180 days immediately preceding the employee's date of hire.**

Prescription Drugs – **Drugs or medicines that require a doctor's signature to dispense and are approved by the U.S.F.D.A. for use in treating the illness or injury for which they are prescribed.**

Reasonable and Customary Charge – **The lowest of the following:**

a) **The usual charge by the Doctor for the same or similar services or supplies,**
b) **The usual charge of Doctors or providers of similar training or experience in the same area or a similar geographic area for the same or similar services or supplies,**
c) **The agreed charge for services subject to the contract between the PPO Network and the participating provider,**
d) **The actual charges for the service or supplies,**
e) **The term "usual charge" as set forth in (a) and (b) above shall be determined by using the reasonable criteria of the Claims Administrator as of the date of service.**

Seasonal Employee – **A full-time employee who is employed in a job title for a period not to exceed 180 calendar days for temporary work related to or caused by seasonal needs. Such appointments shall expire automatically at midnight on the 180th day.**

Skilled Nursing Facility – A licensed institution (other than a hospital) that specializes in inpatient physical rehabilitation, skilled nursing or medical care. The skilled nursing facility must:

- **Maintain all facilities necessary for medical treatment,**
- **Provided treatment under the supervision of doctors,**
- **Provide nursing services 24 hours every day, and**
- **Maintain daily clinical records on all patients.**

A skilled nursing facility does not include any institution or part of an institution that is used primarily for educational care, custodial care, or for the care and treatment of drug addiction or alcoholism.

Sudden and Serious Illness – Any condition or symptom which becomes so acute in nature and which is of such severity that it constitutes an extremely hazardous medical condition which would result in jeopardy to the patient's life or cause serious harm to the patient's health if not treated immediately.

Total Disability – Means that you as the employee are prevented, solely by reason of a disease or accidental bodily injury, from engaging in your regular occupation and are performing no work for any kind of compensation or profit; or as the dependent, you are prevented, solely by reason of a disease or accidental bodily injury, from engaging in substantially all of the normal activities of a person of similar age and sex in good health.