Agency Exhibits

Specification No.: CBO-2019-01

Request for Proposal for
Healthcare PPO/HMO, Medical Review Services,
Vision, Dental PPO/HMO

- City of Chicago
- Cook County – Active Employees
- Cook County Pension Fund
- City Colleges of Chicago
- Chicago Park District

City of Chicago Agency Exhibit

- Open Enrollment Guides for 2019. These guides include provisions for medical PPO and HMO, dental PPO and HMO, vision benefits, and provisions relating to Medical Review Services such as the schedule of services for which Members must contact Medical Review Services Vendor ,mandatory second opinions and the maternity management program, as well as other matters.
    - Open Enrollment Guide for Group A – All employees except sworn police officers below the rank of sergeant.
    - Open Enrolment Guide for Group B – Sworn police officers below the rank of sergeant
- Link to Plan Documents for medical plans for Group A, Group B and retirees
- Retiree Medical
    - Medicare eligible retiree plan Summary Sheet
    - Non-Medicare eligible retiree plan Summary Sheet
- Dental Blue Cross Blue Shield Summary handbooks
    - Dental PPO
    - DMO (Dental HMO)
    - Seasonal Employees
- Vision Benefits
- Insurance Requirements
- Economic Disclosure Requirements
- MBE/WBE Requirements
- Sample Professional Services Agreement, including mandatory Terms and Conditions common to City of Chicago contracts
- Disclaimer: 2019 Agency Exhibits for Provider Proposed To Be Selected Effective 1/1/2020 and in Future Years

City of Chicago

Open Enrollment Guides

- Group A – Employees Other Than Sworn Police Officers Below The Rank of Sergeant
- Group B – Sworn Police Officers Below The Rank of Sergeant
- Group C – Seasonal Employees

CHICAGO
BENEFITS OFFICE

HEALTHCARE AND OTHER BENEFITS
OPEN ENROLLMENT GUIDE
2019

CITY OF CHICAGO

For non-represented employees, and for employees covered under the City's collective bargaining agreements with: The American Federation of State, County and Municipal Employees 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, and 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, and 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.

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Chicago Labor Management Cooperation Committee

October 2018

Dear Employees:

For the past 12 years, the City of Chicago and labor representatives, working together in the Labor Management Cooperation Committee (LMCC), have been engaged to keep your employee benefits package working for you. Below we have listed a few highlights from 2018:

1. A recent report to the LMCC on the ***Chicago Lives Healthy*** **Wellness Plan** showed results since the program began in 2012. Primarily, the Wellness Plan appears to have improved member awareness. In addition, members showed behavioral and status improvements. For example, the number of individuals deemed to be "high-risk" for developing cardiovascular disease decreased by 17% over the six years of the program (from 2012 to 2018). Likewise, the number of individuals at "elevated risk" for developing diabetes decreased by 8%.

2. Part of the **Wellness Plan** involves special outreach, the Health Improvement Plan, or HIP, for members who were identified by Telligen as being at-risk, based upon biometric screening. This includes members with metabolic syndrome, who may have special risk for developing type 2 diabetes and/or cardiovascular disease. Telligen reported that 97% of the HIP participants displayed signs of metabolic syndrome in their first screening for the wellness program. But the percentage of those same HIP participants with metabolic syndrome dropped to 54% in 2018—in other words, 43% of the HIP participants improved their health status enough to no longer have metabolic syndrome.

3. The LMCC received a $95,000 grant from the **Federal Mediation and Conciliation Service**. With Blue Cross, Healthways and Telligen, the LMCC used the grant to study new ways of communicating with members to increase engagement. The pilot outreach program is focusing on telemedicine, preventive dental hygiene, hypertension and hyperlipidemia.

4. An additional, voluntary program for members with **hypertension and hyperlipidemia** started in 2018. Members receive counseling related to nutrition, weight reduction and increased physical activity.

5. With Blue Cross, the LMCC continues its **telemedicine program**, also known as **Virtual Visits**, through an entity called **MDLive**. Check out the ease of accessing Board-certified doctors right from your own home. A quick call to MDLive can save time and trouble—the MDLive "doctor is in" 24/7! Go to MDLive.com/bcbsil or call 1-888-676-4204 for more information.

6. **Best Doctors**, the program for second opinions that started in 2017, reported continued success in 2018. Best Doctors offers timely, highly respected second opinions. They also offer counseling for chronic conditions, answers to treatment questions and can help you locate an in-network specialist who is a "Best Doctor." Members used this service for, among other things, to receive information on treatment options for orthopedic complaints.

7. **Tiered PPO plan:** In-network PPO hospitals, doctors and other providers are in one of two tiers in the OPT PPO plan. Tier I providers offer the most savings for both the City and members; Tier II providers have higher co-payments and out of pocket expense for members. Members can choose providers from either tier, and they can go back and forth between tiers during the year at each provider visit. The tier approach has realized substantial savings in a number of areas for both the plan and LMCC members.

8. **Emergency Room Use:** On its website Blue Cross posts many alternatives to emergency rooms. Members save for themselves and for everyone by using urgent care centers, retail clinics, telemedicine (MDLive) and after-hour physicians.

We ask our members to take advantage of all the programs and information that we continue to offer.

The LMCC thanks you for all your help in slowing down the growth of health benefit costs. We look forward to working with you to continue to improve your health in 2019.

Sincerely,

The City of Chicago Labor Management Cooperation Committee

WELCOME TO ANNUAL OPEN ENROLLMENT

October 17, 2018 through October 31, 2018
Open Enrollment Changes are Effective January 1, 2019

Open enrollment is the time of year when you can:

- ✓ Enroll in or cancel your medical, vision, or dental insurance
- ✓ Switch medical or dental plans
- ✓ Add dependents to your plan (for example a spouse, civil union or same sex domestic partner, or children)
- ✓ Drop dependents from your plan
- ✓ Enroll or re-enroll in a healthcare and/or dependent care Flexible Spending Account (FSA)
- ✓ Buy optional life insurance or voluntary long term disability insurance

To make changes, go to the City of Chicago Benefits Services Center website:

www.cityofchicagobenefits.org

Open enrollment changes can also be made over the phone by calling:

Benefits Service Center 1-877-299-5111

Special hours during open enrollment: Monday through Friday 8:00 a.m. until 6:00 p.m.
Special hours Saturday, October 27, 2018 8:00 a.m. until 6:00 p.m.

Enrollment in a Flexible Spending Account (FSA) does not carry over from year to year. You must re-enroll in an FSA if you want this benefit for 2019.

Enroll online at www.cityofchicagobenefits.org or call the Benefits Service Center

What Is New in 2019

ConnectYourCare is the City's new vendor for healthcare and dependent care Flexible Spending Accounts and transit benefits. Improvements include:

- One vendor replaces the two existing vendors - one stop shopping!
- You will have the option of a debit card for healthcare flexible spending account.

In the near future you will receive communications regarding the change to ConnectYourCare.

CVS Caremark is our new vendor for pharmacy benefits in the BCBS HMO, replacing Prime Therapeutics for the HMO. In the near future you will receive communications regarding the change with instructions that you or your doctor will need to follow to ensure no interruption in your prescriptions.

CVS Caremark continues to provide pharmacy benefits to PPO enrollees.

CHECK YOUR BENEFIT COVERAGE SHEET

Your personalized Benefits Coverage Sheet is included with this Guide. The medical, dental and vision enrollment listed on this Coverage Sheet will remain the same for 2019 unless you make changes during the open enrollment period which runs October 17, 2018 through October 31, 2018. You must re-enroll in healthcare and dependent care Flexible Spending Account(s) to participate in 2019.

Dependent children who reach the age of 26 are automatically terminated from the City's health plan on the last day of the month of his/her birthday. However, if you have a disabled child reaching the age of 26, he/she may be eligible to continue dependent coverage. Contact the Benefits Service Center at least three months before your child's 26th birthday to apply for continued coverage for a disabled dependent child.

Check the personalized Benefits Coverage Sheet to make sure the information is correct for you and your dependents. Call the Benefits Service Center to update any of this information:

- Name and birthdate.
- Social Security number if marked as "N". If any Social Security number is marked "N", you must bring the original Social Security Card to the Chicago Benefits Office to update your dependent's record.

Federal law requires Social Security numbers for everyone enrolled in the City's health plans.

IF YOUR HOME ADDRESS CHANGES

Contact your Department's Human Resources Representative to update your address on file with the City.

ENROLLMENT CHANGES DURING THE YEAR

Benefit enrollment changes are allowed throughout the year only if you have a life change event such as marriage, divorce, birth or adoption of a child or loss of coverage through your spouse. Call the Benefits Service Center within 30 days of the life change event. If you try to make these changes as an open enrollment change, the coverage will not go into effect until January 1, 2019. You must provide documents to prove the life change event within 60 days of the event. Call the Benefits Service Center for more information.

Please note: Life change events are effective on the event date but open enrollment changes are effective January 1, 2019. When you call to make a life change event during the open enrollment period, you need to make sure that you explain that you are calling about a life change event and ask for the benefits to be effective on the event date.

INSTRUCTIONS ON HOW TO ACCESS www.cityofchicagobenefits PORTAL

Step 1: Employee ID Number

In order to create an online account, you will need your eight digit employee ID number.

Where to find your employee ID number?

Look on the upper left of your paystub where it says PAYEE/EMPLOYEE NUMBER. That's it.

This is not your Kronos number, the number you use for City computer access, or your payroll number.

Step 2: Add Zeroes

For online open enrollment, your employee ID number needs to be eight digits long. Simply add zeroes at the front to make it eight numbers. Examples: 5432 becomes 00005432 and 1234567 becomes 01234567.

Please keep this number for future use.

Step 3: Create Online Account

If you plan to enroll online, go to: www.cityofchicagobenefits.org to create your open enrollment username and password to make sure you can get into the system. If you already have an online account, you can test it to ensure it works.

If you've forgotten your username, click "Forgot Your User Name" and enter your eight digit employee ID number. Follow the prompts to get your new username. If you've forgotten your password, click "Forgot Your Password" then enter your username and follow the prompts. If you've forgotten both, get your username first. If you've never used the system, click "First Time Logging In" and follow the prompts.

Step 4: Enrollment

- Select benefits to enroll
- Choose coverage: Single, Employee + One, Family
- Enroll or re-enroll in the healthcare and dependent Flexible Spending Account (FSA) for 2019

Once you have made your enrollment selections ensure you click "submit" on the final screen.

Step 5: Write it Down

Keep your username and password; you need them to use the online open enrollment system in the future.

ADDING A DEPENDENT DURING OPEN ENROLLMENT?

STEP ONE – Enroll your dependents. Enroll your spouse, civil union partner, same sex domestic partner, and children during the open enrollment period online or by phone.

STEP TWO – Provide original documents to prove they are your legal dependents.
Submit your dependents documents as soon as possible. Your dependents will not have medical, vision or dental coverage, effective January 1, 2019 if you fail to submit the required documentation by December 6, 2018.

If you are adding dependents, you must submit the required documents for coverage to begin.

Deadline: If you submit your documents by close of business **Thursday, December 6, 2018** coverage will be reflected on January 1, 2019. For example, if your dependents seek medical care on January 1, 2019, your healthcare service provider will be able to verify coverage online. Please submit your documents to the Chicago Benefits Office by this deadline to properly reflect coverage by the January 1st effective date. ***We encourage you to submit your documents right away to avoid the last minute rush.***

Grace Period. If you fail to submit your documents by **Thursday, December 6, 2018**, you may submit documents through Thursday, January 31, 2019. Your failure to timely submit documents may result in delayed coverage.

If you fail to submit documentation by the end of the grace period on January 31, 2019, you will be required to wait until the next open enrollment period to enroll your dependents.

Bring certified documents and your dependent's social security card to:

Chicago Benefits Office
333 South State Street/Room 400
Chicago, IL 60604-3978

Office hours are Monday through Friday 8:30 a.m. – 4:30 p.m.

Your original certified documents will be copied and returned to you.
Documents required are:

Spouse – certified marriage certificate and spouse's social security card
Child – certified birth certificate and child's social security card
Civil Union – certified certificate and partner's social security card

It should be noted that:

- If healthcare services were received by your dependents during the grace period, and your medical provider submitted claims that were not paid because the required documents deadline of **December 6, 2018** was missed, those claims will be reprocessed retroactive to January 1, 2019 if the required enrollment documents are received by the Chicago Benefits Office by close of business January 31, 2019.
- Your medical provider may need to resubmit claims.
- Alternatively, if you paid out of pocket for healthcare services during the grace period, you may need to submit paper claims.

To avoid inconvenience, and to ensure your dependent's new coverage is reflected at the time of service, submit your documents to the Chicago Benefits Office by **Thursday, December 6, 2018**.

IMPORTANT NOTICE: If an employee or dependent gives false information, or if the dependent is not a legal dependent of the employee, the City will take action to collect any money paid to cover healthcare expenses related to the fraud and/or report the fraud to the appropriate authority.

DO NOT WAIT UNTIL THE LAST MINUTE

ENROLL OR RE-ENROLL IN A FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA) may save you money by reducing your income taxes. An FSA allows you to have money deducted from your paycheck before your federal and Social Security taxes are calculated. Your FSA contributions are automatically tracked in a special FSA account administered by ConnectYourCare. You can choose to have FSA reimbursement checks mailed to you or deposited directly into your bank account. You will have the option for a debit card for healthcare flexible spending account.

FSA contributions are spread over the year and taken out each paycheck. After you decide how much you want to put aside in an FSA, call the Benefits Service Center to enroll (1-877-299-5111) or enroll at www.cityofchicagobenefits.org.

HEALTHCARE FSA

A healthcare FSA allows you to set aside pre-tax dollars for qualified health expenses that are not covered by medical, dental or vision insurance. Qualified expenses include deductibles, co-pays for medical care and prescription medications, vision services and dental care. The maximum FSA contribution in 2019 is $2,650.

Estimate how much you will likely spend in 2019. Consider what medical, vision and dental expenses you are fairly certain you will have next year including deductibles, co-pays and co-insurance amounts, as well as any out-of-pocket expenses for services not covered by the plan (eye laser surgery, dental implants etc). A complete list of healthcare expenses for FSA reimbursement can be found at www.irs.gov/pub/irs-pdf/p502.pdf.

DEPENDENT CARE FSA

Use pre-tax dollars to pay for care for a dependent child, disabled spouse, elderly parent or other tax dependents. Qualified expenses include a babysitter, day care, preschool tuition, before and after school care and day camps for dependents under age 13. Care for other tax dependents who are mentally or physically incapable of caring for themselves also qualifies for FSA reimbursement. The maximum contribution in a Dependent Care FSA in 2019 is $5,000.

USE IT OR LOSE IT

The IRS requires that any money left in your account at the end of the year will be forfeited. If you enroll in either FSA for 2019, qualified expenses have to be incurred before March 15, 2020. You will have until March 31, 2020 to submit your 2019 expenses.

If your employment with the City ends before you have used all the money in your FSA, you have until the end of the annual grace period to submit expenses for FSA reimbursement (for example, March 31, 2020 for expenses incurred in 2019 If you plan to incur expenses after your employment with the City ends, you must elect to continue FSA contributions under PHSA/COBRA.

DON'T FORGET TO RE-ENROLL!

You must re-enroll in the FSA each year during Open Enrollment

www.cityofchicagobenefits.org

1-877-299-5111

FSA enrollment cannot be done by ConnectYourCare

New FSA provider: You will continue to submit 2018 claims to PayFlex through March 31, 2019. Claims for 2019 will be processed by ConnectYourCare. More information coming soon.

SPECIAL REMINDERS

PPO-Mandatory Second Opinion Program for Surgeries

A Second Opinion is needed before obtaining some surgeries. You must call Telligen as soon as your doctor recommends surgery in any of the following areas:

- Knee; shoulder; hip; neck; and back
- Gall bladder
- Uterine, Vagina, Cervix
- Weight loss (Gastric Bypass)

There is no charge for the second opinion, you will not be examined and no travel is required. However, you must give permission for the second opinion provider, Best Doctors, to collect your medical records and test results.

Telligen will first review your proposed surgery for medical necessity and if required, Best Doctors will then arrange for a specialist to review your doctor's diagnosis and recommendations. You will receive a confidential, written report of the second opinion to help you decide how to proceed with treatment. You make the final decision on whether to have surgery; however, if you do not get the second opinion, you will pay for the full cost of the surgical procedure. The second opinion requirement is waived if you are admitted to the hospital for surgery from the emergency room.

Call Telligen at 1-800-373-3727 to begin the second opinion review and out-patient surgery pre-certification process. If you fail to obtain the required pre-certification, or the second opinion, you will pay for the full cost of the surgical procedure.

PPO Virtual Doctor's Visits

PPO members can have a virtual "face-to-face" medical evaluation by a primary care physician using a phone, tablet or computer with a front facing camera. Claims are submitted directly to Blue Cross Blue Shield and you pay a $20 copay for the visit. If necessary, prescriptions are sent to a local pharmacy, Value Formulary and prescription drug copays apply. You must have a valid credit card to be able to use this service. Call Blue Cross Blue Shield at 1-800-772-6895 for more information.

VOLUNTARY CHARITABLE PAYROLL CONTRIBUTIONS PROGRAM

City employees have the opportunity to extend their generosity to thousands of individuals and families through the Employee Voluntary Charitable Payroll Contributions Program. Choose up to ten agencies to receive your contributions from a list of 29 approved Chicagoland area charitable organizations. If you already participate in the program, you can make changes, discontinue deductions, add new charities or increase your contributions at any time. For more information, speak to your payroll administrator or download the Charitable Contribution Allocation form at: http://www.cityofchicago.org/city/en/depts/fin/provdrs/payroll.html under supporting information, "Charitable Giving".

ONLINE PAY SLIPS

Sign up for GreenSlips, the City online pay slips program to view direct deposit of your paycheck online. You can also view and download your W2 tax return as soon as available.

Go to https://greenslips.cityofchicago.org/TransformContentCenter/ and use your employee number to set up a secure account.

HEALTH CARE CONTRIBUTION RATES FOR 2019

Union and Non-Union Employees

(Contributions taken as payroll deductions; 24 pay periods each year)

DENTAL & VISION INSURANCE

PLAN	SINGLE	EMPLOYEE+1	FAMILY
DENTAL HMO	$0.20	$1.08	$2.78
DENTAL PPO	$0.51	$1.02	$2.05
VISION	$0.15	$0.30	$0.61

MEDICAL PLAN (HMO & PPO)

ANNUAL SALARY	SINGLE	EMPLOYEE+1	FAMILY
Up to $30,000	$15.71	$23.88	$27.65
$30,001 and < $89,999	1.2921% of payroll ÷ 24	1.9854% of payroll ÷ 24	2.4765% of payroll ÷ 24
Union Employee $90,000 and above	$48.45	$74.45	$92.87
Non Union Employee $90,000 to $119,999	$48.45	$74.45	$92.87
Non Union Employee $120,000 and above	1.2921% of payroll ÷ 24	1.9854% of payroll ÷ 24	2.4765% of payroll ÷ 24

MEDICAL PLAN (HMO & PPO)*

ANNUAL SALARY	SINGLE	EMPLOYEE+1	FAMILY
Up to $30,000	$15.71	$23.88	$27.65
$30,000 to $114,999	2.2921% of payroll ÷ 24	2.9854% of payroll ÷ 24	3.4765% of payroll ÷ 24
$115,000 and above	$109.83	$143.05	$166.58

*For recently ratified collective bargaining agreements.

Plan A effective 1/1/2019. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

HEALTH CARE CONTRIBUTION RATES FOR 2019

CROSSING GUARDS

(Contributions taken as payroll deductions; 18 pay periods each year)

DENTAL & VISION INSURANCE

PLAN	SINGLE	EMPLOYEE+1	FAMILY
DENTAL HMO	$0.27	$1.08	$2.78
DENTAL PPO	$0.68	$1.36	$2.73
VISION	$0.20	$0.40	$0.81

MEDICAL PLAN (HMO & PPO)

ANNUAL SALARY	SINGLE	EMPLOYEE+1	FAMILY
Up to $30,000	$20.95	$31.84	$36.87
$30,001 and < $89,999	1.2921% of payroll ÷18	1.9854% of payroll ÷18	2.4765% of payroll ÷18
$90,000 and above	$64.61	$99.27	$123.83

PPO MONEY SAVINGS

Save by using doctors and hospitals in the PPO Tier 1 network: The PPO gives you freedom to choose from three different network tiers. You can select doctors and hospitals (providers) from Tier 1 for some of your care, and use Tier 2 or Tier 3 providers for other services. You pay the lowest deductible and coinsurance when you use providers in Tier 1. To find a Tier 1 provider, call 1-800-772-6895 or go to www.bcbsil.com/cityofchicago.

Two ways to save on prescription medications: 1) Choose generic medications and pay the lowest copay. 2) Use mail order for long term "maintenance" medications. You will pay more if you don't use mail order for long term medications after the 3rd fill. Just call 1-866-748-0028 and ask CVS Caremark to contact your doctor for a new prescription to be processed through mail order.

Save on lab tests – **use a free-standing lab:** Get your lab tests paid in full by using a free-standing lab (such as a Quest lab) which is not affiliated with a hospital. Even if your doctor already has an arrangement with Quest, ask for a lab order for tests to be done at a Quest facility. Take this paperwork to the Quest lab and test results will be sent directly to your doctor. Call 1-866-697-8378 to find the location of a Quest lab near you, or go to www.Questdiagnostics.com.

Save on scans – use a free-standing imaging center: Scans are covered in full if done at a free-standing imaging center. When your doctor orders an MRI, CT, or PET scan, call Telligen at 1-800-373-3727 to pre-certify the test and locate a free-standing imaging center near you.

Pregnant? Earn a $100 incentive: Enroll in a free, confidential maternity management program designed to encourage a healthy baby by providing telephone support for moms-to-be. To qualify for the $100 incentive, call Telligen (1-800-373-3727) to enroll and complete at least eight doctors' visits during the pregnancy.

BLUE CHOICE OPTIONS MEDICAL PPO-PLAN A

		Blue Choice OPT Tier 1	Blue Cross PPO Tier 2	Out-of-Network Tier 3
Annual Deductible	**Individual** **Family**	**$300** **$900**	**$350** **$1,050**	**$1,500** **$3,000**
Out-of-Pocket Limit	**Individual** **Family**	**$1,000** **$2,000**	**$1,500** **$3,000**	**$3,500** **$7,000**
PREVENTIVE CARE		**YOU PAY**	**YOU PAY**	**YOU PAY**
Routine checkups & routine lab work for adults & children; well-baby care; well-women visits; mammograms; PSA; colonoscopies, hearing screenings		**$0 copay** No deductible	**$0 copay** No deductible	No coverage out-of-network for preventive care
OFFICE VISITS				
Primary Care Physician, lab work, x-rays, allergy shots, Mental health and substance abuse counseling		**$20 copay** does not apply to deductible	**$25 copay** does not apply to deductible	**40% PPO** allowed rate after out-of-network deductible plus balance billed by provider
Specialist Physician And Chiropractic Care (visit limits)		**$30 copay** does not apply to deductible	**$35 copay** does not apply to deductible	
Annual deductible must be paid before Plan covers these services:		**YOU PAY** After Tier 1 deductible	**YOU PAY** After Tier 2 deductible	**YOU PAY** After Tier 3 deductible
OUTPATIENT SERVICES*				
Outpatient surgery MRI, PET & CT scan*		**10%**	**25%**	**40%** PPO allowed rate plus balance
HOSPITAL SERVICES*				
Hospital stay* including inpatient surgery		**10%**	**25%**	**40%** PPO allowed rate plus balance
EMERGENCY ROOM CARE				
Emergency Room		**$150 co-pay waived if admitted**		
Emergency Room Treatment		**10%**		
Ambulance emergency care		**10% of PPO allowed rate**		
MENTAL HEALTH & SUBSTANCE ABUSE*				
Inpatient hospitalization* **Outpatient therapy***		**10%**	**25%**	**40%** PPO allowed rate plus balance
ALTERNATIVES TO HOSPITAL CARE*				
Skilled nursing facility* **Home health care*, Hospice care***		**10%**	**25%**	**40%** PPO allowed rate plus balance
MATERNITY SERVICES				
Maternity management program		**No charge plus $100 cash incentive**		
Pre and post natal doctor visits		**$20 copay** (first visit)	**$25 copay** (first visit)	**40%** PPO allowed rate plus balance
Delivery and hospital stay*		**10%**	**25%**	
OUTPATIENT REHAB*				
Physical therapy*		**10%**	**25%**	**40%** PPO allowed rate plus balance
Occupational and speech therapy*		**$20 copay**	**$20 copay**	
OTHER SERVICES				
DME*: Oral Surgery; **Ambulance transport between hospitals***		**10%**	**25%**	**40%** PPO allowed rate plus balance

***Care must be pre-certified by calling Telligen at 1-800-373-3727. See the next page.**

Plan A effective 1/1/2019. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

CERTAIN PPO SERVICES NEED TO BE PRE-CERTIFIED

Telligen, the PPO medical advisor, needs to pre-certify the services listed below. There is a $1,000 penalty if Telligen is not contacted in a timely fashion in the event of a hospitalization. This $1,000 penalty does not go towards the deductible or get counted in the out-of-pocket maximum. Telligen's phone number is 1-800-373-3727. This number is also on the back of the PPO ID card.

When To Call Telligen at 1-800-373-3727

HOSPITAL ($1,000 penalty if Telligen is not called)	
Any inpatient stay in the hospital for medical, surgical, maternity, mental health or substance abuse care.	Call before elective admission or within two business days of an emergency admission.
Hospital outpatient treatment for mental health and substance abuse	Call before the treatment begins.
Plan pays nothing for the services listed below unless Telligen certifies	
AMBULANCE	
When ambulance is used for transfer between hospitals or to hospital in a non-emergency situation	Call before the transfer is arranged.
SURGERY	
Organ transplant surgery Bariatric surgery } Must be done at a Blue Distinction Center Gender reassignment surgery	Call before surgery is scheduled.
Inpatient and out-patient surgery for hips; back; neck; gall bladder; uterine, bariatric Outpatient surgery for knees	**Second Opinion review required.** Call before surgery is scheduled to begin the mandatory second opinion process. Plan pays nothing if second opinion or pre-certification not obtained.
MEDICAL EQUIPMENT	
DME (durable medical equipment)	Call before equipment is ordered if more than $500 for each item.
OUTPATIENT THERAPY	
Mental health & substance abuse outpatient therapy/ counseling	Call after a combined total of 7 sessions from one or more providers. Call each year if care is on-going.
Occupational and speech therapy	Call after the 10th session each calendar year from one or more providers. Call each year if care is on-going.
Physical therapy	Call after the 7th visit. Call each year if care is ongoing.
DIAGNOSTIC TESTS	
MRI, PET & CT scans	Call before test is done. Covered 100% if pre-certified and done at a free standing facility. Deductibles and co-insurance amounts apply if pre-certified and done at a hospital facility or billed by a hospital.
OTHER SERVICES	
Home health care	Call before services start.
Skilled nursing facility	Call before being admitted.
Sleep Study, Hospice, Infertility treatment, Non-surgical transplants, Other gender reassignment services	Call before services start.

Plan A effective 1/1/2019. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

PPO PRESCRIPTION DRUG PROGRAM

Administered by CVS Caremark

PPO PRESCRIPTION MEDICATIONS	YOU PAY
RETAIL - Short term medications If purchased at a participating retail pharmacy 34 day supply or 100 units whichever is less.	Generic **$10 copay** Preferred formulary brand name **$30 copay** Non-preferred brand name **$45 copay**
RETAIL - Maintenance or long term medications The 4th fill and any additional refills 34 day supply or 100 units, whichever is less.	Generic **$20 copay** Preferred formulary brand name **$60 copay** Non-preferred brand name **$90 copay**
MAIL ORDER - Long term medications for chronic conditions 90 day supply To get medications through the mail, send your doctor's prescriptions to: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 Call Caremark or visit its website for more information about mail order.	Generic **$20 copay** Preferred formulary brand name **$60 copay**
Generic birth control **Smoking Cessation medications**	**$0 copay**
Annual Rx Deductible	***$35 per household**

VALUE FORMULARY

Your plan has adopted the Value Formulary to encourage use of generics. Prescriptions not on the Value Formulary list will be denied coverage at the pharmacy and the pharmacist will then ask your physician to substitute a Value Formulary drug.

If your physician does not agree to change the prescription, your physician must request an exception from CVS Caremark by submitting clinical information for prior authorization. An approval or a denial will be faxed to your physician and mailed to your home address. Call CVS Caremark or visit the website for information about the prior authorization process and the list of Value Formulary drugs.

*$35 annual Rx deductible may vary based on collective bargaining agreement.

www.caremark.com

1-866-748-0028

Plan A effective 1/1/2019. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

BLUE ADVANTAGE HMO* – A Blue Cross HMO

If care is pre-approved by your HMO primary care physician (PCP)

YOU PAY

DOCTORS VISITS	
Primary Care Physician	**$25 copay**
Specialists	**$35 copay** when approved by PCP
Pre-natal visits	**$25 copay** first visit
HOSPITAL (all hospital services must be approved by PCP)	
Inpatient admission	**$20 copay**
Surgery (inpatient & outpatient)	**$20 copay**
Maternity delivery Care in the hospital for mother & baby	**$0 after $20 hospital copay**
PREVENTIVE SERVICES	
Routine checkups for adults & children; well- baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing tests	**$0 copay**
EMERGENCY SERVICES (see next page for emergency coverage information)	
Emergency room treatment – life threatening	**$150 copay** (waived if admitted)
Ambulance – life threatening	**You pay $0**
MENTAL HEALTH & SUBSTANCE ABUSE (must be pre-approved by PCP)	
Outpatient therapy	**$25 copay**
Inpatient care	**$20 copay** each admission
OUTPATIENT REHAB THERAPY (must be pre-approved by PCP)	
Physical, speech and occupational therapy	**$0 copay** Limit of 60 visits combined each calendar year
OTHER SERVICES (all other services must be pre-approved by PCP)	
Skilled nursing facility	**$0** Limited to 120 days a year
Durable Medical Equipment (DME) Hospice Home health care Ambulance transport between hospitals	**$0**

*HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.

www.bcbsil.com/cityofchicago

1-800-730-8504

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HMO EMERGENCY CARE

The Blue Advantage HMO covers life threatening medical emergencies. It also covers care for acute medical problems when pre-approved by your primary care physician (PCP).

What is a medical emergency?

A life threatening medical emergency is the sudden and unexpected onset of a potentially dangerous situation which, if not treated immediately, could jeopardize your health. Such conditions are also severe and sudden in onset.

EMERGENCY ROOM TREATMENT Go to the nearest emergency room in the event of a life threatening emergency	You pay **$150 copay** – waived if admitted If possible, contact your PCP before seeking emergency care. (Your PCP is available 24 hours a day, seven days a week.) In a life threatening emergency, call 911 and contact your PCP within 48 hours following emergency care.
AMBULANCE For life threatening medical emergencies	You pay **$0**
TREATMENT IN PCP OFFICE For acute medical problems which are not life threatening	You pay **$25 copay** if care is given in your PCP's office. Call your PCP's emergency number on the back of your Blue Advantage HMO ID card. A doctor or nurse will evaluate the problem and give instructions on where to go for medical care.
URGENT MEDICAL CARE AWAY FROM HOME For treatment for unexpected illness and injury when travelling outside the Chicagoland area contact your PCP.	Call the toll-free emergency number on the back of your Blue Advantage HMO ID card. If you or a covered dependent is away from home for more than 90 days, guest membership is provided at affiliate HMOs. Copays maybe different.

*HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.

www.bcbsil/cityofchicago
1-800-730-8504

HMO PRESCRIPTION DRUG PROGRAM

Administered by CVS Caremark

HMO PRESCRIPTION MEDICATIONS	YOU PAY
RETAIL - Short term medications If purchased at a participating retail pharmacy 34 day supply or 100 units whichever is less	Generic **$10 copay** Preferred brand name **$30 copay*** Non-preferred brand name **$45 copay***
RETAIL - Maintenance or long term medications The 4th fill and any additional refills 34 day supply or 100 units, whichever is less.	Generic **$20 copay** Preferred brand name **$60 copay*** Non-preferred brand name **$90 copay***
MAIL ORDER Long term and maintenance medications for chronic conditions 90 day supply To order medications through the mail, send your doctor's prescription to: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 Call Caremark or visit their website for more information about mail order.	Generic **$20 copay** Preferred brand name **$60 copay***
Oral Contraceptives (generic or brand)*	Generic **$0 copay** Preferred brand name **$30 copay*** Non-preferred brand name **$45 copay***
Smoking cessation medications	Certain generic medications **$0 copay**
Annual Rx Deductible	****$35 per household**

*If the member chooses brand when generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay.

**$35 annual Rx deductible may vary based on collective bargaining agreement.

www.caremark.com
1-866-748-0028

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DENTAL PROGRAM

Administered by Blue Cross Blue Shield of Illinois (BCBS)

Enrollment in the dental plan is available after one calendar year of full-time employment. Separate contributions for dental coverage will be taken as payroll deductions. No action is needed if you want to continue your same dental coverage in 2019.

If you want to add or drop dental coverage or change dental plans for 2019, visit www.cityofchicagobenefits.org or call the Benefits Service Center 1-877-299-5111 during open enrollment.

BLUE CARE DENTAL PPO & HMO BENEFITS

	PPO In-Network	PPO Out-of-Network	HMO In-Network*
	YOU PAY	YOU PAY	YOU PAY
Preventive (Two visits each year) **Oral exams** **Cleanings** **X-Rays**	**$10 copay** No deductible for preventive services	**20%** of PPO allowable amount plus balance of billed charges No deductible for pre-ventative services	**$10 copay** for each preventative visit No deductible in the HMO
Annual deductible (amount each member pays first before plan pays benefits)	YOU PAY **$100**	YOU PAY **$200**	YOU PAY No deductible
Annual limit (maximum amount a member receives in dental coverage each year after deductible has been paid)	PLAN PAYS UP TO **$1,500**	PLAN PAYS UP TO **$1,500**	 No annual limit
	YOU PAY	YOU PAY	YOU PAY
Restorative **Endodontics** **Periodontics Surgery** **Oral Surgery** **Crowns**	**20%** **20%** **20%** **40%** **40%**	**50%** of PPO allowed amount plus balance of billed charges	Copays of various amounts (for information about co-pay amounts visit www.bcbsil.com/cityofchicago or call 1-855- 557-5487) Plan pays **100%** after co-pay
Orthodontics	Not covered	Not covered	Covered for children of sworn police and uniformed firefighters up to age 25 with **$1,800** copay. Coverage limited to age 19 for all others with **$1,800** copay. Not covered for employee or spouse

*There is no coverage out-of-network in the Dental HMO. You must use dentists who participate in the Dental HMO. For up-to-date information about HMO dentists visit the dental program website or call for more information.

www.bcbsil.com/cityofchicago
1-855-557-5487

Plan A effective 1/1/2019. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

VISION PROGRAM

You pay separate contributions for vision coverage which will be taken as payroll deductions. No action is needed if you want to continue your same vision coverage in 2019. If you want to drop vision coverage for 2019, visit www.cityofchicagobenefits.org or call the Benefits Service Center 1-877-299-5111 during open enrollment.

The Vision Program is administered by Davis Vision and covers routine eye exams, as well as prescription eyeglasses or contact lenses. How much the plan pays depends on the type of services or eye-wear you choose, and which vision retail store you use.

You get the most value from your vision benefits when you use a provider in the Davis Vision network. To locate Davis Vision providers visit www.DavisVision.com or call 1-888-456-8758.

The Vision Program does not issue ID cards. Your Blue Cross ID or a state ID card will be used to verify coverage in the Davis Vision plan.

DAVIS VISION CARE BENEFITS

	In-Network You Pay	Out-of--Network You Pay
Routine Eye Exam (One exam every 12 months) based on last date of service	**$0**	Balance over **$35**
Frames One pair every 12 months	**$0** for frames from Davis Vision collection: • Or balance over the **$110** allowance for frames at Vision-works stores* • Or balance over the **$50** allowance for frames at other in-net-work stores	Balance over **$50**
Lenses-single vision **Scratch Coatings** **Special lenses and other coatings**	**$0** one set every 12 months **$0** Copays Visit www.davisvision.com or call 1-888-456-8758 for specific copay amounts.	Balance over **$35**
Contact lenses (in lieu of glasses)	Once every 12 months: • Davis vision collection: **$0** for 4 multipacks or 8 boxes. • Other disposables: Balance over **$105**	Balance over **$105**.

* Visit the DavisVision website or call 1-888-456-8758 to locate a Visionworks store

www.davisvision.com
1-888-456-8758

Chicago Lives Healthy WELLNESS PROGRAM FOR 2019

Chicago Lives Healthy is a comprehensive wellness program for covered employees and covered spouses/domestic partners/civil union partner. The program combines the latest science around Biometric Screenings and WellBeing Assessments (WBS) with effective tools, resources and coaching services to empower people to adopt healthier lifestyle habits.

PROGRAM ENROLLMENT

You will be automatically enrolled in the *Chicago Lives Healthy* wellness program starting on January 1, 2019 if you:

- are a City employee who was covered by a City medical plan as of November 1, 2018; or
- are the covered spouse/domestic partner/civil union partner of a City employee and you are covered as a dependent in a City medical plan as of November 1, 2018; or
- returned to work from a leave of absence and your medical coverage was reinstated on or before November 1, 2018.

About Biometric Screenings in the 2019 benefit year: Most employees will **NOT** need to complete a biometric screening in 2019. Personalized letters outlining your enrollment steps and program requirements will be sent to each participant who is automatically enrolled in the *Chicago Lives Healthy* wellness program. Follow the instructions in your letter, not your spouse's letter.

OPTING OUT OF THE CHICAGO LIVES HEALTHY WELLNESS PROGRAM

If you or your covered spouse/domestic partner/civil union partner choose not to participate in the *Chicago Lives Healthy* wellness program, you can select "NO" during open enrollment and opt out of the wellness program. If you select "NO" for yourself or your covered spouse/domestic partner/civil union partner you will pay a $50 per non-participant increase in your monthly employee healthcare contributions for the 2019 benefit year. Increased medical contributions for those who opt out of the wellness program will begin with the first pay period of January 2019.

WAIVER OF ENROLLMENT FROM THE CHICAGO LIVES HEALTHY WELLNESS PROGRAM

If you and/or your covered spouse/domestic partner/civil union partner have a medical condition or illness that prevents you from participating in the *Chicago Lives Healthy* wellness program, you must submit a waiver of enrollment form completed by your doctor. You must submit an updated waiver of enrollment form each benefit year

Please send in a written request for a waiver of enrollment form. All waiver of enrollment forms should be completed by your doctor and returned no later than **December 3, 2018**. Send your requests to:

Wellness Administrator
Chicago Benefits Office
333 South State Street-Room 400
Chicago, IL 60604-3978

Look for more Chicago Lives Healthy wellness program information to arrive at your home address on file with the City of Chicago in December 2018 and January 2019.

PROTECT YOUR-FUTURE INCOME FOR YOU AND YOUR LOVED ONES

The City at no cost to you, provides basic term life insurance. You have an opportunity to buy more coverage through the City's group insurance policy. You may contact the insurance providers at any time to learn more.

BASIC TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

As a City employee, you automatically receive $25,000 of free basic life insurance which pays in the event of your death and/or for certain accidental losses. When your employment with the City ends, you can continue this basic life insurance by paying premiums directly to MetLife.

OPTIONAL TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

During open enrollment you may increase the amount of life insurance for yourself or buy coverage for your eligible dependents. You will pay the cost through payroll deductions. Proof of good health may be required.

Please note:

- Increasing the amount of insurance (1x to 10x your annual earnings, up to $1.5 million) will require proof of good health.
- Buy insurance for a spouse or civil union partner for $10,000, $25,000 or $50,000 of coverage (limits apply)
- Enroll children from birth to age 25 for $5,000 to $10,000 in coverage (one rate covers all your children and no proof of good health is required)

VOLUNTARY PERMANENT LIFE INSURANCE: (Texas Life (formerly MetLife)www.empben.com/CityofChicagoUL/or 1-800-638-6855)

Permanent life insurance also provides a death benefit. Sign up during the open enrollment period and/or apply for coverage for your dependents. (Proof of good health is required satisfactory to Texas Life.)

LONG TERM DISABILITY: (Prudential www.prudential.com 1-800-778-3827)

The LTD is designed to provide you a monthly cash payment in the event you cannot work because of an illness or injury. Your premium is deducted from your paycheck Proof of good health may be required when you sign up during open enrollment. Note: If you are a new City Employee hired on or after April 1, 2018, you were automatically enrolled in the Long Term Disability (LTD) Plan. You may opt out of the benefit by contacting Prudential directly.

DEFERRED COMPENSATION: (Nationwide www.chicagodeferredcomp.com 1-855-457-2489 or 1-877-677-3678). The City offers a tax deferred compensation plan that allows employees to put aside money from each paycheck toward retirement. A deferred compensation plan can supplement your pension and help increase your retirement income. You can enroll in the Deferred Compensation program at any time.

VOLUNTARY SUPPLEMENTAL INSURANCE

Employees will have the opportunity to purchase voluntary supplemental insurance through payroll deduction. Voluntary Supplemental Insurance will be sold by two insurers:

- Combined Insurance Company 1-888-870-3382
- Aflac Insurance Company 1-888-382-3522

Each insurer is authorized to enroll you in one of three supplemental insurance products:

- Hospital Indemnity Insurance pays a fixed dollar amount if you are hospitalized
- Accidental Injury Insurance pays a fixed dollar amount for certain medical and other services if you are injured in a non-work accident
- Critical Care insurance pays a fixed dollar amount if you become ill with a specified critical diagnosis

Employees should carefully consider which of the optional products the City offers best meets their needs for life insurance, disability insurance, medical and dental care and now supplemental insurance through payroll deduction.

Detailed information about these products is available directly from the insurers at the numbers listed above. Additional information will be sent to your home by the insurers. The City of Chicago Benefits Office does not provide advice regarding these insurance products.

BE HONEST!

A REMINDER ABOUT FRAUD

Any kind of fraud on the City of Chicago's benefit plans may result in adverse consequences to an employee and dependent, for example:

- Failure to notify the City Benefits Service Center of an event that would cause coverage to end, e.g. divorce
- Misrepresentation by the employee or dependent regarding the initial eligibility, for example, the dependent's age, or that the dependent is not a legal dependent of the employee
- Any attempt to assign or transfer coverage to someone else (e.g. letting another person use your Plan ID card)

The employee will be required to pay for any claims and all administrative costs that were incurred fraudulently. This may result in coverage being terminated for the employee and action by the City to collect any money paid. The City may also discipline the employee, up to and including termination.

DIVORCED SPOUSE'S HEALTH COVERAGE:

If an employee becomes divorced, he/she must follow the procedure outlined in the City's Plan document available at www.cityofchicagobenefits.org:
Notify the Benefits Service Center within 30 days of the date of the divorce and bring the certified divorce decree to the Chicago Benefits Office within 60 days.

Failure to comply with the procedure will result in the employee being held liable for any healthcare claims and related expenses incurred by the participant and the ex-spouse as of the date of the divorce.

You must call the Benefits Service Center to notify the City of the divorce at 1-877-299-5111 and take the original certified divorce decree to:

Chicago Benefits Office
333 South State Street
Room 400
Chicago, IL 60604-3978

(Open Monday thru Friday, 8:30 a.m. to 4:30 p.m.)

QUESTIONS? WANT TO LEARN MORE?

Visit a Benefits Information Fair and speak directly with representatives from the Chicago Benefits Office, Blue Cross (HMO and PPO), Blue Care Dental (HMO & PPO), Telligen medical advisor, CVS Caremark prescription drug program, Davis Vision Plan, ConnectYourCare, Prudential, MetLife, Nationwide deferred compensation program, Texas Life insurance, Combined and Aflac Voluntary Supplemental Insurance.

Date	Time	Location	Address
Wednesday October 10, 2018	**10:00 AM - 3:30 PM**	**City Hall**	**121 N. LaSalle St.** (11th Floor)
Thursday October 11, 2018	**10:00 AM - 3:30 PM**	**DePaul Center**	**333 S. State St.** (4th Floor)
Wednesday October 17, 2018	**10:00 AM - 3:30 PM**	**Public Safety Headquarters**	**3510 S. Michigan Ave.** (1st Floor)
Thursday October 18, 2018	**10:00 AM - 3:30 PM**	**Family and Support Services**	**1615 W. Chicago Ave.** (2nd Floor)
Wednesday October 24, 2018	**10:00 AM - 3:30 PM**	**Midway Airport** AMC Building	**6201 S. Laramie St.** (1st Floor)
Thursday October 25, 2018	**10:00 AM - 3:30 PM**	**O'Hare Airport** Department of Aviation	**10510 W. Zemke Blvd.**
Monday October 29, 2018	**10:00 AM - 3:30 PM**	**2FM Building**	**900 E. 103rd St.**
Tuesday October 30, 2018	**10:00 AM - 3:30 PM**	**2FM Building**	**1869 W. Pershing Rd.**

Benefits Information Fairs are for current employees and their spouses/civil union partners/domestic partners to learn more about healthcare and other benefits related to the annual open enrollment process.

BLUE CROSS BLUE SHIELD ONLINE

Check the status of your claims, request new ID cards, download an image of your ID card onto your phone, and find providers in the City of Chicago's PPO and Blue Advantage HMO plans.

To register: locate your group number and member ID number on your Blue Cross Blue Shield card. Then go to the website www.bcbsil.com/cityofchicago and click "Register Now" and follow the prompts to create a username and password.

BLUE 365 DISCOUNT PROGRAM www.blue365deals.com

A program offered by Blue Cross Blue Shield of Illinois to HMO and PPO members. Save money on health care products and services that are not covered by the City of Chicago's medical plans. Get discounts from top national and local retailers on fitness gear, gym memberships, family activities and healthy eating options. Examples include Reebok shoes, Life Time Fitness memberships, Procter and Gamble dental products and TruHearing services. Register to receive weekly featured deals which offer additional discounts for a short period of time. There are no claims to file.

Blue Access For Members (BAM)

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the Blue Cross Blue Shield of Illinois secure member website, Blue Access for Members (BAM). With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card – or print a temporary one
- Visit Health Care School to see articles and videos to help you make the most of your benefits

2019 IMPORTANT WEBSITES AND PHONE NUMBERS

SERVICE PROVIDER	WEBSITE	PHONE NUMBER
City of Chicago Benefits Service Center	**www.cityofchicagobenefits.org**	**1-877-299-5111**
Medical PPO Blue Cross Blue Shield of Illinois CVS Caremark Telligen medical plan advisor Best Doctors Comprehensive Physician Care	www.bcbsil.com/cityofchicago www.caremark.com www.telligen.qualitrac.com	**1-800-772-6895** **1-866-748-0028** **1-800-373-3727** **1-866-904-0910** **1-773-702-0781**
Medical HMO Blue Advantage HMO CVS Caremark	www.bcbsil.com/cityofchicago www.caremark.com	**1-800-730-8504** **1-866-748-0028**
BlueCare Dental Dental PPO and HMO	www.bcbsil.com/cityofchicago	**1-855-557-5487**
Davis Vision	www.davisvision.com	**1-888-456-8758**
Quest Diagnostics	www.questdiagnostics.com	**1-866-697-8378**
PayFlex (2018 claims) Flexible Spending Account (FSA)	www.HealthHub.com	**1-800-284-4885**
ConnectYourCare (January 1, 2019) Flexible Spending Account (FSA) Dependent Care Account Transit Benefit	www.connectyourcare.com/cityofchicago	**1-833-229-4428**
Healthways	www.chicagoliveshealthy.com	**1-866-556-7671**
MetLife Basic term life insurance Optional life insurance	www.metlife.com/mybenefits	**1-866-492-6983**
Prudential Long term disability	www.prudential.com	**1-800-778-3827**
Texas Life Universal permanent life insurance	www.empben.com/CityofChicagoUL/	**1-800-638-6855**
Nationwide Retirement Services	www.chicagodeferredcomp.com	**1-877-677-3678**
Voluntary Supplemental Insurance Combined Aflac		**1-888-870-3382** **1-888-382-3522**

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2019 IMPORTANT WEBSITES AND PHONE NUMBERS

SERVICE PROVIDER	WEBSITE	PHONE NUMBER
Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	**1-312-726-5823**
Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	**1-312-744-3891**
Municipal Employees' Annuity and Benefit Fund of Chicago	www.meabf.org	**1-312-236-4700**
Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago	www.labfchicago.org	**1-312-236-2065**

LEGAL NOTICES

CITY OF CHICAGO
MEDICAL PPO PLANS ("MEDICAL PLANS")

NOTICE TO ENROLLEES OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT EXEMPTION FOR 2019

Generally, group health plans sponsored by state and local governmental employers, such as the City of Chicago (the "City" or "plan sponsor") must comply with federal law requirements in title XXVII of the Public Health Service Act, and the amendments thereto set forth in the Mental Health Parity and Addiction Equity Act. However, these governmental employers are permitted to elect to exempt a plan from all of the requirements listed below for any part of the plan that is self-funded by the employer rather than provided through a health insurance policy. The purpose of this Notice is to inform you that the City of Chicago has elected to exempt the City of Chicago Medical PPO Plans as follows:

1. *Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan (sometimes referred to as "mental health parity requirements").* The plan sponsor has elected to maintain the existing terms and conditions of the Medical Plans by exempting the Medical Plans from this requirement. Therefore, the City will continue in place the current requirement that Plan Participants who receive outpatient mental health and substance abuse treatment by a behavioral health specialist must obtain pre-certification by a Medical Advisor, under the Plans' Medical Advisor Review Program, after the first seven sessions each year with one or more such providers. This requirement will continue in effect for the 2019 plan year (beginning January 1, 2019, and ending December 31, 2019), and may be renewed for subsequent plan years pursuant to a subsequent exemption election, unless modified through the collective bargaining process.

2. *Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.* The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

3. *Certain requirements to provide benefits for breast reconstruction after a mastectomy.* The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

4. *Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.* The Medical Plans no longer use student status and provides an opportunity to elect coverage to age 26 and thus this requirement currently applies under the terms of the Medical Plans without exception.

ANNUAL HEALTHCARE REMINDER

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan offered by the City of Chicago provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between breasts, as well as prostheses and complications resulting from a mastectomy (including lymphedema). Contact your PPO or HMO administrator for more information.

CHICAGO
BENEFITS OFFICE

HEALTHCARE AND OTHER BENEFITS
OPEN ENROLLMENT GUIDE
2019

CITY OF CHICAGO

For Sworn Police Officers below the rank of Sergeant represented by the Fraternal Order of Police (FOP)

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WELCOME TO ANNUAL OPEN ENROLLMENT

October 17, 2018 through October 31, 2018
Open Enrollment Changes are Effective January 1, 2019

Open enrollment is the time of year when you can:

- ✓ Enroll in or cancel your health insurance
- ✓ Switch medical or dental plans
- ✓ Add dependents to your plan (for example a spouse, civil union or same sex domestic partner, or children)
- ✓ Drop dependents from your plan
- ✓ Enroll or re-enroll in a healthcare Flexible Spending Account (FSA)
- ✓ Buy optional life insurance or voluntary long term disability insurance

To make changes, go to the City of Chicago Benefits Services Center website:

www.cityofchicagobenefits.org

Open enrollment changes can also be made over the phone by calling:

Benefits Service Center 1-877-299-5111

Special hours during open enrollment: Monday through Friday 8:00 a.m. until 6:00 p.m.
Special hours Saturday, October 27, 2018 8:00 a.m. until 6:00 p.m.

Enrollment in the Flexible Spending Account (FSA) does not carry over from year to year. You must re-enroll in an FSA if you want this benefit for 2019.

Enroll online at www.cityofchicagobenefits.org or call the Benefits Service Center

What Is New in 2019

ConnectYourCare is the City's new vendor for healthcare Flexible Spending Account and transit benefits.

Improvements include:

- One vendor replaces the two existing vendors - one stop shopping!
- You will have the option of a debit card for healthcare flexible spending account.

In the near future you will receive communications regarding the change to ConnectYourCare.

CVS Caremark is our new vendor for pharmacy benefits in the BCBS HMO, replacing Prime Therapeutics for the HMO. In the near future you will receive communications regarding the change with instructions that you or your doctor will need to follow to ensure no interruption in your prescriptions.

CVS Caremark continues to provide pharmacy benefits to PPO enrollees.

CHECK YOUR BENEFIT COVERAGE SHEET

Your personalized Benefits Coverage Sheet is included with this Guide. The medical, dental and vision enrollment listed on this Coverage Sheet will remain the same for 2019 unless you make changes during the open enrollment period which runs October 17, 2018 through October 31, 2018. You must re-enroll in the healthcare Flexible Spending Account to participate in 2019.

Dependent children who reach the age of 26 are automatically terminated from the City's health plan on the last day of the month of his/her birthday. However, if you have a disabled child reaching the age of 26, he/she may be eligible to continue dependent coverage. Contact the Benefits Service Center at least three months before your child's 26th birthday to apply for continued coverage for a disabled dependent child.

Check the personalized Benefits Coverage Sheet to make sure the information is correct for you and your dependents. Call the Benefits Service Center to update any of this information:

- Name and birthdate.
- Social Security number if marked as "N". If any Social Security number is marked "N", you must bring the original Social Security Card to the Chicago Benefits Office to update your dependent's record.

Federal law requires Social Security numbers for everyone enrolled in the City's health plans.

IF YOUR HOME ADDRESS CHANGES

Contact the Police Department's Human Resources Department to update your address on file with the City.

ENROLLMENT CHANGES DURING THE YEAR

Benefit enrollment changes are allowed throughout the year only if you have a life change event such as marriage, divorce, birth or adoption of a child or loss of coverage through your spouse. Call the Benefits Service Center within 30 days of the life change event. If you try to make these changes as an open enrollment change, the coverage will not go into effect until January 1, 2019. You must provide documents to prove the life change event within 60 days of the event. Call the Benefits Service Center for more information.

Please note: Life change events are effective on the event date but open enrollment changes are effective January 1, 2019. When you call to make a life change event during the open enrollment period, you need to make sure that you explain that you are calling about a life change event and ask for the benefits to be effective on the event date.

INSTRUCTIONS ON HOW TO ACCESS www.cityofchicagobenefits PORTAL

Step 1: Employee ID Number

In order to create an online account, you will need your eight digit employee ID number.

Where to find your employee ID number?

Look on the upper left of your paystub where it says PAYEE/EMPLOYEE NUMBER. That's it.

This is not your Kronos number, the number you use for City computer access, or your payroll number.

Step 2: Add Zeroes

For online open enrollment, your employee ID number needs to be eight digits long. Simply add zeroes at the front to make it eight numbers. Examples: 5432 becomes 00005432 and 1234567 becomes 01234567.

Please keep this number for future use.

Step 3: Create Online Account

If you plan to enroll online, go to: www.cityofchicagobenefits.org to create your open enrollment username and password to make sure you can get into the system. If you already have an online account, you can test it to ensure it works.

If you've forgotten your username, click "Forgot Your User Name" and enter your eight digit employee ID number. Follow the prompts to get your new username. If you've forgotten your password, click "Forgot Your Password" then enter your username and follow the prompts. If you've forgotten both, get your username first. If you've never used the system, click "First Time Logging In" and follow the prompts.

Step 4: Enrollment

- Select benefits to enroll
- Choose coverage: Single, Employee + One, Family
- Enroll or re-enroll in the healthcare Flexible Spending Account (FSA) for 2019

Once you have made your enrollment selections ensure you click "submit" on the final screen.

Step 5: Write it Down

Keep your username and password; you need them to use the online open enrollment system.

ADDING A DEPENDENT DURING OPEN ENROLLMENT?

STEP ONE – Enroll your dependents. Enroll your spouse, civil union partner, same sex domestic partner, and children during the open enrollment period online or by phone.

STEP TWO – Provide original documents to prove they are your legal dependents.
Submit your dependents documents as soon as possible. Your dependents will not have medical, vision or dental coverage, effective January 1, 2019 if you fail to submit the required documentation by December 6, 2018.

If you are adding dependents, you must provide the required documents for coverage to begin.

Deadline: If you submit your documents by close of business **Thursday, December 6, 2018** coverage will be reflected on January 1, 2019. For example, if your dependents seek medical care on January 1, 2019, your healthcare service provider will be able to verify coverage online. Please submit your documents to the Chicago Benefits Office by this deadline to properly reflect coverage by the January 1st effective date. ***We encourage you to submit your documents right away to avoid the last minute rush.***

Grace Period. If you fail to submit your documents by **Thursday, December 6, 2018**, you may submit documents through Thursday, January 31, 2019. Your failure to timely submit documents may result in delayed coverage.

If you fail to submit documentation by the end of the grace period on January 31, 2019, you will be required to wait until the next open enrollment period to enroll your dependents.

Bring certified documents and your dependent's social security card to:

Chicago Benefits Office
333 South State Street/Room 400
Chicago, IL 60604-3978

Office hours are Monday through Friday 8:30 a.m. – 4:30 p.m.

Your original certified documents will be copied and returned to you.
Documents required are:

Spouse – certified marriage certificate and spouse's social security card
Child – certified birth certificate and child's social security card
Civil Union – certified certificate and partner's social security card

It should be noted that:

- If healthcare services were received by your dependents during the grace period, and your medical provider submitted claims that were not paid because the required documents deadline of **December 6, 2018** was missed, those claims will be reprocessed retroactive to January 1, 2019 if the required enrollment documents are received by the Chicago Benefits Office by close of business January 31, 2019.
- Your medical provider may need to resubmit claims.
- Alternatively, if you paid out of pocket for healthcare services during the grace period, you may need to submit paper claims.

To avoid inconvenience, and to ensure your dependent's new coverage is reflected at the time of service, submit your documents to the Chicago Benefits Office by **Thursday, December 6, 2018.**

IMPORTANT NOTICE: If an employee or dependent gives false information, or if the dependent is not a legal dependent of the employee, the City will take action to collect any money paid to cover healthcare expenses related to the fraud and/or report the fraud to the appropriate authority.

DO NOT WAIT UNTIL THE LAST MINUTE

ENROLL OR RE-ENROLL IN A FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA) may save you money by reducing your income taxes. An FSA allows you to have money deducted from your paycheck before your federal and Social Security taxes are calculated. Your FSA contributions are automatically tracked in a special FSA account administered by ConnectYourCare. You can choose to have FSA reimbursement checks mailed to you or deposited directly into your bank account. You will have the option for a debit card for healthcare flexible spending account.

FSA contributions are spread over the year and taken out each paycheck. After you decide how much you want to put aside in an FSA, call the Benefits Service Center to enroll (1-877-299-5111) or enroll at www.cityofchicagobenefits.org

HEALTHCARE FSA

A healthcare FSA allows you to set aside pre-tax dollars for qualified health expenses that are not covered by medical, dental or vision insurance. Qualified expenses include deductibles, co-pays for medical care and prescription medications, vision services and dental care. The maximum FSA contribution in 2019 is $2,650.

Estimate how much you will likely spend in 2019. Consider what medical, vision and dental expenses you are fairly certain you will have next year including deductibles, co-pays and co-insurance amounts, as well as any out-of-pocket expenses for services not covered by the plan (eye laser surgery, dental implants etc). A complete list of health care expenses for FSA reimbursement can be found at www.irs.gov/pub/irs-pdf/p502.pdf.

USE IT OR LOSE IT

The IRS requires that any money left in your account at the end of the year will be forfeited. If you enroll in an FSA for 2019, qualified expenses have to be incurred before March 15, 2020. You will have until March 31, 2020 to submit your 2019 expenses.

If your employment with the City ends before you have used all the money in your FSA, you have until the end of the annual grace period to submit expenses for FSA reimbursement (for example, March 31, 2020 for expenses incurred in 2019). If you plan to incur expenses after your employment with the City ends, you must elect to continue FSA contributions under PHSA/COBRA.

DON'T FORGET TO RE-ENROLL!

You must re-enroll in the FSA each year during Open Enrollment

www.cityofchicagobenefits.org

1-877-299-5111

FSA enrollment cannot be done by ConnectYourCare

New FSA provider: You will continue to submit 2018 claims to PayFlex through March 31, 2019. Claims for 2019 will be processed by ConnectYourCare. More information coming soon.

SPECIAL REMINDERS

Blue Cross Blue Shield of Illinois www.bcbsil.com/cityofchicago
Check the status of your claims, request new ID cards, download an image of your ID card onto your phone, and find providers in the City of Chicago's PPO and Blue Advantage HMO plans.

To register: locate your group number and member ID number on your Blue Cross Blue Shield card. Then go to the website and click "Register Now" and follow the prompts to create a username and password.

Blue 365 Discount Program www.blue365deals.com
A program offered by Blue Cross Blue Shield of Illinois to HMO and PPO members. Save money on health care products and services that are not covered by the City of Chicago's medical plans. Get discounts from top national and local retailers on fitness gear, gym memberships, family activities and healthy eating options. Examples include Reebok shoes, Life Time Fitness memberships, Procter and Gamble Dental Products and TruHearing services. Register to receive weekly featured deals which offer additional discounts for a short period of time. There are no claims to file.

VOLUNTARY CHARITABLE PAYROLL CONTRIBUTIONS PROGRAM

City employees have the opportunity to extend their generosity to thousands of individuals and families through the Employee Voluntary Charitable Payroll Contributions Program. Choose up to ten agencies to receive your contributions from a list of 29 approved Chicagoland area charitable organizations. If you already participate in the program, you can make changes, discontinue deductions, add new charities or increase your contributions at any time. For more information, speak to your payroll administrator or download the donations form at: http://www.cityofchicago.org/city/en/depts/fin/provdrs/payroll.html under supporting information, "Charitable Giving".

ONLINE PAY SLIPS

Sign up for GreenSlips, the City online pay slips program to view direct deposit of your paycheck online. You can also view and download your W2 tax return as soon as available.

Go to https://greenslips.cityofchicago.org/TransformCon-tentCenter/ and use your employee number to set up a secure account.

HEALTH CARE CONTRIBUTION RATES FOR 2019

Rates Effective 7/1/2006

For Sworn Police Officers below the rank of Sergeant represented by the Fraternal Order of Police (FOP)
(Contributions taken as payroll deductions; 24 pay periods each year)

ANNUAL SALARY	SINGLE	EMPLOYEE+1	FAMILY
Up to $30,000*	**$15.71**	**$23.88**	**$27.65**
$30,001 and < $90,000	**1.2921% of payroll ÷ 24**	**1.9854% of payroll ÷ 24**	**2.4765% of payroll ÷ 24**
$90,000 and above	**$48.45**	**$74.45**	**$92.87**

*If your salary is under $30,000 and you enroll for single coverage, you pay a flat rate of $15.71 each pay period

If your salary is more than $30,000 but less than $90,000 and you enroll in single coverage, your premium is calculated as a percentage and divided by 24 pay periods. Here is an example of the premium calculation for an employee who makes $46,000 a year:

Single	$46,000 x .012921 ÷ 24 = $24.77 each pay period
Employee + 1	$46,000 x .019854 ÷ 24 = $38.05 each pay period
Family	$46,000 x .024765 ÷ 24 = $47.47 each pay period

PPO MONEY SAVINGS

Save by using doctors and hospitals in the PPO Tier 1 network: The PPO gives you freedom to choose from three different network tiers. You can select doctors and hospitals (providers) from Tier 1 for some of your care, and use Tier 2 or Tier 3 providers for other services. You pay the lowest deductible and coinsurance when you use providers in Tier 1. To find a Tier 1 provider, call 1-800-772-6895 or go to www.bcbsil.com/cityofchicago.

Two ways to save on prescription medications: 1) Choose generic medications and pay the lowest copay. 2) Use mail order for long term "maintenance" medications. You will pay more if you don't use mail order for long term medications after the 3rd fill. Just call 1-866-748-0028 and ask CVS Caremark to contact your doctor for a new prescription to be processed through mail order.

Save on lab tests – use a free-standing lab: Get your lab tests paid in full by using a free-standing lab (such as a Quest lab) which is not affiliated with a hospital. Even if your doctor already has an arrangement with Quest, ask for a lab order for tests to be done at a Quest facility. Take this paperwork to the Quest lab and test results will be sent directly to your doctor. Call 1-866-697-8378 to find the location of a Quest lab near you, or go to www.Questdiagnostics.com.

Save on scans – use a free-standing imaging center: Scans are covered in full if done at a free-standing imaging center. When your doctor orders an MRI, CT, or PET scan, call Telligen at 1-800-373-3727 to pre-certify the test and locate a free-standing imaging center near you.

Pregnant? Earn a $100 incentive: Enroll in a free, confidential maternity management program designed to encourage a healthy baby by providing telephone support for moms-to-be. To qualify for the $100 incentive, call Telligen (1-800-373-3727) to enroll and complete at least eight doctors' visits during the pregnancy.

BLUE CHOICE OPTIONS MEDICAL PPO-PLAN B

		Blue Choice OPT Tier 1	Blue Cross PPO Tier 2	Out-of-Network Tier 3
Annual Deductible	**Individual** **Family**	**$300** **$900**	**$350** **$1,050**	**$1,500** **$3,000**
Out-of-Pocket Limit	**Individual** **Family**	**$1,000** **$2,000**	**$1,500** **$3,000**	**$3,500** **$7,000**
PREVENTIVE CARE		**YOU PAY**	**YOU PAY**	**YOU PAY**
Routine checkups & routine lab work for adults & children; well-baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing screenings		**$0 copay** No deductible	**$0 copay** No deductible	No coverage out-of-network for preventive care
OFFICE VISITS				
Primary Care Physician, lab work, x-rays, allergy shots, Mental health and substance abuse counseling		**$20 copay** does not apply to deductible	**$25 copay** does not apply to deductible	**40% PPO** allowed rate after out-of-network deductible plus balance billed by provider
Specialist Physician And Chiropractic Care (visit limits)		**$30 copay** does not apply to deductible	**$35 copay** does not apply to deductible	
Annual deductible must be paid before Plan covers these services:		**YOU PAY** **After Tier 1 deductible**	**YOU PAY** **After Tier 2 deductible**	**YOU PAY** **After Tier 3 deductible**
OUTPATIENT SERVICES*				
Outpatient surgery MRI, PET & CT scan*		**10%**	**25%**	**40%** PPO allowed rate plus balance
HOSPITAL SERVICES*				
Hospital stay* including inpatient surgery		**10%**	**25%**	**40%** PPO allowed rate plus balance
EMERGENCY ROOM CARE				
Emergency Room		**$150 co-pay waived if admitted**		
Emergency Room Treatment		**10%**		
Ambulance emergency care		**10% of PPO allowed rate**		
MENTAL HEALTH & SUBSTANCE ABUSE*				
Inpatient hospitalization* **Outpatient therapy***		**10%**	**25%**	**40%** PPO allowed rate plus balance
ALTERNATIVES TO HOSPITAL CARE*				
Skilled nursing facility* **Home health care*, Hospice care***		**10%**	**25%**	**40%** PPO allowed rate plus balance
MATERNITY SERVICES				
Maternity management program		**No charge plus $100 cash incentive**		
Pre and post natal doctor visits		**$20 copay** (first visit)	**$25 copay** (first visit)	**40%** PPO allowed rate plus balance
Delivery and hospital stay*		**10%**	**25%**	
OUTPATIENT REHAB				
Physical therapy **Occupational and speech therapy***		**10%** **$20 copay**	**25%** **$20 copay**	**40%** PPO allowed rate plus balance
OTHER SERVICES				
DME*: Oral Surgery; **Ambulance transport between hospitals***		**10%**	**25%**	**40%** PPO allowed rate plus balance

***Limit 60/cal. yr. Also, care must be pre-certified by calling Telligen at 1-800-373-3727. See the next page.**

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CERTAIN PPO SERVICES NEED TO BE PRE-CERTIFIED

Telligen, the PPO medical advisor, needs to pre-certify the services listed below. There is a $1,000 penalty if Telligen is not contacted in a timely fashion in the event of a hospitalization. This $1,000 penalty does not go towards the deductible or get counted in the out-of-pocket maximum. Telligen's phone number is 1-800-373-3727. This number is also on the back of the PPO ID card.

When To Call Telligen at 1-800-373-3727

HOSPITAL ($1,000 penalty if Telligen is not called)	
Any inpatient stay in the hospital for medical, surgical, maternity, mental health or substance abuse care.	Call before elective admission or within two business days of an emergency admission.
Hospital outpatient treatment for mental health and substance abuse	Call before the treatment begins.
Plan pays nothing for the services listed below unless Telligen certifies	
AMBULANCE	
When ambulance is used for transfer between hospitals or to a hospital in a non-emergency situation	Call before the transfer is arranged.
SURGERY	
Organ transplant surgery Bariatric surgery Gender reassignment surgery } Must be done at a Blue Distinction Center	Call before surgery is scheduled.
MEDICAL EQUIPMENT	
DME (durable medical equipment)	Call before equipment is ordered if more than $500 for each item.
OUTPATIENT THERAPY	
Mental health & substance abuse outpatient therapy/ counseling	Call after a combined total of 7 sessions from one or more providers. Call each year if care is on-going.
Occupational and speech therapy	Call after the 10th session each calendar year from one or more providers. Call each year if care is on-going.
DIAGNOSTIC TESTS	
MRI, PET & CT scans	Call before test is done. Covered 100% if pre-certified and done at a free standing facility. Deductibles and co-insurance amounts apply if pre-certified and done at a hospital facility or billed by a hospital.
OTHER SERVICES	
Home health care	Call before services start.
Skilled nursing facility	Call before being admitted.
Hospice Infertility treatment Non-surgical transplants Other gender reassignment services	Call before services start.

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PPO PRESCRIPTION DRUG PROGRAM

Administered by CVS Caremark

PPO PRESCRIPTION MEDICATIONS	YOU PAY
RETAIL - Short term medications If purchased at a participating retail pharmacy 34 day supply or 100 units whichever is less.	Generic **$10 copay** Preferred formulary brand name **$30 copay** Non-preferred brand name **$45 copay**
RETAIL - Maintenance or long term medications The 4th fill and any additional refills 34 day supply or 100 units, whichever is less.	Generic **$20 copay** Preferred formulary brand name **$60 copay** Non-preferred brand name **$90 copay**
MAIL ORDER - Long term medications for chronic conditions 90 day supply To get medications through the mail, send your doctor's prescriptions to: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 Call Caremark or visit its website for more information about mail order.	Generic **$20 copay** Preferred formulary brand name **$60 copay**
Generic birth control **Smoking Cessation medications**	**$0 copay**

VALUE FORMULARY

Your plan has adopted the Value Formulary to encourage use of generics. Prescriptions not on the Value Formulary list will be denied coverage at the pharmacy and the pharmacist will then ask your physician to substitute a Value Formulary drug.

If your physician does not agree to change the prescription, your physician must request an exception from CVS Caremark by submitting clinical information for prior authorization. An approval or a denial will be faxed to your physician and mailed to your home address. Contact CVS Caremark for information about the prior authorization process and the list of Value Formulary drugs.

www.caremark.com
1-866-748-0028

BLUE ADVANTAGE HMO* – A Blue Cross HMO

If care is pre-approved by your HMO primary care physician (PCP)

YOU PAY

DOCTORS VISITS	
Primary Care Physician (PCP)	**$25 copay**
Specialists	**$35 copay** when approved by PCP
Pre-natal visits	**$25 copay** first visit
HOSPITAL (all hospital services must be approved by PCP)	
Inpatient admission	**$20 copay**
Surgery (inpatient & outpatient)	**$20 copay**
Maternity delivery Care in the hospital for mother & baby	**$0 after $20 hospital copay**
PREVENTIVE SERVICES	
Routine checkups for adults & children; well- baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing tests	**$0 copay**
EMERGENCY SERVICES (see next page for emergency coverage information)	
Emergency room treatment – life threatening	**$150 copay** (waived if admitted)
Ambulance – life threatening	**You pay $0**
MENTAL HEALTH & SUBSTANCE ABUSE (must be pre-approved by PCP)	
Outpatient therapy	**$25 copay**
Inpatient care	**$20 copay** each admission
OUTPATIENT REHAB THERAPY (must be pre-approved by PCP)	
Physical, speech and occupational therapy	**$0 copay** Limit of 60 visits combined each calendar year
OTHER SERVICES (all other services must be pre-approved by PCP)	
Skilled nursing facility	**$0** Limited to 120 days a year
Durable Medical Equipment (DME) Hospice Home health care Ambulance transport between hospitals	**$0**

*HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.

www.bcbsil.com/cityofchicago

1-800-730-8504

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HMO EMERGENCY CARE

The Blue Advantage HMO covers life threatening medical emergencies. It also covers care for acute medical problems when pre-approved by your primary care physician (PCP).

What is a medical emergency?

A life threatening medical emergency is the sudden and unexpected onset of a potentially dangerous situation which, if not treated immediately, could jeopardize your health. Such conditions are also severe and sudden in onset.

EMERGENCY ROOM TREATMENT Go to the nearest emergency room in the event of a life threatening emergency	You pay **$150 copay** – waived if admitted If possible, contact your PCP before seeking emergency care. (Your PCP is available 24 hours a day, seven days a week.) In a life threatening emergency, call 911 and then contact your PCP within 48 hours following emergency care.
AMBULANCE For life threatening medical emergencies	You pay **$0**
TREATMENT IN PCP OFFICE For acute medical problems which are not life threatening	You pay **$25 copay** if care is given in your PCP's office. Call your PCP's emergency number on the back of your Blue Advantage HMO ID card. A doctor or nurse will evaluate the problem and give instructions on where to go for medical care.
URGENT MEDICAL CARE AWAY FROM HOME For treatment for unexpected illness and injury when travelling outside the Chicagoland area contact your PCP.	Call the toll-free emergency number on the back of your Blue Advantage HMO ID card. If you or a covered dependent is away from home for more than 90 days, guest membership is provided at affiliate HMOs. Copays maybe different.

*HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.

www.bcbsil/cityofchicago
1-800-730-8504

HMO PRESCRIPTION DRUG PROGRAM

Administered by CVS Caremark

HMO PRESCRIPTION MEDICATIONS	YOU PAY
RETAIL - Short term medications If purchased at a participating retail pharmacy 34 day supply or 100 units whichever is less	Generic **$10 copay** Preferred brand name **$30 copay*** Non-preferred brand name **$45 copay***
RETAIL - Maintenance or long term medications The 4th fill and any additional refills 34 day supply or 100 units, whichever is less.	Generic **$20 copay** Preferred brand name **$60 copay*** Non-preferred brand name **$90 copay***
MAIL ORDER Long term and maintenance medications for chronic conditions 90 day supply To order medications through the mail, send your doctor's prescription to: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 Call Caremark or visit their website for more information about mail order.	Generic **$20 copay** Preferred brand name **$60 copay***
Oral Contraceptives (generic or brand)*	Generic **$0 copay** Preferred brand **$30 copay*** Non-preferred brand **$45 copay***
Smoking cessation medications	Certain generic medications **$0 copay**

*If the member chooses brand when generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay.

www.caremark.com

1-866-748-0028

DENTAL PROGRAM

Administered by Blue Cross Blue Shield of Illinois (BCBS)

Enrollment in the dental plan is available after one calendar year of full-time employment. You are automatically enrolled in the Dental PPO with the option to switch to the Dental HMO within 30 days of being eligible for dental coverage. You can also change dental plans during open enrollment, if currently enrolled. No action is needed if you want to continue your same dental coverage in 2019.

BLUE CARE DENTAL PPO & HMO BENEFITS

	PPO In-Network	PPO Out-of-Network	HMO In-Network*
	YOU PAY	YOU PAY	YOU PAY
Preventive (Two visits each year) **Oral exams** **Cleanings** **X-Rays**	**$10 copay** No deductible for preventive services	**20%** of PPO allowable amount plus balance of billed charges No deductible for pre-ventative services	**$10 copay** for each preventative visit No deductible in the HMO
Annual deductible (amount each member pays first before plan pays benefits)	YOU PAY	YOU PAY	YOU PAY
	$100	**$200**	No deductible
Annual limit (maximum amount a member receives in dental coverage each year after deductible has been paid)	PLAN PAYS UP TO	PLAN PAYS UP TO	
	$1,200	**$1,200**	No annual limit
	YOU PAY	YOU PAY	YOU PAY
Restorative **Endodontics** **Periodontics** **Oral Surgery** **Crowns**	**40%**	**50%** of PPO allowed amount plus balance of billed charges.	Copays of various amounts (for information about co-pay amounts visit www.bcbsil.com/cityofchicago or call 1-855- 557-5487). Plan pays **100%** after co-pay
Orthodontics	Not covered	Not covered	Covered for children up to age 25 with **$2,300** copay. Not covered for employee or spouse.

*There is no coverage out-of-network in the Blue Care Dental HMO. You must use dentists who participate in the Blue Care Dental HMO. For up-to-date information about HMO dentists visit the dental program website or call for more information.

www.bcbsil.com/cityofchicago
1-855-557-5487

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VISION PROGRAM

You are automatically enrolled in the Vision Program when you enroll in the City's PPO or Blue Advantage HMO plan.

The Vision Program is administered by Davis Vision and covers routine eye exams, prescription eyeglasses and contact lenses. How much the plan pays depends on the type of services or eye-wear you choose, and which vision retail store you use.

You get the most value from your vision benefits when you use a provider in the Davis Vision network. To locate Davis Vision providers visit www.DavisVision.com or call 1-888-456-8758.

The Vision Program does not issue ID cards. Your Blue Cross HMO or PPO ID card will be used to verify coverage in the Davis Vision plan.

DAVIS VISION CARE BENEFITS

	In-Network You Pay	Out-of--Network You Pay
Routine Eye Exam (One exam every 12 months) based on last date of service	**$0**	Balance over **$35**
Frames One pair every 12 months	**$0** for frames from Davis Vision collection: • Or balance over the **$110** allowance for frames at Vision-works* stores • Or balance over the **$50** allowance for frames at other in-network stores	Balance over **$50**
Lenses-single vision **Tinting** **Coatings** **Special lenses**	**$0** one set every 12 months Copays for tinting, coatings and special lenses vary. Visit www.davisvision.com or call 1-888-456-8758 for specific copay amounts.	Balance over **$35**
Contact lenses (in lieu of glasses)	**$0** one pair every 12 months	Balance over **$105**

www.davisvision.com
1-888-456-8758

You are automatically enrolled in the Vision Program when you enroll in the City's PPO or Blue Advantage HMO plan.
* Visit the Davis Vision website or call 1-888-456-8758 to locate a Vision-works store.

PROTECT YOUR-FUTURE INCOME FOR YOU AND YOUR LOVED ONES

The City at no cost to you, provides basic term life insurance. You have an opportunity to buy more coverage through the City's group insurance policy. You may contact the insurance providers at any time to learn more.

BASIC TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

As a City employee, you automatically receive $25,000 of free basic life insurance which pays in the event of your death and/or for certain accidental losses. This amount increases for sworn Police to $75,000 after the first year of full employment. When your employment with the City ends, you can continue this basic life insurance by paying premiums directly to MetLife.

OPTIONAL TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

During open enrollment you may increase the amount of life insurance for yourself or buy coverage for your eligible dependents. You will pay the cost through payroll deductions. Proof of good health may be required.

Please note:

- Increasing the amount of insurance (1x to 10x your annual earnings, up to $1.5 million) will require proof of good health.
- Buy insurance for a spouse or civil union partner for $10,000, $25,000 or $50,000 of coverage (limits apply)
- Enroll children from birth to age 25 for $5,000 to $10,000 in coverage (one rate covers all your children and no proof of good health is required)

VOLUNTARY PERMANENT LIFE INSURANCE: (Texas Life (formerly MetLife)www.empben.com/CityofChicagoUL/ or 1-800-638-6855)

Permanent life insurance provides a death benefit. Sign up during the open enrollment period and/or apply for coverage for your dependents. (Proof of good health is required satisfactory to Texas Life)

LONG TERM DISABILITY: (Prudential www.prudential.com 1-800-778-3827)

Long term disability insurance (LTD) is designed to give you a monthly cash payment in the event you cannot work because of an illness or injury. Proof of good health may be required when you sign up during open enrollment.

DEFERRED COMPENSATION: (Nationwide www.chicagodeferredcomp.com 1-855-457-2489 or 1-877-677-3678). The City offers a tax deferred compensation plan that allows employees to put aside money from each paycheck toward retirement. A deferred compensation plan can supplement your pension and help increase your retirement income. You can enroll in the Deferred Compensation program at any time.

VOLUNTARY SUPPLEMENTAL INSURANCE

Employees will have the opportunity to purchase voluntary supplemental insurance through payroll deduction. Voluntary Supplemental Insurance will be sold by two insurers:

- Combined Insurance Company 1-888-870-3382
- Aflac Insurance Company 1-888-382-3522

Each insurer is authorized to enroll you in one of three supplemental insurance products:

- Hospital Indemnity Insurance pays a fixed dollar amount if you are hospitalized
- Accidental Injury Insurance pays a fixed dollar amount for certain medical and other services if you are injured in a non-work accident
- Critical Care insurance pays a fixed dollar amount if you become ill with a specified critical diagnosis

Employees should carefully consider which of the optional products the City offers best meets their needs for life insurance, disability insurance, medical and dental care and now supplemental insurance through payroll deduction.

Detailed information about these products is available directly from the insurers at the numbers listed above. Additional information will be sent to your home by the insurers. The City of Chicago Benefits Office does not provide advice regarding these insurance products.

BE HONEST!

A REMINDER ABOUT FRAUD

Any kind of fraud on the City of Chicago's benefit plans may result in adverse consequences to an employee and dependent, for example:

- Failure to notify the City Benefits Service Center and Chicago Benefits Office of an event that would cause coverage to end, e.g. divorce
- Misrepresentation by the employee or dependent regarding the initial eligibility, for example, the dependent's age, or that the dependent is not a legal dependent of the employee
- Any attempt to assign or transfer coverage to someone else (e.g. letting another person use your Plan ID card)

The employee will be required to pay for any claims and all administrative costs that were incurred fraudulently. This may result in coverage being terminated for the employee and action by the City to collect any money paid. The City may also discipline the employee, up to and including termination.

DIVORCED SPOUSE'S HEALTH COVERAGE:

If an employee becomes divorced, he/she must follow the procedure outlined in the City's Plan document available at www.cityofchicagobenefits.org:
Notify the Benefits Service Center within 30 days of the date of the divorce and bring the certified divorce decree to the Chicago Benefits Office within 60 days.

Failure to comply with the procedure will result in the employee being held liable for any healthcare claims and related expenses incurred by the participant and the ex-spouse, as of the date of the divorce.

You must call the Benefits Service Center to notify the City of the divorce at 1-877-299-5111 and take the original certified divorce decree to:

Chicago Benefits Office
333 South State Street
Room 400
Chicago, IL 60604-3978

(Open Monday thru Friday, 8:30 a.m. to 4:30 p.m.)

QUESTIONS? WANT TO LEARN MORE?

Visit a Benefits Information Fair and speak directly with representatives from the Chicago Benefits Office, Blue Cross (HMO and PPO), Blue Care Dental (HMO & PPO), Telligen medical advisor, CVS Caremark prescription drug program, Davis Vision Plan, ConnectYourCare, Prudential, MetLife, Nationwide deferred compensation program, Combined and Aflac Voluntary Supplemental insurance, Texas Life insurance, and the Chicago Patrolmen's Federal Credit Union.

Date	Time	Location	Address
Wednesday October 10, 2018	**10:00 AM - 3:30 PM**	**City Hall**	**121 N. LaSalle St.** (11th Floor)
Thursday October 11, 2018	**10:00 AM - 3:30 PM**	**DePaul Center**	**333 S. State St.** (4th Floor)
Wednesday October 17, 2018	**10:00 AM - 3:30 PM**	**Public Safety Headquarters**	**3510 S. Michigan Ave.** (1st Floor)
Thursday October 18, 2018	**10:00 AM - 3:30 PM**	**Family and Support Services**	**1615 W. Chicago Ave.** (2nd Floor)
Wednesday October 24, 2018	**10:00 AM - 3:30 PM**	**Midway Airport** AMC Building	**6201 S. Laramie St.** (1st Floor)
Thursday October 25, 2018	**10:00 AM - 3:30 PM**	**O'Hare Airport** Department of Aviation	**10510 W. Zemke Blvd.**
Monday October 29, 2018	**10:00 AM - 3:30 PM**	**2FM Building**	**900 E.103rd St.**
Tuesday October 30, 2018	**10:00 AM - 3:30 PM**	**2FM Building**	**1869 W. Pershing Rd.**

Benefits Information Fairs are for current employees and their spouses/civil union partners/ domestic partner to learn more about healthcare and other benefits related to the annual open enrollment process.

2019 IMPORTANT WEBSITES AND PHONE NUMBERS

SERVICE PROVIDER	WEBSITE	PHONE NUMBER
City of Chicago **Benefits Service Center**	**www.cityofchicagobenefits.org**	**1-877-299-5111**
Medical PPO Blue Cross Blue Shield of Illinois CVS Caremark PPO Pharmacy Telligen medical plan advisor	 www.bcbsil.com/cityofchicago www.caremark.com www.telligen.qualitrac.com	 **1-800-772-6895** **1-866-748-0028** **1-800-373-3727**
Medical HMO Blue Advantage HMO CVS Caremark	 www.bcbsil.com/cityofchicago www.caremark.com	 **1-800-730-8504** **1-866-748-0028**
Blue Care Dental Dental PPO and HMO	www.bcbsil.com/cityofchicago	**1-855-557-5487**
Davis Vision	www.davisvision.com	**1-888-456-8758**
Quest Diagnostics	www.questdiagnostics.com	**1-866-697-8378**
PayFlex (2018 Claims) Flexible Spending Account (FSA)	www.HealthHub.com	**1-800-284-4885**
ConnectYourCare (January 1, 2019) Flexible spending account (FSA) Transit benefit	www. connectyourcare.com/cityofchicago	**1-833-229-4428**
MetLife Basic term life insurance Optional life insurance	www.metlife.com/mybenefits	**1-866-492-6983**
Prudential Long term disability	www.prudential.com	**1-800-778-3827**
Texas Life Universal permanent life insurance	www.empben.com/CityofChicagoUL/	**1-800-638-6855**
Nationwide Retirement Services	www.chicagodeferredcomp.com	**1-877-677-3678**
Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	**1-312-744-3891**
Voluntary Supplemental Insurance Combined Aflac		 **1-888-870-3382** **1-888-382-3522**

Plan B effective 1/1/2019. This is a summary of benefits offered to City of Chicago Sworn Police Officers below the rank of Sergeant represented by the Fraternal Order of Police. The Plan Document and subsequent updates always supersedes this summary.

LEGAL NOTICES

CITY OF CHICAGO
MEDICAL PPO PLANS ("MEDICAL PLANS")

NOTICE TO ENROLLEES OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT EXEMPTION FOR 2019

Generally, group health plans sponsored by state and local governmental employers, such as the City of Chicago (the "City" or "plan sponsor") must comply with federal law requirements in title XXVII of the Public Health Service Act, and the amendments thereto set forth in the Mental Health Parity and Addiction Equity Act. However, these governmental employers are permitted to elect to exempt a plan from all of the requirements listed below for any part of the plan that is self-funded by the employer rather than provided through a health insurance policy. The purpose of this Notice is to inform you that the City of Chicago has elected to exempt the City of Chicago Medical PPO Plans as follows:

1. *Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan (sometimes referred to as "mental health parity requirements")*. The plan sponsor has elected to maintain the existing terms and conditions of the Medical Plans by exempting the Medical Plans from this requirement. Therefore, the City will continue in place the current requirement that Plan Participants who receive outpatient mental health and substance abuse treatment by a behavioral health specialist must obtain pre-certification by a Medical Advisor, under the Plans' Medical Advisor Review Program, after the first seven sessions each year with one or more such providers. This requirement will continue in effect for the 2019 plan year (beginning January 1, 2019, and ending December 31, 2019), and may be renewed for subsequent plan years pursuant to a subsequent exemption election, unless modified through the collective bargaining process.

2. *Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section*. The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

3. *Certain requirements to provide benefits for breast reconstruction after a mastectomy.* The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

4. *Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution*. The Medical Plans no longer use student status and provides an opportunity to elect coverage to age 26 and thus this requirement currently applies under the terms of the Medical Plans without exception.

ANNUAL HEALTH CARE REMINDER

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan offered by the City of Chicago provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between breasts, as well as prostheses and complications resulting from a mastectomy (including lymphedema). Contact your PPO or HMO administrator for more information.

City of Chicago Medical Healthcare Plan Documents

The plan documents are online. You may navigate to them by going to the benefits website. Start at the link: www.cityofchicago.org/benefits and on click on Employee / Annuitant Handbooks.

You may also go to these deep links:

- Deep links to Plan Document for medical plans for Group A: **https://www.chicago.gov/content/dam/city/depts/fin/supp_info/Benefits/Handbooks/Group_A_Medical_PPO_Plan_Booklet.pdf and https://www.chicago.gov/content/dam/city/depts/fin/supp_info/Benefits/Handbooks/2017_Group_A_and_B_Medical_HMO_Plan_Booklet.pdf**

- Deep links to Plan Document for medical plans for Group B: https://www.chicago.gov/content/dam/city/depts/fin/supp_info/Benefits/Handbooks/Group_A_Medical_PPO_Plan_Booklet.pdf and

- Deep link to Plan Document for medical plans for Retirees: https://www.chicago.gov/content/dam/city/depts/fin/supp_info/Benefits/Handbooks/City_of_Chicago_Retiree_Health_Plans_010115.pdf

City of Chicago
Retiree Medical

- Medicare eligible retiree plan Summary Sheet
- Non-Medicare eligible retiree plan Summary Sheet

PPO STANDARD PLAN BENEFITS SUMMARY†
Effective January 1, 2019
For Non-Medicare Eligible Retirees Retired Before 8/23/89

†The plan document defines and controls the terms of the benefits provided.

The PPO Standard Plan pays as shown below after you meet the annual deductible. The maximum amount that the Plan will pay is based on the Plan's PPO maximum allowance.** Services must be medically necessary. ***This Plan includes the Blue Cross Blue Shield PPO Network.***

Medical Benefits		In Network PPO Providers	Out Of Network Providers
Lifetime Maximum		$1.5 million per covered person for medical and prescription drugs. The lifetime maximum includes expenses paid under all Non-Medicare and Medicare plans combined.	
Deductible			
Individual	2019	$467	$1091
Family	2019	$1,401	$3,273
Out-of-Pocket Expense Limit			
Individual	2019	$2,728	$5,452
Family	2019	$5,456	$10,904
		In-network and not in network cannot be combined	
Coinsurance		**Plan Pays:**	
Emergency Room Services		90%**	
MRI Scans, PET Scans, CAT Scans *		80%**	
Occupational and Speech Therapy *			
Prosthetic Devices and Durable Medical Equipment (DME) *			
Ambulance Transportation *			
Skilled Nursing Facility *			
Skilled Home Health Care *			
Hospice Care *			
Outpatient Mental Health and Substance Abuse *			
Diagnostic Testing Incentive Program**			
Diagnostic Lab Tests performed by an independent PPO lab (i.e. Quest) paid in full by Plan if all requirements are met. Members must use a free standing in network lab, e.g., Quest, for diagnostic tests ordered by their physician to have the expense paid in full by the Plan. If a member uses a hospital based laboratory or the claims for lab services are billed by a hospital, the expenses are subject to deductible and co-insurance.**			
Other Covered Services, for example: • Hospital Inpatient * • Hospital Outpatient • Doctor (Office) Visits Note: Routine Screening Exams/Physicals are not covered Preventive care is not covered.		90%**	70%**

*These services require pre-certification through Telligen. Call 1-800-373-3727.

****PPO maximum allowance*** – The amount that providers who have contracted with the claims administrator have agreed to accept as reimbursement. The maximum amount that will be considered by the plan as covered for services is the lowest of the provider's actual charge, the PPO contracted rate or the usual and customary charge.

CBO
YELLOW
Rev. 9/2018

BENEFITS SUMMARY RETIREE HEALTH PLAN
For Retirees Who Retired Prior To 8/23/89
PRESCRIPTION DRUG COVERAGE
Effective January 1, 2018

†The plan document defines and controls the terms of the benefits provided.

Prescription Drug Benefits	Coverage
Caremark Retail Pharmacy – up to a 30 day supply or 100 unit dose (whichever is less)	After you've met the separate $100 annual prescription drug deductible (does not apply to Means Test Eligible Retirees*), for each prescription, you pay: • 20% of the contracted cost for generic drugs • 20% of the contracted cost for formulary brand name drugs** when no generic is available • 20% of the contracted cost plus $15 for non-formulary brand name drugs*** when no generic is available
Mail Order Program - Up to a 90 day supply	For each prescription, you pay: • $30 for 2019 ($7 for Means Test Eligible Retirees) for generic drugs • $83 for 2019 ($20 for Means Test Eligible Retirees) for formulary brand name drugs when no generic is available **Note: non-formulary brand name medications are not available through the mail order program.**
Restrictions: Why choose a generic?	If a brand name drug is dispensed when a generic alternative is available, you pay the difference in cost between the generic and the brand name as well as the generic copayment. The Plan will not pay more than it would pay for the generic medication if you buy a brand name drug when a generic alternative is available.
Generic Step Therapy Program for generics available in the therapeutic class	If you elect to purchase a brand medication without trying an appropriate generic medication in the same therapeutic class, you will pay the full cost of the medication. **If you try the generic medication and your physician finds that the generic medication is not effective in treating your condition, you will be able to receive the brand medication at the copayment applicable to non-formulary or formulary drugs.**
Specialty Medications	If you do not try the preferred medication for the therapeutic class, you will pay the full cost of the medication. If you try the preferred specialty medication and it is not effective in treating your condition, you will be able to receive a non-preferred formulary drug at retail.
Mandatory Mail Order	Requiring the use of mail order will reduce costs for the City and Retirees. After 2 fills of your generic or formulary brand medication at a retail pharmacy, you will be required to use mail order for any additional fills through CVS-Caremark in Mount Prospect, IL. If you do not use the mail order program for your 3rd or any subsequent fills, you will pay the full cost of the prescription. If your medication is non-formulary, however, you must continue to use the retail pharmacy.
Out-of-network pharmacy reimbursement	If you do not go to a network retail pharmacy, you pay the full amount when you pick up your prescription. You must then submit a receipt for reimbursement. The Plan will pay 60% of the Plan's cost, after you've met the deductible (if applicable). There is no formulary list if you go to an out-of-network pharmacy.

* **Means test eligible retiree –** generally, the combined household adjusted gross income, as reported to the Internal Revenue Service in the immediately preceding tax year, must be at or below 250% of federal poverty guidelines for your family size that year.

** **Formulary brand name drugs –** a formulary drug is a brand name drug that has been designated as a preferred drug by CVS Caremark. The preferred drug list (formulary) may change periodically at the discretion of the pharmacy benefits manager.

*** **Non-formulary brand name drug –** a non-formulary brand name drug is a brand name drug that is not on the preferred list of formulary drugs.

BENEFITS SUMMARY †
Medicare Eligible
Effective January 1, 2019

†The plan document defines and controls the terms of the benefits provided.

Medicare Supplement
Retiree Healthcare Plan Retired Before 8/23/89

The Medicare Supplement Retiree Healthcare Plan pays the percentages listed below after Medicare pays and you meet any annual deductibles. The maximum amount that the Plan will pay is based on the Medicare allowable charge.* Services must be medically necessary.

Medical Benefits	Coverage
Lifetime Maximum	$1.5 million per person for medical and prescription drug benefits [1]
Plan Deductible [2]	$100 per person each calendar year (separate from Medicare Part B deductible)
Hospitalization	
Days 1 – 60	You pay $50 of the Medicare Part A Inpatient Deductible for the first hospital stay in each calendar year. The Plan pays all but $50 of the Medicare Part A Inpatient Deductible for the first hospital stay each calendar year.
Days 61 – 90	You pay $0. Plan pays 100% of the Medicare daily co-payment, which is 25% of the Medicare Part A Inpatient Deductible.
Days 91 – 150	You pay $0. Plan pays 100% of the Medicare daily co-payment, which is 50% of the Medicare Part A Inpatient Deductible.
Additional Days	Additional days may be covered under Medicare Part A and/or the Plan.
Skilled Nursing Facility	
Days 1 – 20	You pay $0. Medicare pays 100% of first 20 days each Medicare Benefit Period.
Days 21 – 100	You pay $0. Plan pays 100% of the Medicare daily co-payment, which is 1/8 of the Medicare Part A Inpatient Deductible.
Additional Days	You pay 100%. No Medicare or Plan benefits are paid after 100 days in a Medicare Benefit Period.
Other Covered Services	Plan pays 20% of the Medicare approved amount after Part B deductible and Plan deductible.
Out-of-Country Services	If you are in a foreign country and are hospitalized due to an emergency, the Plan pays 80% of eligible charges for medically necessary services during the first 60 days of your hospitalization. Benefits are subject to a separate $250 calendar year deductible. The total lifetime maximum that the City's Plan pays is limited to $50,000.
Diabetic Supplies	Medicare Part B covers diabetic supplies such as glucose testing monitors, blood glucose test strips, lancets, and glucose control solutions. There may be limits on supplies or how to get them. Ask your pharmacy or supplier if they are enrolled in the Medicare program. If they are not, Medicare will not pay and neither will the City's Plan because the City's Plan is only a supplement to Medicare. If you have paid the yearly Part B deductible as well as the City's $100 annual deductible, the City will pay 20% of the Medicare approved amount.

[1] The lifetime maximum includes expenses paid under both the Non-Medicare and Medicare plans combined.

[2] Medicare Part A and Medicare Part B: **No expense is covered by the Plan if Medicare does not cover it unless otherwise specified.** If you are only enrolled in Medicare Part A, the Plan will pay benefits as though you are enrolled in both Medicare Part A and Medicare Part B.

(See Reverse Side)

Prescription Drug Benefits	Coverage
Caremark Retail Pharmacy – up to a 30 day supply or 100 unit dose (whichever is less)	After you've met the separate $100 annual prescription drug deductible (does not apply to Means Test Eligible Retirees**), for each prescription, you pay: • 20% of the contracted cost for generic drugs • 20% of the contracted cost for formulary brand name drugs*** when no generic is available • 20% of the contracted cost plus $15 for non-formulary brand name drugs**** when no generic is available
Mail Order Program - Up to a 90 day supply	For each prescription, you pay: • $30 for 2019 ($7 for Means Test Eligible Retirees) for generic drugs • $83 for 2019 ($20 for Means Test Eligible Retirees) for formulary brand name drugs when no generic is available **Note: non-formulary brand name medications are not available through the mail order program.**
Restrictions: Why choose a generic?	If a brand name drug is dispensed when a generic alternative is available, you pay the difference in cost between the generic and the brand name as well as the generic co-payment. The Plan will not pay more than it would pay for the generic medication if you buy a brand name drug when a generic alternative is available.
Generic Step Therapy Program for generics available in the therapeutic class	If you elect to purchase a brand medication without trying an appropriate generic medication in the same therapeutic class, you will pay the full cost of the medication. **If you try the generic medication and your physician finds that the generic medication is not effective in treating your condition, you will be able to receive the brand medication at the co-payment applicable to non-formulary or formulary drugs.**
Specialty Medications	If you do not try the preferred medication for the therapeutic class, you will pay the full cost of the medication. If you try the preferred specialty medication and it is not effective in treating your condition, you will be able to receive a non-preferred formulary drug at retail.
Mandatory Mail Order	Requiring the use of mail order will reduce costs for the City and Retirees. After 2 fills of your generic or formulary brand medication at a retail pharmacy, you will be required to use mail order for any additional fills through CVS-Caremark in Mount Prospect, IL. If you do not use the mail order program for your 3rd or any subsequent fills, you will pay the full cost of the prescription. If your medication is non-formulary, however, you must continue to use the retail pharmacy.
Out-of-network pharmacy reimbursement	If you do not go to a network retail pharmacy, you pay the full amount when you pick up your prescription. You must then submit a receipt for reimbursement. The Plan will pay 60% of the Plan's cost, after you've met the deductible (if applicable). There is no formulary list if you go to an out-of-network pharmacy.

* **Medicare allowable charge –** the amount that Medicare determines a particular service or supply should cost. The Medicare Supplement Retiree Healthcare Plan bases payment on the Medicare allowable charge.

** **Means test eligible retiree –** generally, the combined household adjusted gross income, as reported to the Internal Revenue Service in the immediately preceding tax year, must be at or below 250% of federal poverty guidelines for your family size that year.

*** **Formulary brand name drugs –** a formulary drug is a brand name drug that has been designated as a preferred drug by CVS Caremark. The preferred drug list (formulary) may change periodically at the discretion of the pharmacy benefits manager.

**** **Non-formulary brand name drug –** a non-formulary brand name drug is a brand name drug that is not on the preferred list of formulary drugs.

City of Chicago

Dental PPO and HMO Plans

- Dental PPO Group 652374 (PPO Plan B - FOP)
- Dental PPO Group 652375 (PPO Plan A - LMCC)
- Dental HMO Group D16600 Plan 705 (HMO Plan B - FOP)
- Dental HMO Group D16601 Plan 706 (HMO Plan A - LMCC)

Your Dental Care Benefit Program

City of Chicago

652374

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

A message from

City of Chicago

This booklet describes the Dental Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your dental care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your dental care benefits. If you want more information or have any questions about your dental care benefits, please contact the Employee Benefits Department.

Sincerely,

City of Chicago

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

Your dental care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

DENTAL BENEFITS	
Benefit Waiting Period	None
In-Network Deductible	$100 per benefit period
Out-of-Network Deductible	$200 per benefit period
Diagnostic and Preventive Care Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Miscellaneous Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Restorative Dental Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
General Dental Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Endodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Periodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Oral Surgery Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance

Crowns, Inlays/Onlays Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Prosthodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Benefit Period Maximum	$1,200

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

BENEFIT WAITING PERIOD.....means the number of months that you must be continuously covered under this benefit program before you are eligible to receive benefits for certain dental Covered Services.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health

insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Dental Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

A "Participating Dentist" means a Dentist who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to you at the time you receive services.

A "Non-Participating Dentist" means a Dentist who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMPLOYER.....means the company with which you are employed.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Dental Care Plan.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses, and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as Eligible for participation under Title XVIII, Health Insurance for the aged and Disabled.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Dental Care Plan for yourself but not your spouse and/or dependents.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Dentists, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

NON-PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PROVIDER OPTION.....means a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of his or her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for exsample, a Physician or Dentist) or entity duly licensed to render Covered Services to you, and operating within the scope of such license.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized

instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

ELIGIBILITY SECTION

This benefit booklet contains information about the dental care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description and comply with the other terms and conditions of this benefit booklet, including but limited to payment of premiums, you are entitled to the benefits of this program.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. All of the provisions of this benefit booklet that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. The coverage for children will end on the birthday.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a disabling condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:

  a. The other coverage was in effect when you were first eligible to enroll for this coverage;

  b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and

  c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:

  a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;

  b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;

  c. Reaching a lifetime limit on all benefits in another group health plan;

  d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

  e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

  f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Dental Care Plan described in this benefit booklet except as otherwise specifically stated in the ''Extension of Benefits in Case of Termination'' provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Dental Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

DENTAL BENEFIT SECTION

Your employer has chosen the Claim Administrator's Participating Provider Option for the administration of your dental benefits. The Participating Provider Option is a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services.

As a participant in the Participating Provider Option program you will receive a directory of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Claim Administrator until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term ''Dentist'' is used in this Benefit Section, it will mean Dentist or Physician.

Diagnostic and Preventive Dental Services

Your benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine

bitewing X-rays are limited to two sets per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.

- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 14, without frequency limitations.
- Sealants—Limited to a lifetime maximum of 1 on the 1st and 2nd molars up to age 16.

Miscellaneous Dental Services

- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Labs and Tests—Pulp vitality tests.

Restorative Dental Services

- Amalgams (Fillings)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under ''Special Limitations'' of this Benefit Section.

General Dental Services

- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Stainless Steel Crowns.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Endodontic Services

- Root canal therapy
- Pulp cap
- Apicoectomy
- Apexification
- Retrograde filling
- Root amputation/hemisection
- Therapeutic pulpotomy
- Pulpal debridement.

Periodontic Services

- Periodontal scaling and root planing.
- Full mouth debridement.
- Gingivectomy/gingivoplasty. Your benefits are limited to one full mouth treatment per 24 months.
- Gingival flap procedure
- Osseous Surgery. Your benefits are limited to one full mouth treatment per 24 months.
- Osseous grafts.
- Soft tissue grafts.
- Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

Oral Surgery Services

- Surgical tooth extraction
- Alveoloplasty
- Vestibuloplasty
- Other necessary dental surgical procedures.

Crowns, Inlays/Onlays Services

- Prefabricated post and cores
- Cast post and cores
- Crowns, inlays/onlays repairs
- Recementation of crowns, inlays/onlays

Prosthodontic Services

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline/Rebase.

Prosthodontic Services

- Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable. Missing tooth exclusion applies for dentures and bridges. Initial placement of a full or partial denture or bridge replacing teeth extracted prior to effective date of the policy.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

In-Network Deductible

Each benefit period, you (and each member of your family) must satisfy a $100 in -network deductible for services rendered by a participating (contracted) dentist. This deductible applies to:

- Diagnostic and Preventive Care
- Miscellaneous Dental Services
- Restorative Dental Services
- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services

In other words, after you incur eligible charges of more than $100 for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

An additional $10 copay for preventive services applies once per benefit period from a Participating Provider.

Out-of-Network Deductible

Each benefit period, you (and each member of you family) must satisfy a $200 out-of-network deductible for services rendered by a non-participating (non-contracted) dentist. This deductible applies to:

- Restorative Dental Services

- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services

In other words, after you incur eligible charges of more than $200 for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

Benefit Payment for Dental Services

The benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist.

Participating Dentists are Dentists who have signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator benefit payment and the Maximum Allowance for the particular Covered Service–that is, your Coinsurance amounts and deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Claim Administrator benefit payment and such Dentist's charge to you. Custom Maximum Allowable charge will be scheduled for the Non–Participating reimbursement level.

Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance after you have met your deductible.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance after you have met your deductible.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Non-Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be

provided at 50% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Emergency Care

Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at 60% of the Maximum Allowance when rendered by a Participating Dentist, after you have met your in–network deductible. Benefits for palliative care will be provided at 50% of the Maximum Allowance, when rendered by a Non-Participating Dentist, after you have met your out–of–network deductible.

Benefit Maximum

The maximum amount of dental benefits available for you (and each covered member of your family) each benefit period is $1,200. This is an individual maximum. There is no family maximum. The benefit period maximum does not apply to preventive services for participants under the age of 19.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard

procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — surgical removal of complete bony impacted teeth;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - — excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
3. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
4. Hospital and ancillary charges.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Plan.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental procedures which are not Medically Necessary.**
PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE PLAN PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Dental Care Plan.

— Implants - Including the crown over the implant.

— Hospitalization for any dental procedure;

— Home visits;

— Hospital bedside visits;

— Hospital-administered anesthesia;

— Experimental procedures

— Implantation;

— Pharamacological regimens;

— Prescription or over-the-counter medications;

— Convenience and personal item;

— The setting of fractures of dislocation;

— Treatment of malignancies, cysts or neoplasms;

— Service which, in the opinion of the attending dentist, are not necessary for the patient's dental health;

— Missed appointment fees;

— Orthodontic work in progress;

— Any items covered under the Medical Plan;

— Services covered by Workers' Compensation or employer's liability laws;

— Services provided to the member , without cost, by any municipality, county or other political subdivision, other than Medicaid services;

— Dental services with respect congenital malformation or primarily for cosmetic or aesthetic purposes, except where such services are within the scope of benefits;

— Any services, treatment or supplies which are not reasonably necessary for the care and treatment of a person;

— Orthodontic treatment including, but not limited to, removable and fixed appliances, pre-orthodontic treatment and orthodontic retention;

— Separate laboratory charges when not included and billed by dentist;

— Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group;

— Dental services rendered or supplies furnished after the termination date of the person's Dental PPO Plan coverage;

— Dental services for which coverage is available to the person, in whole or in part, under a medical plan;

— Sealants (except for back molars);

— Mouth rehabilitation where the obligation of the dental plan administrator will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth; the balance of the treatment including cost to increase vertical dimension or restore the occlusion will remain the responsibility of the patient;

— Initial placement of a full or partial denture or bridge replacing teeth extracted prior to the effective date of the policy;

— Bruxism appliances, mouth guards, occlusal guards or bite plates;

— Anything not listed as a covered service.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have dental care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled under this Health Care. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this ''birthday'' type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

In order to prevent duplicate payment of benefits for a Claim, the Claim Administrator uses the following process to determine benefits when it is the secondary payor.

— determines what the payment for service would be following the payment provisions of this coverage; and

— deducts from this resulting amount the amount paid by the primary payor. The difference is the amount that will be paid under this coverage.

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children. This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is a party to a Civil Union and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is party to a Civil Union or their child and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits, it is necessary for a Claim to be filed with the Claim Administrator.

To file a Claim, obtain an Attending Dentist's Statement from your Employee Benefits Department before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within two years from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30–day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for dental care services to all persons entitled to dental care benefits under dental policies and contracts to which the Claim Administrator is a party, including all persons covered under the Dental Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Dentists, the calculation of any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Maximum Allowance or Provider's Claim Charge for Covered Services rendered to you. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Dental Care Plan will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Cov-

ered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Dental Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person's claim for benefits under this Dental Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Dental Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Dental Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Dental Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Dental Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to

such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person tom or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non–Participating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non–Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy's Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED PUBLIC EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Public employees and surviving spouses or surviving parties to a Civil Union of such employees who are eligible for continued group health coverage under Sections 367 (g), (h) and (i) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The public employee, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such employee, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the public employee, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Sections 367 (g), (h) and (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or surviving party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the public employee, surviving spouse or surviving party to a Civil Union.
4. If the public employee, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a ''direct-payment'' conversion policy, as described above under Conversion Privilege, such employee, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN

NOTE: The CONTINUATION OF COVERAGE FOR DISABLED OR RETIRED FIREMEN applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

Firemen and surviving spouses or surviving parties to a Civil Union of such firemen who are eligible for continued group health coverage under Section 367 (f) of the Illinois Insurance Code may continue their coverage under this Certificate subject to the following conditions:

1. The fireman, surviving spouse or surviving party to a Civil Union must be covered under this Certificate up to the date of eligibility for continued group health coverage. If such fireman, spouse or party to a Civil Union has Family Coverage, he/she may continue to have Family Coverage.
2. Group coverage can be continued until the fireman, surviving spouse or surviving party to a Civil Union is no longer eligible, as specified in Section 367 (i) of the Illinois Insurance Code, subject to all of the termination provisions of this Certificate (for example, termination of the Group's Policy or reaching the limiting age for dependent children). Coverage for a surviving spouse or surviving party to a Civil Union will end if such spouse or party to a Civil Union should remarry or enter another Civil Union. It is the employee/spouse's or surviving party to a Civil Union's responsibility to inform the Plan of his/her loss of eligibility.
3. The total monthly premium for this continuation of coverage must be paid by the Group to the Plan, whether such premium is deducted from a pension payment or paid directly to the Group by the fireman, surviving spouse or surviving party to a Civil Union.
4. If the fireman, surviving spouse or surviving party to a Civil Union should choose to convert his or her group coverage to a ''direct-payment'' conversion policy, as described above under Conversion Privilege, such fireman, spouse or party to a Civil Union will no longer be eligible for this continuation of group coverage.

CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

NOTE: The CONTINUATION OF COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES applies only to certain employers. See your employer or Group Administrator should you have any questions about this continuation provision.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued group health insurance under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such group health insurance under the following conditions:

1. You and your eligible dependents must have been insured under this Certificate on the day immediately preceding the date of eligibility for continued group health insurance.
2. Your Group shall pay the entire premium of the group health insurance coverage for you, your spouse, your party to a Civil Union and each dependent child until the child reaches the limiting age under this Certificate.
3. If you subsequently die, your Group shall continue to pay the entire health insurance premium for your surviving spouse or your surviving party to a Civil Union until he or she remarries or enters another Civil Union and for your dependent children under the conditions established in 2. above.
4. Health insurance benefits under this Certificate shall be reduced by health insurance benefits payable from any other source.

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

ASO-1

Effective Date: January 1, 2018

www.bcbsil.com

Your Dental Care Benefit Program

City of Chicago

652375

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

A message from

City of Chicago

This booklet describes the Dental Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your dental care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your dental care benefits. If you want more information or have any questions about your dental care benefits, please contact the Employee Benefits Department.

Sincerely,

City of Chicago

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your dental care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

DENTAL BENEFITS	
Deductible	
— Participating Provider	$100 per benefit period
— Non–Participating Provider	$200 per benefit period
Diagnostic and Preventive Care Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Miscellaneous Dental Services Benefit Payment Level	
— Participating Provider	100% of the Maximum Allowance
— Non-Participating Provider	80% of the Maximum Allowance
Restorative Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
General Dental Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Endodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Periodontic Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Oral Surgery Services Benefit Payment Level	
— Participating Provider	80% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance

Crowns, Inlays/Onlays Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Prosthodontic Services Benefit Payment Level	
— Participating Provider	60% of the Maximum Allowance
— Non-Participating Provider	50% of the Maximum Allowance
Benefit Period Maximum	$1,500

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Dental Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

A "Participating Dentist" means a Dentist who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to you at the time you receive services.

A "Non-Participating Dentist" means a Dentist who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a Participating Provider Option Dental program to provide services to participants in the Participating Provider Option program.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMPLOYER.....means the company with which you are employed.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Dental Care Plan.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Dental Care Plan for yourself but not your spouse and/or dependents.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator, which Participating Dentists have agreed to accept as payment in full for a particular dental Covered Service. All benefit payments for Covered Services rendered by Dentists, whether Participating or Non-Participating will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

NON-PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTICIPATING DENTIST.....SEE DEFINITION OF DENTIST.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PROVIDER OPTION.....means a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of his or her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you, and operating within the scope of such license.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized

instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

ELIGIBILITY SECTION

This benefit booklet contains information about the dental care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description and comply with the other terms and conditions of this benefit booklet, including but not limited to payment of premiums, you are entitled to the benefits of this program.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren), a child(ren) for whom you have received a court order requiring that you are financially responsible for providing coverage under 26 years of age, a child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. All of the provisions of this benefit booklet that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. The coverage for children will end on the birthday.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a disabling condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for this coverage;
    b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

  This includes, but is not limited to, loss of coverage due to:
    a. Legal separation, divorce, dissolution from a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
    b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
    c. Reaching a lifetime limit on all benefits in another group health plan;
    d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
    e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
    f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Dental Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Dental Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

DENTAL BENEFIT SECTION

Your employer has chosen the Claim Administrator's Participating Provider Option for the administration of your dental benefits. The Participating Provider Option is a program of dental care benefits designed to provide you with economic incentives for using designated Providers of dental care services.

As a participant in the Participating Provider Option program you will receive a directory of Participating Dentists. While there may be changes in the directory from time to time, selection of Participating Dentists by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Dentist before undergoing treatment to make certain of his/her participation status. Although you can go to the Dentist of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Dentist.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Claim Administrator until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term ''Dentist'' is used in this Benefit Section, it will mean Dentist or Physician.

Diagnostic and Preventive Dental Services

Your benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Diagnostic and Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine

bitewing X-rays are limited to one set per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.

- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 14 and are limited to two applications each benefit period.
- Sealants—Covered for 1st and 2nd molars every five years up to age 14.

Miscellaneous Dental Services

- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Labs and Tests—Pulp vitality tests.

Restorative Dental Services

- Amalgams (Fillings)
- Pin Retention
- Composites
- Simple Extractions, except as specifically excluded under ''Special Limitations'' of this Benefit Section.

General Dental Services

- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.
- Stainless Steel Crowns
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Endodontic Services

- Root canal therapy
- Pulp cap
- Apicoectomy
- Apexification
- Retrograde filling
- Root amputation/hemisection
- Therapeutic pulpotomy

- Pulpal debridement

Periodontic Services

- Periodontal scaling and root planing
- Full mouth debridement
- Gingivectomy/gingivoplasty. Your benefits are limited to one full mouth treatment per 24 months.
- Gingival flap procedure
- Osseous Surgery. Your benefits are limited to one full mouth treatment per 24 months.
- Osseous grafts
- Soft tissue grafts
- Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.

Oral Surgery Services

- Surgical tooth extraction
- Alveoloplasty
- Vestibuloplasty
- Other necessary dental surgical procedures

Crowns, Inlays/Onlays Services

- Prefabricated post and cores
- Cast post and cores
- Crowns, inlays/onlays repairs
- Recementation of crowns, inlays/onlays

Prosthodontic Services

- Bridges
- Dentures
- Adjustments to Bridges and Dentures—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Bridge and Denture repairs
- Addition of tooth or clasp
- Reline/Rebase

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

Temporomandibular Joint (TMJ) Services

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

Deductible

Each benefit period, you must satisfy a $100 deductible for Dental Services rendered by a Participating Dentist and a separate $200 deductible for Dental Services rendered by a Non-Participating Dentist. This deductible applies to:

- Restorative Dental Services
- General Dental Services
- Endodontic Services
- Periodontic Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services
- Temporomandibular Joint Services

In other words, after you incur eligible charges for more than the deductible amount for the Covered Services listed above in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

An additional $10 copay for preventive services applies once per benefit period from a Participating Provider.

Family Deductible

If you have Family Coverage and your family has reached the dental deductible amount of $100 for Covered Services rendered by Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

If you have Family Coverage and your family has reached the dental deductible amount of $200 for Covered Services rendered by Non-Participating Dentists, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits from a Non-Participating Dentist. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

Benefit Payment for Dental Services

The benefits provided by the Plan and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Dentist.

Participating Dentists are Dentists who have signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator benefit payment and the Maximum Allowance for the particular Covered Service–that is, your Coinsurance amounts and deductible.

Non-Participating Dentists are Dentists who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Dentists for the difference between the Claim Administrator benefit payment and such Dentist's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Dentist is a Participating Dentist, contact your Employer, your Dentist or the Claim Administrator.

Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 60% of the Maximum Allowance after you have met your deductible.

Temporomandibular Joint Services – Benefits for Temporomandibular Joint Services described in this Dental Benefits Section received from a Participating Dentist will be provided at 100% of the Maximum Allowance after you have met your deductible.

Non-Participating Dentists

Diagnostic and Preventive Services – Benefits for Diagnostic and Preventive Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance.

Miscellaneous Dental Services – Benefits for Miscellaneous Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance.

Restorative Dental Services – Benefits for Restorative Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

General Dental Services – Benefits for General Dental Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Endodontic Services – Benefits for Endodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Periodontic Services – Benefits for Periodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be

provided at 50% of the Maximum Allowance after you have met your deductible.

Oral Surgery Services – Benefits for Oral Surgery Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Crowns, Inlays/Onlays Services – Benefits for Crowns, Inlays/Onlays Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Prosthodontic Services – Benefits for Prosthodontic Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 50% of the Maximum Allowance after you have met your deductible.

Temporomandibular Joint Services – Benefits for Temporomandibular Joint Services described in this Dental Benefits Section received from a Non-Participating Dentist will be provided at 80% of the Maximum Allowance after you have met your deductible.

Emergency Care

Benefits for emergency oral examinations and palliative emergency treatment for the temporary relief of pain will be provided at 100% of the Maximum Allowance when rendered by either a Participating Dentist or Non-Participating Dentist.

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $1,500. This is an individual maximum. There is no family maximum.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard

procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders, unless specifically mentioned in this benefit section.
3. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — surgical removal of complete bony impacted teeth;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - — excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Plan.

EXCLUSIONS – WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental procedures which are not Medically Necessary.**
PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE PLAN PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Dental Care Plan.

— Implants – Including the crown over the implant.

— Hospitalization for any dental procedure;

— Home visits;

— Hospital bedside visits;

— Hospital–administered anesthesia;

— Experimental procedures

— Implantation;

— Pharamacological regimens;

— Prescription or over–the–counter medications;

— Convenience and personal item;

— The setting of fractures of dislocation;

— Treatment of malignancies, cysts or neoplasms;

— Service which, in the opinion of the attending dentist, are not necessary for the patient's dental health;

— Missed appointment fees;

— Orthodontic work in progress;

— Any items covered under the Medical Plan;

— Services covered by Workers' Compensation or employer's liability laws;

— Services provided to the member , without cost, by any municipality, county or other political subdivision, other than Medicaid services;

— Dental services with respect congenital malformation or primarily for cosmetic or aesthetic purposes, except where such services are within the scope of benefits;

— Any services, treatment or supplies which are not reasonably necessary for the care and treatment of a person;

— Orthodontic treatment including, but not limited to, removable and fixed appliances, pre–orthodontic treatment and orthodontic retention;

— Separate laboratory charges when not included and billed by dentist;

— Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group;

— Dental services rendered or supplies furnished after the termination date of the person's Dental PPO Plan coverage;

— Dental services for which coverage is available to the person, in whole or in part, under a medical plan;

— Sealants (except for back molars);

— Mouth rehabilitation where the obligation of the dental plan administrator will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth; the balance of the treatment including cost to increase vertical dimension or restore the occlusion will remain the responsibility of the patient;

— Initial placement of a full or partial denture or bridge replacing teeth extracted prior to the effective date of the policy;

— Bruxism appliances, mouth guards, occlusal guards or bite plates;

— Anything not listed as a covered service.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have dental care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this ''birthday'' type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children. This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is a party to a Civil Union and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is party to a Civil Union or their child and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits, it is necessary for a Claim to be filed with the Claim Administrator.

To file a Claim, obtain an Attending Dentist's Statement from your Employee Benefits Department before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within 365 days from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30–day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (''Administrator Providers'') in its service area to provide and pay for dental care services to all persons entitled to dental care benefits under dental policies and contracts to which the Claim Administrator is a party, including all persons covered under the Dental Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Dentists, the calculation of any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Maximum Allowance or Provider's Claim Charge for Covered Services rendered to you. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Dental Care Plan will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Adminis-

trator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Dental Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person's claim for benefits under this Dental Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Dental Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Dental Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Dental Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Dental Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or

other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.

7. PHYSICAL EXAMINATION AND AUTOPSY

The Claim Administrator, at its own expense shall have the right and opportunity to examine your person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person tom or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another blue Cross and Blue Shield administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future benefit payment owed to one or more Participating or Non-Participating Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy's Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

RIDER TO THE BENEFIT BOOKLET FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

The benefit booklet to which this Rider is attached and becomes a part, is hereby amended as follows:

If you are a public employee and are eligible for continued coverage for accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued health coverage under this Health Care Plan, if you meet the following conditions:

1. You and your eligible dependents, must have been covered under this Health Care Plan on the day immediately preceding the effective date of eligibility for continued health coverage.
2. Once properly established, continued health coverage under this Health Care Plan may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform the Claim Administrator of the loss of eligibility.
3. The election by you or your surviving spouse, to obtain a conversion plan as described in the conversion provisions of this Health Care Plan shall terminate any right to continue health coverage according to Sections 367g, 367h and 367j of the Insurance Code. No reinstatement of continued health coverage shall be permitted after such conversion has been effected or if the continued health coverage provided by this Rider has been terminated for any reason.
4. If you or your surviving spouse is continuing coverage under this Health Care Plan and becomes eligible for Medicare, the benefits under this Health Care Plan shall be reduced in accordance with the benefit provisions for Medicare Eligibles stated in this benefit booklet.
5. If a timely and valid election of continued health coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Employer by you.

Except as amended by this Rider, all terms and conditions of the benefit booklet to which the Rider is attached will remain in full force and effect.

RIDER TO THE BENEFIT BOOKLET FOR CONTINUED HEALTH CARE PLAN FOR CERTAIN DISABLED OR RETIRED FIREMEN

The benefit booklet, to which this Rider is attached and becomes a part, is hereby amended to add the following provisions:

If you are a fireman and are eligible for continued group accident and health insurance under Section 367f of the Illinois Insurance Code, as amended, you may establish and maintain such continued health coverage only under the following conditions:

1. You and your eligible dependents, if any, must have been covered under this Health Care Plan in effect on the day immediately preceding the day on which such eligibility for continued health coverage begins.
2. Once properly established, continued health coverage under this Health Care Plan may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Section 367f of the Insurance Code. It shall be the responsibility of you or your surviving spouse to inform the Claim Administrator of the loss of eligibility.
3. The election by you or your surviving spouse to obtain a conversion plan as described in the conversion provisions of this Health Care Plan relating to conversion, shall automatically terminate any right to continue health coverage under Section 367f of the Insurance Code. No reinstatement of continued health coverage shall be permitted after such conversion has been in effect or if the continued health coverage provided by this Rider is terminated for any reason.
4. If you or your surviving spouse are continuing coverage under this Health Care Plan and become eligible for Medicare, the benefits under this Health Care Plan shall become secondary to the benefits provided under Medicare.
5. If a timely and valid election of continued health coverage has been made, you or your surviving spouse shall remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you or your surviving spouse, deducted from a pension payment, paid directly to your Employer by you or your surviving spouse, or by any combination of the above.

Except as amended by this Rider, all terms and conditions of the benefit booklet to which the Rider is attached will remain in full force and effect.

RIDER TO THE BENEFIT BOOKLET FOR CONTINUED HEALTH CARE PLAN COVERAGE FOR CERTAIN PUBLIC SAFETY EMPLOYEES

The benefit booklet, to which this Rider is attached and becomes a part, is amended as stated below.

If you are a full-time law enforcement, correctional or correctional probation officer, or firefighter and are eligible for continued health coverage under the Public Safety Employee Benefits Act (820 ILCS 320), you may maintain such health coverage under the following conditions:

1. You and your eligible dependents must have been covered under this Health Care Plan on the day immediately preceding the date of eligibility for continued health coverage.
2. Your Employer shall pay the entire cost of the health coverage for you, your spouse, and each dependent child until the child reaches the limiting age under the benefit booklet or until the end of the calendar year in which the child reaches the age of 25, if the child continues to be dependent for support, whichever is later.
3. If you subsequently die, your Employer shall continue to pay the entire health coverage cost for your surviving spouse until he or she remarries and for your dependent children under the conditions established in 2. above.
4. Health coverage benefits under this Health Care Plan shall be reduced by health coverage benefits payable from any other source.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the benefit booklet to which this Rider is attached will remain in full force and effect.

Administered by:

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

ASO-1

Effective Date: January 1, 2018

www.bcbsil.com

Your Dental Care Benefit Program

BLUECARE® DENTAL HMO
PLAN NUMBER 705

BlueCross BlueShield of Illinois

GROUP CERTIFICATE RIDER REGARDING DEPENDENT LIMITING AGE

For Dental Plans

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

This Rider is attached to and becomes a part of your Certificate. The Certificate and any Riders thereto are amended as stated below.

DEPENDENT COVERAGE

Benefits will be provided under this Certificate for your and/or your spouse's enrolled child(ren) under the age of 26.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of your child(ren),child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status,, eligibility for other coverage or any combination of those factors. If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY section of this Certificate.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Sincerely,

Maurice Smith
President

A message from BLUE CROSS AND BLUE SHIELD

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. We are pleased to provide you with the dental program described in this BlueCare Dental Certificate. We hope that most of your questions about your dental coverage will be answered after you have read this Certificate.

You and your eligible dependents (if you have Family Coverage) are entitled to the benefits described in this Certificate as long as you receive them from the Dental Center you have selected. Your coverage will begin on your "Coverage Date" and continue through the period authorized by your Group (provided your Group pays all premiums and you remain an eligible participant in your Group).

Throughout this Certificate we will refer to the company that you work for as your "Group" and we refer to our company as "Blue Cross and Blue Shield."

Every effort has been made to explain your dental benefits as simply and as thoroughly as possible. However, should you have questions after reading this Certificate, contact Blue Cross Blue Shield of Illinois. It is important to all of us that you understand your benefits.

Welcome to the security and peace of mind of knowing that you have Blue Cross and Blue Shield!

Sincerely,

Maurice Smith
President

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and blue Shield of Illinois)

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DEFINITIONS

The terms listed below are used throughout this Certificate and have a specific meaning when applied to your dental coverage.

These terms will always begin with a capital letter.

Accidental Injury means damage inflicted to the hard and soft tissues of the oral cavity resulting from forces external to the mouth.

Certificate means this benefit booklet. This Certificate describes the BlueCare dental coverage applicable to you (and your eligible dependents if you have Family Coverage).

Civil Union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

COBRA means the sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), including any amendments to this Act, which regulate the conditions and manner in which an employer can offer continuation of group health and dental insurance to insureds and dependents whose coverage would otherwise terminate under the terms of this Certificate.

Copayment means a specific dollar amount that you are required to pay towards a covered service.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Service means an American Dental Association (ADA) approved dental procedure or treatment plan specified in this Certificate for which benefits will be provided. Such service or treatment plan must be delivered by: 1) a licensed dentist acting within the scope of his license; 2) a licensed physician performing dental services within the scope of his license; or 3) a licensed dental hygienist acting under the supervision and direction of a licensed dentist.

Course of Treatment means any number of orthodontic dental procedures performed by a dentist in a planned series following a dental examination that determines the need for these procedures.

- **Full Course of Treatment** means a complete and comprehensive banding of teeth in order to guide the teeth into their correct relationship (to correct a malocclusion). Treatment usually will involve both the upper and lower arches of the mouth. The length of treatment is about 24 months and should be followed by passive retention treatment.
- **Partial Course of Treatment** means any treatment which is less than a Full Course of Treatment. Treatment may not exceed 24 months. Treatment in progress means a person who is presently banded becomes

covered under this Certificate. Benefits for these situations should be clarified by contacting Blue Cross Blue Shield of Illinois at 1-800-323-7201.

Emergency Dental Care means the provision of dental care for a sudden, acute dental condition that would lead a prudent layperson, who possesses an average knowledge of dentistry, to reasonably expect the absence of immediate care to result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Family Coverage means coverage under this Certificate for the employee of the Group and the employee's eligible dependents. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union, unless specifically noted otherwise.

Group means the employer of the Insured.

Individual Coverage means that only the employee of the Group is covered under this Certificate. His or her dependents are not covered.

Insured means the person who is the employee of the Group who has applied for dental coverage under this Certificate.

Medically Necessary means that a specific service provided to you or your dependents (if you have Family Coverage) is essential for the treatment or management of a symptom or condition. The service must be provided in the most efficient and economic manner. In addition, Medically Necessary means:

1. A generally accepted standard of practice for the particular situation being addressed.
2. One for which there is reasonable expectation that your condition will be significantly improved or aided by the service in terms of function and, or, relief of pain and similarly there is reasonable expectation that there will be significant deterioration in your condition, if the service is not performed.

COVERAGE INFORMATION

Eligibility

Blue Cross and Blue Shield has an agreement with your Group to provide dental benefits to you (and to your dependents if you have Family Coverage).

The term "**Group"** refers to a sole proprietor, partnership, corporation or other organization. The term **"Insured"** refers to the employee engaged in the normal activities of the Group who is employed on an active, full-time basis (as defined by the Group). The employment is reasonably expected to be permanent at the time the employee is hired and this Certificate goes into effect. New employees of the Group will become eligible for coverage on the first day of the month following the date notification of coverage is provided to Blue Cross and Blue Shield or on a date that is otherwise determined by the Group. Employees of the Group whose applications have been accepted by Blue Cross and Blue Shield shall receive dental coverage as provided in this Certificate.

Individual Coverage

If you have Individual Coverage, this means that only your dental expenses are covered under this Certificate. No other members of your family will be covered.

Family Coverage

If you have Family Coverage, this means that your dental expenses and the expenses of your eligible family members will be covered, according to the terms of your group contract.

Family Coverage is subject to the following rules:

- Your application for Family Coverage must include all of your eligible dependents on the date such application is made.
- Dependent coverage for a child born to you while you are covered under Family Coverage will be effective from the date of birth.
- If you acquire a dependent (other than through the birth of a child) while you are enrolled for Family Coverage, your Family Coverage for that dependent will go into effect upon receipt of your written notification to Blue Cross and Blue Shield and upon the completion of Blue Cross and Blue Shield's membership change.

If you are the Insured, **"Dependent"** means:

1. Your legal spouse.
2. Your children or the children of your legal spouse who are under the limiting age specified in the Schedule of Dental Services.
3. Children who are in your custody in accordance with an interim court order prior to finalization of adoption or placement of adoption vesting temporary care of the children. Such children must be under the limiting age specified in the Schedule of Dental Services of this Certificate.

4. Your legally adopted children who are under the limiting age specified in the Schedule of Dental Services.
5. Your children who are under the limiting age specified in the Schedule of Dental Services and who are legally dependent upon you for support and maintenance while full-time students at an accredited institution of higher education.

   In addition, enrolled unmarried children will be covered up to the age of 30 if they:

   - Live within Blue Cross and Blue Shield's service area; and
   - Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
   - Have received a release or discharge other than a dishonorable discharge.
6. Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age, will be covered regardless of age, as long as they were covered prior to reaching the limiting age specified in the Schedule of Dental Services of this Certificate.
7. Your dependent who is a party to a Civil Union and his or her children.

Payment of Premiums

Your Group will pay your premiums. The premiums are paid monthly in advance and any arrangement requiring you to reimburse your Group for a portion of the premium is entirely between you and your Group. Blue Cross and Blue Shield looks solely to the Group for payment of premiums.

Your Group will be allowed a grace period of 31 days for the late payment of premiums. During this period, this Certificate will remain in effect. If the Group fails to pay any premium, this Certificate will automatically terminate at the end of the grace period. Blue Cross and Blue Shield will not be obligated to give you or your Group notice if this Certificate is automatically terminated. However, if Blue Cross and Blue Shield accepts payment from the Group after the expiration of the grace period, your coverage will be reinstated as of that acceptance date.

If this Certificate is terminated for any reason, the Group will be liable for all premiums then due, including charges for any period this Certificate was in effect during a grace period.

Termination of Coverage

Your coverage under this Certificate (and the coverage of your dependents if you have Family Coverage) will end if:

1. you are no longer a covered employee with your Group; or
2. your Group fails to pay premiums; or

3. your Group terminates its BlueCare Dental Agreement with Blue Cross and Blue Shield.

Your dependent's coverage will automatically end if:

1. this Certificate is terminated; or
2. he or she ceases to be a dependent according to the definition of Dependent stated in the Family Coverage provision of this Certificate, or
3. he or she reaches the limiting age specified in the Schedule of Dental Services of this Certificate.

ABOUT YOUR DENTAL BENEFITS

Types of Dental Services

The following is a summary of the types of dental services your BlueCare Certificate covers:

- **Diagnostic and Preventive Care Services**

  Diagnostic services means the procedures necessary to aid the dentist in evaluating your existing dental condition and to determine what type of dental care is required. Preventive care services means those procedures necessary to prevent oral disease. Diagnostic and Preventive Care services include:

  a. Dental examinations.

  b. X-rays — full mouth x-rays, panoramic x-rays, bitewing x-rays and other routine x-rays.

  c. Prophylaxis — cleaning and polishing of teeth.

  d. Topical fluoride applications for dependent children.

- **Oral Surgery Services**

  Oral Surgery means the procedures for surgical extractions and other dental surgery under local anesthetics which do not require that you be hospitalized.

- **Restorative Services**

  Restorative services means procedures necessary to restore your teeth to a healthy condition, including amalgam and resin based composite restorations.

- **Periodontal Services**

  Periodontics involves procedures necessary for the treatment of disease of the gums and bones supporting the teeth.

- **Endodontic Services**

  Endodontics involves procedures necessary for the treatment of disease of the pulp chamber and pulp canals. Endodontics procedures include:

  a. Root canal therapy.

  b. Pulpotomy.

  c. Pulp capping.

- **Crowns, Inlays/Onlays**

  Procedures necessary when teeth cannot be restored with other filling material.

- **Prosthodontics**

  Prosthodontics involves procedures necessary for providing artificial replacements for missing natural teeth. Procedures include the following:

  a. Construction, placement, and insertion of bridges; partial and complete dentures.

  b. Repair of bridges and relining and rebasing of partial and complete dentures.

- **Pediatric Dentistry**

  a. Dependents under age 6, who cannot be treated at a participating general dentist, can be referred to a participating Pediatric Dentist. Benefits for eligible services will be provided until age 6.

  b. Dependents age 6 and over, who cannot be treated at a participating general dentist, must have appropriate documentation in order to be referred to a participating Pediatric Dentist.

- **General Services**

  a. Prefabricated stainless steel crown.

  b. Deep sedation/general anesthesia.

  c. Occlusal adjustment.

- **Miscellaneous Services**

  a. Palliative treatment – non-invasive treatment for relief of pain.

  b. Space maintainers.

  c. Sealant application.

  d. Pulp vitality tests.

- **Orthodontics**

  Orthodontics means the proper alignment of teeth, including retention, for the treatment of malocclusion. Refer to the Schedule of Dental Services section of this Certificate for additional information about your orthodontic benefits.

Your Selected Dental Center

When you enroll for BlueCare Dental HMO coverage under this Certificate, you will be required to select a Dental Center. If you enrolled in Family Coverage, your dependents may select a different Dental Center. You must obtain dental Covered Services, including written referrals to specialists (with the exception of emergency care), from your selected Dental Center. Reimbursement for emergency treatment may differ depending upon if you receive treatment from your Dental Center or from another dentist or Dental Center. For information

regarding Emergency Treatment, refer to the Emergency Treatment section of this Certificate.

You will receive a *BlueCare Wallet Card* containing the toll-free customer service telephone number. Your Dental Center will receive a monthly list of all persons who are eligible for BlueCare dental coverage.

Changing Your Dental Center

You may transfer from one Dental Center to another at any time. Changes submitted to BlueCare Dental by the 20th of the current month will be effective the 1st of the following month. Transfers may be requested in writing or by calling customer service at 1-800-323-7201.

Appointment for Services

To receive dental treatment, telephone your selected Dental Center and give the Dental Center your name and member ID so that your enrollment can be verified.

Dental services will be provided by appointment only. Appointments will be made according to the following order of priority:

a. Emergency treatment for the relief of pain;

b. X-rays, teeth cleaning, and examinations;

c. Regular appointments to complete non-emergency dental treatment.

Every reasonable effort will be made to schedule your non-emergency appointments (routine preventive services as determined by your dentist) within 30 days of your request.

Emergency Treatment

The following rules will apply to dental services received for emergency treatment:

If you have an emergency, you can receive emergency care from any provider, not only your Dental Center. You should first attempt to contact your Dental Center or customer service at 1-800-323-7201 and follow the directions you receive.

In the event you cannot reach your Dental Center or customer service, you may seek emergency dental treatment from the nearest dentist or Dental Center. Remember, only services for palliative care (for the relief of pain) will be covered.

Reimbursement for emergency care will be provided as follows:

- ***Benefits for emergency care received from your Dental Center will be provided according to the Schedule of Dental Services in this Certificate (any Copayment indicated in the Schedule of Dental Services applies).***
- ***Benefits for emergency care received from a dentist or dental office other than your selected Dental Center will be provided up to a maximum amount of $50.00. You will need to obtain a paid receipt and itemized***

statement of services rendered from the dentist or dental office providing your treatment.

Send Claims to:
BlueCare Dental HMO
701 E. 22nd Street
Lombard, Illinois 60148

Questions About Your Benefits

Any questions you have about benefits or dental services should be directed to your Dental Center. Additional information can be obtained by writing or calling your Benefits Administrator at your Group.

If you need more detailed information about BlueCare dental coverage, address your concerns to:

BlueCare Dental HMO
701 E. 22nd Street
Lombard, Illinois 60148

A second opinion regarding dental surgery can be arranged only if you submit a written request to BlueCare Dental at the above address. Benefit questions can also be answered by calling customer service at **1-800-323-7201.**

Department of Insurance Address

In compliance with Section 143(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Department of Insurance. These addresses are:

Illinois Department of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601
or
Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767

Grievance Procedures

To resolve grievances concerning dental care and treatment, a customer oriented plan has been established.

First, it is important to work within the traditional dentist-patient relationship. You are encouraged to contact the dental office or provider directly to discuss your questions or concerns. If a satisfactory conclusion can not be reached or you do not wish to discuss your concerns with the provider, BlueCare Dental will serve as an intermediary.

You must submit a written request, providing details of your concerns, to:

BlueCare Dental HMO
701 E. 22nd Street
Lombard, Illinois 60148
Attn.: Customer Relations

BlueCare Dental will acknowledge receipt of your inquiry within 72 hours of receipt. Within 30 days of receiving your inquiry you will be notified of a resolution. All parties will be notified in writing if additional time is needed for the review.

Extended Benefits at Termination

Benefits will be provided under this Certificate after the termination date of coverage only if the dental procedure began prior to the termination date and is completed within 30 days after the termination date. Orthodontic treatment in progress is an exception and benefits will end upon termination. Any balance owed will be your responsibility.

SCHEDULE OF DENTAL SERVICES FOR PLAN 705

The Covered Services specified in this Schedule of Dental Services are subject to all of the terms, conditions, limitations, and exclusions of this Certificate, and to the annual maximum indicated below.

Covered Services must be received at the Dental Center you have selected for your dental care — except for an emergency or if you have received prior written authorization from Blue Cross and Blue Shield, authorizing you to receive dental services elsewhere.

Annual Maximum

No annual maximum applies to your benefits under this Certificate.

Age Limitations

Dental Coverage excludes Orthodontic coverage. Unmarried eligible dependents are covered to age 26. Unmarried eligible dependents of sworn police or fire personnel are covered to age 26. Coverage will automatically terminate on the Dependent's birthday.

Orthodontic Coverage. Unmarried eligible dependents to age 19. Unmarried eligible dependents of sworn police or fire personnel to age 25.

Accidental Injury

There is no coverage for accidental injury. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Failed Appointments

If you fail to give your Dental Center 24-hour notice of cancellation or fail to keep your appointment, you will be responsible for any fee your Dental Center charges for failed appointments.

COVERED SERVICES

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
00120	Periodic Oral Evaluation	$10.00
00140	Limited Oral Evaluation - Problem Focused	$10.00
00150	Comprehensive Oral Evaluation	$10.00
00160	Detailed Extended Oral Evaluation - Problem Focused	$10.00
00170	Re-Evaluation - Limited Problem Focused	$10.00
00180	Comprehensive Periodontal Evaluation	$10.00
00210	Intraoral radiographs - complete series (including bitewings) once every 3 years	No Charge
00220	Intraoral periapical radiograph - first film	No Charge
00230	Intraoral periapical radiograph - each additional film	No Charge
00240	Intraoral occlusal film	No Charge
00270	Bitewing radiograph -1 film	No Charge
00272	Bitewing radiograph - 2 films - once per year	No Charge
00274	Bitewing radiograph - 4 films - once per year	No Charge
00277	Vertical Bitewing radiograph - 7 to 8 films	No Charge
00330	Panoramic film	No Charge
00340	Cephalometric film	No Charge
01110	Prophylaxis (adult) - 2 per year	No Charge
01120	Prophylaxis (child) - 2 per year	No Charge
01201	Topical application of fluoride including prophylaxis (child)	No Charge
01203	Topical application of fluoride excluding prophylaxis (child) - once per year to age 19	No Charge

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
01310	Nutritional counseling - control dental of disease	No Charge
01330	Oral hygiene instructions	No Charge

ADA CODE	MISCELLANEOUS SERVICES	COPAYMENT AMOUNT
00460	Pulp vitality tests	No Charge
00470	Diagnostic casts	No Charge
01351	Sealant - per tooth	No Charge
01510	Space Maintainer - fixed - unilateral	No Charge
01515	Space Maintainer - fixed - bilateral	No Charge
01520	Space Maintainer - removable - unilateral	No Charge
01525	Space Maintainer - removable - bilateral	No Charge
01550	Recementation of Space Maintainer	No Charge
09110	Palliative (emergency) treatment -dental pain -minor procedure	$17.00

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
02140	Amalgam - one surface, primary or permanent	$20.00
02150	Amalgam - two surfaces, primary or permanent	$24.00
02160	Amalgam - three surfaces, primary or permanent	$31.00
02161	Amalgam - four or more surfaces, primary or permanent	$40.00
02330	Resin - one surface, anterior	$24.00
02331	Resin - two surfaces, anterior	$31.00
02332	Resin - three surfaces, anterior	$45.00

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
02335	Resin - four or more surfaces or involving incisal angle (anterior)	$45.00
02390	Resin - crown (anterior)	$45.00
02391	Resin - one surface, posterior	$29.00
02392	Resin - two surfaces, posterior	$39.00
02393	Resin - three surfaces, posterior	$45.00
02394	Resin - four or more surfaces, posterior	$50.00
02940	Sedative filling	$47.00
02951	Pin retention - per tooth, in addition to restoration	$31.00
07111	Coronal remnants - deciduous tooth	$24.00
07140	Extraction - erupted tooth or exposed root	$24.00

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
02930	Prefabricated stainless steel crown - primary	$96.00
02931	Prefabricated stainless steel crown - permanent	$126.00
02932	Prefabricated resin crown	$110.00
02933	Prefabricated stainless steel crown with resin window	$44.00
02934	Prefabricated esthetic coated stainless steel crown - primary	$44.00
09210	Local anesthesia - not in conjunction with operative or surgical procedure	$16.00
09211	Regional block anesthesia	No Charge
09212	Trigeminal division block anesthesia	No Charge
09215	Local anesthesia	No Charge
09220	Deep sedation - general anesthesia - first 30 minutes (SEE EXCLUSIONS)	$47.00

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
09221	Deep sedation - general anesthesia - each additional 15 minutes (SEE EXCLUSIONS)	$20.00
09241	Intravenous conscious sedation - analgesia - first 30 minutes (SEE EXCLUSIONS)	$37.00
09242	Intravenous conscious sedation - analgesia - each additional 15 minutes (SEE EXCLUSIONS)	$15.00
09248	Non-intravenous conscious sedation (SEE EXCLUSIONS)	$5.00
09430	Office visit for observation (regular hours) - no other services performed	No Charge
09440	Office visit (after regular hours)	$70.00
09450	Case presentation - detailed and extensive treatment planning	No Charge
09951	Occlusal adjustment – limited	$26.00
09952	Occlusal adjustment – complete	$98.00

ADA CODE	ENDODONTICS (includes postoperative evaluation and treatment under local anesthetic)	COPAYMENT AMOUNT
03110	Pulp capping - direct (excluding final restoration)	$15.00
03120	Pulp capping - indirect (excluding final restoration)	$15.00
03220	Therapeutic Pulpotomy (excluding final restoration)	$48.00
03221	Pulpal debridement - primary and permanent teeth	$48.00
03230	Pulpal therapy (resorbable fill) anterior primary tooth	$48.00
03240	Pulpal therapy (resorbable fill) posterior primary tooth	$48.00
03310	Root canal - anterior (excluding final restoration)	$149.00

ADA CODE	ENDODONTICS (includes postoperative evaluation and treatment under local anesthetic)	COPAYMENT AMOUNT
03320	Root canal - bicuspid (excluding final restoration)	$160.00
03330	Root canal - molar (excluding final restoration)	$215.00
03332	Incomplete endodontics therapy; inoperable/fractured tooth	$121.00
03346	Retreatment of previous root canal therapy - anterior	$193.00
03347	Retreatment of previous root canal therapy - bicuspid	$240.00
03348	Retreatment of previous root canal therapy - molar	$317.00
03351	Apexification/recalcification - initial visit	$82.00
03352	Apexification/recalcification - interim medication replacement	$57.00
03353	Apexification/recalcification - final visit	$149.00
03410	Apicoectomy/periradicular surgery - anterior	$138.00
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	$138.00
03425	Apicoectomy/periradicular surgery - molar (first root)	$138.00
03426	Apicoectomy/periradicular surgery (each additional root)	$52.00
03430	Retrograde filling - per root	$111.00
03450	Root amputation - per root	$58.00
03920	Hemisection (including root removal) not including root canal therapy	$76.00

ADA CODE	PERIODONTICS (includes postoperative evaluations, treatment under local anesthetic and biologic materials to aid in soft and osseous tissue regeneration)	COPAYMENT AMOUNT
04210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	$183.00
04211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	$29.00
04240	Gingival flap procedure including root planing - four or more teeth per quadrant	$175.00
04241	Gingival flap procedure including root planing - one to three teeth per quadrant	$92.00
04249	Clinical crown lengthening - hard tissue	$142.00
04260	Osseous surgery, including flap entry and closure - four or more teeth per quadrant	$203.00
04261	Osseous surgery, including flap entry and closure - one to three teeth per quadrant	$108.00
04270	Pedicle soft tissue graft procedure	$119.00
04271	Free soft tissue graft procedure (including donor site surgery)	$117.00
04273	Subepithelial connective tissue graft procedure	$142.00
04274	Distal or proximal wedge procedure	$50.00
04276	Combined connective tissue and double pedicle graft	$142.00
04341	Periodontal scaling and root planing - four or more teeth per quadrant (4 quadrants per year)	$45.00
04342	Periodontal scaling and root planing - one to three teeth per quadrant (4 quadrants per year)	$23.00
04355	Full mouth debridement - enable periodontal evaluation and diagnosis	$45.00
04910	Periodontal maintenance procedure following active therapy (limit one)	$29.00

ADA CODE	ORAL SURGERY (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07210	Surgical removal of erupted tooth	$45.00
07220	Surgical removal of tooth - soft tissue impaction	$58.00
07230	Surgical removal of tooth - partial bony impaction	$83.00
07240	Surgical removal of tooth - complete bony impaction	$83.00
07241	Surgical removal of tooth - complete bony impaction (unusual complication)	$98.00
07250	Surgical removal of residual tooth roots (cutting procedure)	$47.00
07280	Surgical access of an unerupted tooth	$96.00
07310	Alveoloplasty - in conjunction with extractions - per quadrant	$75.00
07311	Alveoloplasty - in conjunction with extractions - one to three teeth per quadrant	$38.00
07320	Alveoloplasty - not in conjunction with extractions - per quadrant	$96.00
07321	Alveoloplasty - not in conjunction with extractions - one to three teeth per quadrant	$49.00
07450	Removal of benign odontogenic cyst, tumor or lesion (less than 1.25 cm)	$109.00
07451	Removal of benign odontogenic cyst, tumor or lesion (1.25 cm or larger)	No Charge
07510	Incision and drainage of abscess - intraoral soft tissue	$47.00
07511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$58.00
07960	Frenulectomy or Frenectomy (separate procedures)	$75.00

ADA CODE	ORAL SURGERY (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07963	Frenuloplasty	$94.00
07970	Excision of hyperplastic tissue (per arch)	$109.00
07971	Excision of pericoronal gingiva	$60.00

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02510	Inlay - metallic, one surface	$276.00
02520	Inlay - metallic, two surfaces	$330.00
02530	Inlay - metallic, three or more surfaces	$352.00
02542	Onlay - metallic, two surfaces	$373.00
02543	Onlay - metallic, three surfaces	$373.00
02544	Onlay - metallic, four or more surfaces	$373.00
02610	Inlay - porcelain/ceramic - one surface	$299.00
02620	Inlay - porcelain/ceramic - two surfaces	$299.00
02630	Inlay - porcelain/ceramic - three or more surfaces	$299.00
02642	Onlay porcelain/ceramic - two surfaces	$373.00
02643	Onlay porcelain/ceramic - three surfaces	$373.00
02644	Onlay porcelain/ceramic - four or more surfaces	$373.00
02650	Inlay - resin - one surface	$301.00
02651	Inlay - resin - two surfaces	$301.00
02652	Inlay - resin - three or more surfaces	$301.00
02662	Onlay - resin - two surfaces	$373.00
02663	Onlay - resin - three surfaces	$373.00
02664	Onlay - resin - four or more surfaces	$373.00
02710	Crown - resin	$157.00
02712	Crown - 3/4 resin-based composite (indirect)	$157.00

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02720	Crown - resin fused to high noble metal	$416.00
02721	Crown - resin fused to predominantly base metal	$405.00
02722	Crown - resin fused to noble metal	$405.00
02740	Crown - porcelain/ceramic substrate	$385.00
02750	Crown - porcelain fused to high noble metal	$416.00
02751	Crown - porcelain fused to predominantly base metal	$405.00
02752	Crown - porcelain fused to noble metal	$405.00
02780	Crown - 3/4 cast high noble metal	$405.00
02781	Crown - 3/4 cast predominantly base metal	$395.00
02782	Crown - 3/4 cast noble metal	$395.00
02783	Crown - 3/4 porcelain/ceramic	$385.00
02790	Crown - full cast high noble metal	$405.00
02791	Crown - full cast predominantly base metal	$394.00
02792	Crown - full cast noble metal	$395.00
02794	Crown - titanium	$405.00
02799	Provisional crown	$147.00
02910	Recement inlay, onlay or partial coverage restoration (See Limitations)	$31.00
02915	Recement - cast or prefabricated post and core (See Limitations)	$31.00
02920	Recement crown (See Limitations)	$31.00
02950	Core build-up, including any pins	$110.00
02952	Cast post and core, in addition to crown	$159.00
02953	Each additional cast post (same tooth)	$36.00
02954	Prefabricated post and core, in addition to crown	$136.00

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02957	Each additional prefabricated post (same tooth)	$25.00
02980	Crown repair by report	$85.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05110	Complete denture - maxillary	$485.00
05120	Complete denture - mandibular	$485.00
05130	Immediate denture - maxillary	$504.00
05140	Immediate denture - mandibular	$504.00
05211	Maxillary partial denture - resin base (clasp/rests)	$524.00
05212	Mandibular partial denture - resin base (clasp/rests)	$524.00
05213	Maxillary partial denture - metal frame with resin base	$524.00
05214	Mandibular partial denture - metal frame with resin base	$524.00
05225	Maxillary partial denture - flexible base (clasp/rests)	$524.00
05226	Mandibular partial denture - flexible base (clasp/rests)	$524.00
05281	Removable unilateral partial denture - one piece metal (with resin base)	$330.00
05410	Adjust complete denture - maxillary	$31.00
05411	Adjust complete denture - mandibular	$31.00
05421	Adjust partial denture - maxillary	$31.00
05422	Adjust partial denture - mandibular	$31.00
05510	Repair broken complete denture base	$75.00
05520	Replace missing/broken teeth - complete denture - per tooth	$60.00
05610	Repair resin denture base	$75.00
05620	Repair cast framework, partial denture	$85.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05630	Repair or replace broken clasp, partial denture	$75.00
05640	Replace broken teeth - partial denture - per tooth	$60.00
05650	Add tooth to existing partial denture	$96.00
05660	Add clasp to existing partial denture	$136.00
05670	Replace all teeth and acrylic cast metal framework - maxillary	$222.00
05671	Replace all teeth and acrylic cast metal framework - mandibular	$222.00
05710	Rebase complete maxillary denture	$222.00
05711	Rebase complete mandibular denture	$222.00
05720	Rebase partial denture - maxillary	$222.00
05721	Rebase partial denture - mandibular	$222.00
05730	Reline complete denture - maxillary (chairside)	$147.00
05731	Reline complete denture - mandibular (chairside)	$147.00
05740	Reline partial denture - maxillary (chairside)	$197.00
05741	Reline partial denture - mandibular (chairside)	$197.00
05750	Reline complete denture - maxillary (laboratory)	$180.00
05751	Reline complete denture - mandibular (laboratory)	$180.00
05760	Reline partial denture - maxillary (laboratory)	$180.00
05761	Reline partial denture - mandibular (laboratory)	$180.00
05860	Overdenture - complete	$379.00 SEE LIMITATIONS
05861	Overdenture - partial	$419.00 SEE LIMITATIONS

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06205	Pontic - indirect resin based composite	$142.00
06210	Pontic - cast high noble metal	$383.00
06211	Pontic - cast predominantly base metal	$339.00
06212	Pontic - cast noble metal	$361.00
06214	Pontic - titanium	$383.00
06240	Pontic - porcelain fused to high noble metal	$427.00
06241	Pontic - porcelain fused to predominantly base metal	$405.00
06242	Pontic - porcelain fused to noble metal	$416.00
06245	Pontic - porcelain/ceramic	$416.00
06250	Pontic - resin fused to high noble metal	$427.00
06251	Pontic - resin fused to predominantly base metal	$405.00
06252	Pontic - resin fused to noble metal	$416.00
06253	Provisional Pontic	$147.00
06545	Retainer - cast metal - resin bonded fixed prosthesis	$184.00
06548	Retainer - porcelain/ceramic - resin bonded fixed prosthesis	$184.00
06600	Inlay - porcelain/ceramic - two surfaces	$416.00
06601	Inlay - porcelain/ceramic - three or more surfaces	$416.00
06602	Inlay - cast high noble metal - two surfaces	$243.00
06603	Inlay - cast high noble metal - three or more surfaces	$343.00
06604	Inlay - cast fused to predominantly base metal - two surfaces	$243.00
06605	Inlay - cast fused to predominantly base metal - three or more surfaces	$343.00
06606	Inlay - cast noble metal - two surfaces	$243.00
06607	Inlay - cast noble metal - three or more surfaces	$343.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06608	Onlay - porcelain/ceramic - two surfaces	$416.00
06609	Onlay - porcelain/ceramic - three or more surfaces	$416.00
06610	Onlay - cast high noble metal - two surfaces	$391.00
06611	Onlay - cast high noble metal - three or more surfaces	$407.00
06612	Onlay - cast fused to predominantly base metal - two surfaces	$391.00
06613	Onlay - cast fused to predominantly base metal - three or more surfaces	$407.00
06614	Onlay - cast noble metal - two surfaces	$391.00
06615	Onlay - cast noble metal - three or more surfaces	$407.00
06624	Inlay - titanium	$343.00
06634	Onlay - titanium	$407.00
06710	Crown - indirect resin based composite	$157.00
06720	Crown - resin fused to high noble metal	$416.00
06721	Crown - resin fused to predominantly base metal	$405.00
06722	Crown - resin fused to noble metal	$405.00
06740	Crown - porcelain/ceramic	$385.00
06750	Crown - porcelain fused to high noble metal	$438.00
06751	Crown - porcelain fused to predominantly base metal	$416.00
06752	Crown - porcelain fused to noble metal	$427.00
06780	Crown - 3/4 cast high noble metal	$339.00
06781	Crown - 3/4 cast fused to predominantly base metal	$405.00
06782	Crown - 3/4 cast fused to noble metal	$395.00
06783	Crown - 3/4 porcelain/ceramic	$395.00

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06790	Crown - full cast high noble metal	$405.00
06791	Crown - full cast predominantly base metal	$339.00
06792	Crown - full cast noble metal	$372.00
06793	Crown - provisional	$147.00
06794	Crown - titanium	$405.00
06930	Recement fixed partial denture (See Limitations)	$63.00
06970	Cast post and core/addition to bridge retainer	$100.00
06971	Cast post as part of bridge retainer	$88.00
06972	Prefabricated post and core in addition to bridge retainer	$81.00
06973	Core build up for retainer, including any pins	$65.00
06976	Each additional cast post - same tooth	$42.00
06977	Each additional prefabricated post - same tooth	$41.00
06980	Fixed partial denture repair by report	$36.00
06985	Fixed partial denture - pediatric	$524.00
09942	Repair and/or reline of occlusal guard	$75.00

	ORTHODONTICS	COPAYMENT AMOUNT
Dependent Orthodontics		
	Orthodontic benefits for a dependent child **Full Course of Treatment**	$2,300.00
Orthodontic benefits for the treatment to correct malocclusions are limited to one Phase II Course of Treatment and Retention. Benefits include consultation, office records, comprehensive full banding and/or bonding of the dentition, the initial retention appliances and office visits for retention. The benefit period for treatment and retention will not exceed 24 months and will begin with the initial banding and/or bonding of the particular case as reported by the participating dentist. Should your coverage terminate during a course of orthodontic treatment, the balance of payments would be your responsibility.		

SPECIAL LIMITATIONS

Your dental benefits under this Certificate will be subject to the special conditions and limitations stated below.

Prosthodontics (Prosthetic appliances such as bridges, partial and full dentures)

A prosthetic appliance will be provided only once in every 4-year period. However, your existing appliance must be unserviceable or not functional (as determined by your dentist). The 4-year period will begin on the date on which the existing appliance was last supplied. The term "existing" means an appliance that was in place on and before the 4-year period begins.

The following appliances will be covered as indicated below:

1. **Fixed versus Removable Appliance.** If there are multiple spaces in the same arch, benefits will be provided for a removable appliance. If one or more missing teeth in the same arch can be replaced using a maximum of 4 units (a combination of retainers and pontics), benefits will be provided for a fixed bridge. If more than 4 units are required, benefits will be provided for a removable appliance.
2. **Recementation.** Recementation of inlays, crowns, bridges and Maryland bridges initially placed by your Dental Center will not be charged to you (within the first 12 (twelve) months). Recementation of pre-existing inlays, crowns, bridges and Maryland bridges not placed by your Dental Center will be provided according to the actual fee-for-service normally charged.
3. **Partial Dentures**. Benefits for a removable appliance will be provided if a satisfactory result can be achieved by a standard cast chrome and/or acrylic partial denture, but if you and your dentist select a more personal appliance or one involving special techniques, benefits under this Certificate will be limited to the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will be your responsibility.
4. **Complete Dentures.** If a satisfactory result can be achieved by using standard procedures and materials, but you and your dentist select a more personal appliance or one which may involve a special technique, benefits under this Certificate will be limited to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of your cost will be your responsibility.
5. **Overdenture.** If an overdenture is the treatment you choose, benefits will be provided to the limits of a standard denture. All other related services or procedures will not be covered.
6. **Temporary Full or Partial Dentures.** If you decide to have a temporary appliance instead of the conventional prosthesis, your copayment will be the same as that applicable to the conventional prosthesis (and you will have used the benefit available for the 4-year period).

7. **Prosthetic Appliances.** Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Crowns, Inlays/Onlays (Silver or tooth colored fillings, inlays, porcelain, metal, or porcelain to metal crowns)

1. Inlays, porcelain, metals, or porcelain to metal crowns. If a tooth can be restored with amalgam or composite resins, these materials will be used to restore the tooth. The judgment will be up to the dentist providing the service.
2. Restorations for abrasion, erosion and attrition will be covered only when a clinical recommendation has been made by your dentist.
3. Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Mouth Rehabilitation

If you and your dentist agree to select a course of mouth rehabilitation, your benefits under this Certificate will be limited to covering only those procedures necessary to eliminate oral disease and replace missing teeth. The balance of the cost of your treatment, including costs to increase vertical dimension or restore the occlusion, will be your responsibility.

Referrals to Specialists

Benefits, excluding emergency care, will be provided for services received from a specialist only when the referral has been made by your primary dentist.

EXCLUSIONS

The following treatments, procedures or costs are not covered under this Certificate.

General Exclusions

1. Services not specifically mentioned in this Certificate.
2. Procedures which were begun but not completed prior to coverage under this Certificate, except for Orthodontics.
3. Dental treatment for cosmetic purposes.
4. Dental service performed in a hospital, including any related hospital fee, unless you have received written authorization.
5. Procedures deemed experimental by prevailing dental standards.
6. Treatment of congenital malformation, including but not limited to cleft palate, anodontia, mandibular prognathism and enamel hypoplasia in the absence of dental carries.
7. Treatment which, in the professional judgment of the attending dentist, will not produce a satisfactory result.
8. Major restorative work caused by orthodontic treatment.
9. Dental implants, transplants or augmentation and any diagnostic or definitive treatment related to implants, transplants or augmentations.
10. Accidental injury, except as provided under palliative emergency treatment.
11. The cost of services received from physicians, dentists, oral surgeons or dental offices outside of your selected Dental Center, unless you have received written authorization from your Dental Center (or as indicated under the Emergency Treatment provisions of this Certificate).
12. Treatment for any condition to the extent to which benefits are recovered or found to be recoverable, whether by adjudication or settlement under any Workers Compensation, Occupational Disease or other law, even though you or your dependents fail to claim the right to such benefits.
13. Diagnostic procedures related to non-covered services.
14. Treatment for any disease, condition, or injuries received as a result of war, declared or undeclared, or if caused by atomic explosion, whether or not the result of war.
15. Treatment obtained from, or which payment is made by, any federal, state, county, municipal, or other governmental agency, including any foreign government.
16. Temporomandibular joint (TMJ) disorders or dysfunctions and related services.

17. General anesthesia and IV sedation without documented medical necessity. Allergy to local anesthesia must be documented by a licensed physician following testing procedures. If you decide to have general anesthesia or IV sedation without obtaining medical documentation and this requires a referral to a dental office not affiliated with the Network, or a referral to a dental office affiliated with the Network but not responsible for providing the covered services specified in the Schedule of Dental Services, benefits will not be provided for these services.

Orthodontic Exclusions

1. Retreatment of a prior orthodontic cases.
2. Patients with severe medical disabilities which may prevent satisfactory orthodontic results.
3. Any charge made by an orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient which was lost or broken through no fault of the orthodontist.
4. Orthognathic surgery.
5. Removal of asymptomatic erupted teeth associated with Orthodontics (unless you have received written authorization). This exclusion does not apply to the removal of third molars.

COORDINATION OF BENEFITS

If you should receive payment under another group policy, certificate or agreement providing the same kind of dental benefits that this Certificate provides, Blue Cross and Blue Shield or your Dental Center shall have the right to recover such payments from you, to the extent such recovery is consistent with the priority of benefit applications indicated in this section.

When the total value of benefits or services you are entitled to under this Certificate and under any other group contract exceeds your actual expense (including the premiums), Blue Cross and Blue Shield or your Dental Center reserves the right to reduce the total benefits and services provided under this Certificate so that the benefits will not exceed the total expense for the covered services received.

If any other group contract contains provisions establishing similar rules as those stated below, then the benefits under this Certificate and the other group contract will be determined by applying the following rules:

1. The benefits of the group contract which covers the person with the claim as an Insured rather than as a dependent will be determined before the benefits of the group contract which covers that person as a dependent.

2. The benefits of the group contract which covers a dependent as the *Relative* (that is, a person who is entitled to benefits under this Certificate because of a connection or relationship to the Insured) of a person whose date of birth (but not year of birth) occurs earlier in a calendar year will be determined before the benefits under any other group contract which covers that dependent as a Relative of a person whose date of birth (but not year of birth) occurs later in the calendar year. If the dependent's Relatives have the same date of birth (but not year of birth), the benefits under the group contract covering the dependent as a Relative of the person whose group policy has been in effect for the longer period of time will be determined first – except that if the claim is for a dependent child, the following rules will apply:

   (i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the group contract which covers the child as a dependent of the parent without custody.

   (ii) when the parents are divorced and the parent with custody of the child has remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody will be determined before the benefits of the group contract which covers that child as a dependent of the stepparent and the benefits of the group contract which covers the child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Despite the provisions stated above, if there is a court decree which establishes financial responsibility for the dental care expenses of the child, the benefits of the group contract which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of the group contract which covers the child as a dependent child.

3. When the rules stated above do not establish an order of benefit determination, the benefits of the group contract which has been in effect for the longer period of time will decide, provided that:

   (i) the benefits of the group contract covering the person with the claim as a laid-off or retired employee or as the dependent of a laid-off or retired employee will be determined after the benefits of the group contract covering such person as an employee who is not laid off or retired; and

   (ii) if any group contract does not have a provision regarding laid-off or retired employees and the group contract determines its benefits after this contract, then the provisions of (i) above will not apply.

If the other group contract does not contain provisions establishing the same rules as set forth in this section, then the benefits under the other group contract will be determined before the benefits under this Certificate.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Law)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the former spouse of or former party to a Civil Union with the Insured who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article B will apply if you are the dependent child of the Insured who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided in Article A.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: Continuation of Coverage if you are the former spouse of the Insured or spouse of a retired Insured

If the coverage of the spouse of the Insured should terminate because of the death of the Insured, a divorce from the Insured, dissolution of a Civil Union from the Insured, or the retirement of an Insured, the former spouse or retired Insured's spouse if at least 55 years of age will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Insured or spouse of a retired Insured only if you provide the employer of the Insured with written notice of the dissolution of marriage, or Civil Union, the death or retirement of the Insured within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage to or Civil Union with the Insured, the death of the Insured or the retirement of the Insured as well as notice of your address. Such notice will include the Group Number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

c. instructions for returning the election form by certified mail, return receipt requested, within 30 days after the date of mailing receipt of such instruction by Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Insured under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Insured. Your right to continuation of coverage will then be forfeited.

4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Insured, with Individual or Family Coverage, as the case may be, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

   If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry or enter another Civil Union.

d. the date on which you become an insured employee under any other group health plan.

e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate, except due to the retirement of the Insured, under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry or enter another Civil Union.

   d. the date on which you become an insured employee under any other group health plan.

   e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation of coverage under this Certificate you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.

10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE B: **Continuation of Coverage if you are the dependent child of the Insured**

If the coverage of a dependent child should terminate because of the death of the Insured and the dependent child is not eligible to continue coverage under ARTICLE A or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Insured only if you, or a responsible adult acting on your behalf as the dependent

child, provide the employer of the Insured with written notice of the death of the Insured within 30 days of the date the coverage terminates.

2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Insured with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

3. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the death of the Insured or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:

   a. a form for election to continue coverage under this Certificate.

   b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

   c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.

4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Insured under this Certificate as a result of the death of the Insured or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.

5. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.

6. The monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Insured, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
    a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Insured.
    c. the date on which you become an insured employee, after the date of election, under any other group health plan.
    d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a ''direct pay'' basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this provision of your Certificate is to explain the options available for temporarily continuing your coverage after termination if you are covered under this Certificate as the party to a Civil Union with the Insured or as the dependent child of a party to a Civil Union. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA provision does not apply to your dependent who is a party to a Civil Union and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Plan Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

GENERAL PROVISIONS

1. This Certificate, including any endorsement attached to it, is the entire agreement between you and Blue Cross and Blue Shield. Your dental benefits will be provided in accordance with the terms and conditions described in this Certificate. No statement you make in your application shall void this Certificate or be used in any legal proceedings unless your application, or an exact copy of it, is attached to this Certificate.
2. No agent of Blue Cross and Blue Shield has authority to change this Certificate or to waive any of its provisions. No change shall be valid unless it has been approved by an officer of Blue Cross and Blue Shield and such approval is endorsed and attached to this Certificate.
3. The Dental Center you select will be solely responsible for all dental advice and services performed or prescribed. Neither Blue Cross and Blue Shield, its agents, nor any employer shall be liable for injuries, damages or expenses resulting from negligence, malfeasance, nonfeasance or malpractice on the part of any officer or employee or agent of Blue Cross and Blue Shield. Neither shall Blue Cross and Blue Shield be responsible for such acts on the part of any person, organization or entity rendering services to you or your family members under this Certificate. You agree and acknowledge that Blue Cross and Blue Shield does not practice dentistry or medicine. Dentists are not employees or agents of Blue Cross and Blue Shield. The relationship between Blue Cross and Blue Shield and the dentists is that of purchaser and seller of dental services.
4. The dental services described in this Certificate are personal to you and your family and are not assignable.
5. All Copayments and additional fees or charges specified in this Certificate are due to the Dental Center. Neither Blue Cross and Blue Shield nor your Group will have any liability for the collection of such fees or charges.
6. All dental services rendered to you must be performed at the Dental Center you have selected. You may select a personal dentist from those on staff at the Dental Center you have chosen. You have the right to transfer to another Dental Center at any time. Changes submitted by the 20th of the month will become effective the 1st of the following month.
7. Payments will not be made to you for any dental services described in this Certificate unless such payment is for emergency treatment or reimbursement for payments you made to a dentist or specialist after receiving written authorization from Blue Cross and Blue Shield.

BlueCross BlueShield of Illinois

GB-17 HCSC
Plan ID: DHMO0705
www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Your Dental Care Benefit Program

BLUECARE® DENTAL HMO
PLAN NUMBER 706

BlueCross BlueShield of Illinois

GROUP CERTIFICATE RIDER REGARDING DEPENDENT LIMITING AGE

For Dental Plans

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

This Rider is attached to and becomes a part of your Certificate. The Certificate and any Riders thereto are amended as stated below.

DEPENDENT COVERAGE

Benefits will be provided under this Certificate for your and/or your spouse's enrolled child(ren) under the age of 26.

"Child(ren)" used hereafter, means a natural child(ren), a stepchild(ren), a child(ren) of your Domestic Partner, a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of your child(ren),child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status,, eligibility for other coverage or any combination of those factors. If the covered child(ren) is eligible military personnel, the limiting age is 30 years of age as described under the **FAMILY COVERAGE** provision in the ELIGIBILITY section of this Certificate.

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the Certificate to which this Rider is attached will remain in full force and effect.

Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

Sincerely,

Maurice Smith
President

A message from BLUE CROSS AND BLUE SHIELD

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. We are pleased to provide you with the dental program described in this BlueCare Dental Certificate. We hope that most of your questions about your dental coverage will be answered after you have read this Certificate.

You and your eligible dependents (if you have Family Coverage) are entitled to the benefits described in this Certificate as long as you receive them from the Dental Center you have selected. Your coverage will begin on your "Coverage Date" and continue through the period authorized by your Group (provided your Group pays all premiums and you remain an eligible participant in your Group).

Throughout this Certificate we will refer to the company that you work for as your "Group" and we refer to our company as "Blue Cross and Blue Shield."

Every effort has been made to explain your dental benefits as simply and as thoroughly as possible. However, should you have questions after reading this Certificate, contact Blue Cross Blue Shield of Illinois. It is important to all of us that you understand your benefits.

Welcome to the security and peace of mind of knowing that you have Blue Cross and Blue Shield!

Sincerely,

Maurice Smith
President

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and blue Shield of Illinois)

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DEFINITIONS

The terms listed below are used throughout this Certificate and have a specific meaning when applied to your dental coverage.

These terms will always begin with a capital letter.

Accidental Injury means damage inflicted to the hard and soft tissues of the oral cavity resulting from forces external to the mouth.

Certificate means this benefit booklet. This Certificate describes the BlueCare dental coverage applicable to you (and your eligible dependents if you have Family Coverage).

Civil Union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

COBRA means the sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), including any amendments to this Act, which regulate the conditions and manner in which an employer can offer continuation of group health and dental insurance to insureds and dependents whose coverage would otherwise terminate under the terms of this Certificate.

Copayment means a specific dollar amount that you are required to pay towards a covered service.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Service means an American Dental Association (ADA) approved dental procedure or treatment plan specified in this Certificate for which benefits will be provided. Such service or treatment plan must be delivered by: 1) a licensed dentist acting within the scope of his license; 2) a licensed physician performing dental services within the scope of his license; or 3) a licensed dental hygienist acting under the supervision and direction of a licensed dentist.

Course of Treatment means any number of orthodontic dental procedures performed by a dentist in a planned series following a dental examination that determines the need for these procedures.

- **Full Course of Treatment** means a complete and comprehensive banding of teeth in order to guide the teeth into their correct relationship (to correct a malocclusion). Treatment usually will involve both the upper and lower arches of the mouth. The length of treatment is about 24 months and should be followed by passive retention treatment.
- **Partial Course of Treatment** means any treatment which is less than a Full Course of Treatment. Treatment may not exceed 24 months. Treatment in progress means a person who is presently banded becomes

covered under this Certificate. Benefits for these situations should be clarified by contacting Blue Cross Blue Shield of Illinois at 1-800-323-7201.

Domestic Partner means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership means a long-term committed relationship of indefinite duration with a person which meets the following criteria:

a) You and your Domestic Partner have lived together for at least six months;

b) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

c) Both you and your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;

d) You and your Domestic Partner reside together and intend to do so indefinitely;

e) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

f) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

Emergency Dental Care means the provision of dental care for a sudden, acute dental condition that would lead a prudent layperson, who possesses an average knowledge of dentistry, to reasonably expect the absence of immediate care to result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Family Coverage means coverage under this Certificate for the employee of the Group and the employee's eligible dependents. All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union, unless specifically noted otherwise.

Group means the employer of the Insured.

Individual Coverage means that only the employee of the Group is covered under this Certificate. His or her dependents are not covered.

Insured means the person who is the employee of the Group who has applied for dental coverage under this Certificate.

Medically Necessary means that a specific service provided to you or your dependents (if you have Family Coverage) is essential for the treatment or

management of a symptom or condition. The service must be provided in the most efficient and economic manner. In addition, Medically Necessary means:

1. A generally accepted standard of practice for the particular situation being addressed.
2. One for which there is reasonable expectation that your condition will be significantly improved or aided by the service in terms of function and, or, relief of pain and similarly there is reasonable expectation that there will be significant deterioration in your condition, if the service is not performed.

COVERAGE INFORMATION

Eligibility

Blue Cross and Blue Shield has an agreement with your Group to provide dental benefits to you (and to your dependents if you have Family Coverage).

The term "**Group"** refers to a sole proprietor, partnership, corporation or other organization. The term **"Insured"** refers to the employee engaged in the normal activities of the Group who is employed on an active, full-time basis (as defined by the Group). The employment is reasonably expected to be permanent at the time the employee is hired and this Certificate goes into effect. New employees of the Group will become eligible for coverage on the first day of the month following the date notification of coverage is provided to Blue Cross and Blue Shield or on a date that is otherwise determined by the Group. Employees of the Group whose applications have been accepted by Blue Cross and Blue Shield shall receive dental coverage as provided in this Certificate.

Individual Coverage

If you have Individual Coverage, this means that only your dental expenses are covered under this Certificate. No other members of your family will be covered.

Family Coverage

If you have Family Coverage, this means that your dental expenses and the expenses of your eligible family members will be covered, according to the terms of your group contract.

Family Coverage is subject to the following rules:

- Your application for Family Coverage must include all of your eligible dependents on the date such application is made.
- Dependent coverage for a child born to you while you are covered under Family Coverage will be effective from the date of birth.
- If you acquire a dependent (other than through the birth of a child) while you are enrolled for Family Coverage, your Family Coverage for that dependent will go into effect upon receipt of your written notification to Blue Cross and Blue Shield and upon the completion of Blue Cross and Blue Shield's membership change.

If you are the Insured, **"Dependent"** means:

1. Your legal spouse.
2. Your children or the children of your legal spouse who are under the limiting age specified in the Schedule of Dental Services.
3. Children who are in your custody in accordance with an interim court order prior to finalization of adoption or placement of adoption vesting temporary care of the children. Such children must be under the limiting age specified in the Schedule of Dental Services of this Certificate.

4. Your legally adopted children who are under the limiting age specified in the Schedule of Dental Services.
5. Your children who are under the limiting age specified in the Schedule of Dental Services and who are legally dependent upon you for support and maintenance while full-time students at an accredited institution of higher education.

   In addition, enrolled unmarried children will be covered up to the age of 30 if they:

   - Live within Blue Cross and Blue Shield's service area; and
   - Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
   - Have received a release or discharge other than a dishonorable discharge.
6. Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age, will be covered regardless of age, as long as they were covered prior to reaching the limiting age specified in the Schedule of Dental Services of this Certificate.
7. Your Domestic Partner and his or her children who are under the limiting age specified in the Schedule of Dental Services.
8. Your dependent who is a party to a Civil Union and his or her children.

Payment of Premiums

Your Group will pay your premiums. The premiums are paid monthly in advance and any arrangement requiring you to reimburse your Group for a portion of the premium is entirely between you and your Group. Blue Cross and Blue Shield looks solely to the Group for payment of premiums.

Your Group will be allowed a grace period of 31 days for the late payment of premiums. During this period, this Certificate will remain in effect. If the Group fails to pay any premium, this Certificate will automatically terminate at the end of the grace period. Blue Cross and Blue Shield will not be obligated to give you or your Group notice if this Certificate is automatically terminated. However, if Blue Cross and Blue Shield accepts payment from the Group after the expiration of the grace period, your coverage will be reinstated as of that acceptance date.

If this Certificate is terminated for any reason, the Group will be liable for all premiums then due, including charges for any period this Certificate was in effect during a grace period.

Termination of Coverage

Your coverage under this Certificate (and the coverage of your dependents if you have Family Coverage) will end if:

1. you are no longer a covered employee with your Group; or

2. your Group fails to pay premiums; or
3. your Group terminates its BlueCare Dental Agreement with Blue Cross and Blue Shield.

Your dependent's coverage will automatically end if:

1. this Certificate is terminated; or
2. he or she ceases to be a dependent according to the definition of Dependent stated in the Family Coverage provision of this Certificate, or
3. he or she reaches the limiting age specified in the Schedule of Dental Services of this Certificate.

ABOUT YOUR DENTAL BENEFITS

Types of Dental Services

The following is a summary of the types of dental services your BlueCare Certificate covers:

- **Diagnostic and Preventive Care Services**

  Diagnostic services means the procedures necessary to aid the dentist in evaluating your existing dental condition and to determine what type of dental care is required. Preventive care services means those procedures necessary to prevent oral disease. Diagnostic and Preventive Care services include:

  a. Dental examinations.

  b. X-rays — full mouth x-rays, panoramic x-rays, bitewing x-rays and other routine x-rays.

  c. Prophylaxis — cleaning and polishing of teeth.

  d. Topical fluoride applications for dependent children.

- **Oral Surgery Services**

  Oral Surgery means the procedures for surgical extractions and other dental surgery under local anesthetics which do not require that you be hospitalized.

- **Restorative Services**

  Restorative services means procedures necessary to restore your teeth to a healthy condition, including amalgam and resin based composite restorations.

- **Periodontal Services**

  Periodontics involves procedures necessary for the treatment of disease of the gums and bones supporting the teeth.

- **Endodontic Services**

  Endodontics involves procedures necessary for the treatment of disease of the pulp chamber and pulp canals. Endodontics procedures include:

  a. Root canal therapy.

  b. Pulpotomy.

  c. Pulp capping.

- **Crowns, Inlays/Onlays**

  Procedures necessary when teeth cannot be restored with other filling material.

- **Prosthodontics**

  Prosthodontics involves procedures necessary for providing artificial replacements for missing natural teeth. Procedures include the following:

  a. Construction, placement, and insertion of bridges; partial and complete dentures.

  b. Repair of bridges and relining and rebasing of partial and complete dentures.

- **Pediatric Dentistry**

  a. Dependents under age 6, who cannot be treated at a participating general dentist, can be referred to a participating Pediatric Dentist. Benefits for eligible services will be provided until age 6.

  b. Dependents age 6 and over, who cannot be treated at a participating general dentist, must have appropriate documentation in order to be referred to a participating Pediatric Dentist.

- **General Services**

  a. Prefabricated stainless steel crown.

  b. Deep sedation/general anesthesia.

  c. Occlusal adjustment.

- **Miscellaneous Services**

  a. Palliative treatment – non-invasive treatment for relief of pain.

  b. Space maintainers.

  c. Sealant application.

  d. Pulp vitality tests.

- **Orthodontics**

  Orthodontics means the proper alignment of teeth, including retention, for the treatment of malocclusion. Refer to the Schedule of Dental Services section of this Certificate for additional information about your orthodontic benefits.

Your Selected Dental Center

When you enroll for BlueCare Dental HMO coverage under this Certificate, you will be required to select a Dental Center. If you enrolled in Family Coverage, your dependents may select a different Dental Center. You must obtain dental Covered Services, including written referrals to specialists (with the exception of emergency care), from your selected Dental Center. Reimbursement for emergency treatment may differ depending upon if you receive treatment from your Dental Center or from another dentist or Dental Center. For information

regarding Emergency Treatment, refer to the Emergency Treatment section of this Certificate.

You will receive a *BlueCare Wallet Card* containing the toll-free customer service telephone number. Your Dental Center will receive a monthly list of all persons who are eligible for BlueCare dental coverage.

Changing Your Dental Center

You may transfer from one Dental Center to another at any time. Changes submitted to BlueCare Dental by the 20th of the current month will be effective the 1st of the following month. Transfers may be requested in writing or by calling customer service at 1-800-323-7201.

Appointment for Services

To receive dental treatment, telephone your selected Dental Center and give the Dental Center your name and member ID so that your enrollment can be verified.

Dental services will be provided by appointment only. Appointments will be made according to the following order of priority:

a. Emergency treatment for the relief of pain;

b. X-rays, teeth cleaning, and examinations;

c. Regular appointments to complete non-emergency dental treatment.

Every reasonable effort will be made to schedule your non-emergency appointments (routine preventive services as determined by your dentist) within 30 days of your request.

Emergency Treatment

The following rules will apply to dental services received for emergency treatment:

If you have an emergency, you can receive emergency care from any provider, not only your Dental Center. You should first attempt to contact your Dental Center or customer service at 1-800-323-7201 and follow the directions you receive.

In the event you cannot reach your Dental Center or customer service, you may seek emergency dental treatment from the nearest dentist or Dental Center. Remember, only services for palliative care (for the relief of pain) will be covered.

Reimbursement for emergency care will be provided as follows:

- ***Benefits for emergency care received from your Dental Center will be provided according to the Schedule of Dental Services in this Certificate (any Copayment indicated in the Schedule of Dental Services applies).***
- ***Benefits for emergency care received from a dentist or dental office other than your selected Dental Center will be provided up to a maximum amount of $50.00. You will need to obtain a paid receipt and itemized***

statement of services rendered from the dentist or dental office providing your treatment.

Send Claims to:
BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148

Questions About Your Benefits

Any questions you have about benefits or dental services should be directed to your Dental Center. Additional information can be obtained by writing or calling your Benefits Administrator at your Group.

If you need more detailed information about BlueCare dental coverage, address your concerns to:

BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148

A second opinion regarding dental surgery can be arranged only if you submit a written request to BlueCare Dental at the above address. Benefit questions can also be answered by calling customer service at **1-800-323-7201.**

Department of Insurance Address

In compliance with Section 143(c) of the Illinois Insurance Code, you are hereby given notice of the addresses of the Consumer Divisions of the Department of Insurance. These addresses are:

Illinois Department of Insurance
Consumer Division
100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601
or
Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767

Grievance Procedures

To resolve grievances concerning dental care and treatment, a customer oriented plan has been established.

First, it is important to work within the traditional dentist-patient relationship. You are encouraged to contact the dental office or provider directly to discuss your questions or concerns. If a satisfactory conclusion can not be reached or you do not wish to discuss your concerns with the provider, BlueCare Dental will serve as an intermediary.

You must submit a written request, providing details of your concerns, to:

BlueCare Dental HMO
701 E. 22nd Street, Suite 300
Lombard, Illinois, 60148
Attn.: Customer Relations

BlueCare Dental will acknowledge receipt of your inquiry within 72 hours of receipt. Within 30 days of receiving your inquiry you will be notified of a resolution. All parties will be notified in writing if additional time is needed for the review.

Extended Benefits at Termination

Benefits will be provided under this Certificate after the termination date of coverage only if the dental procedure began prior to the termination date and is completed within 30 days after the termination date. Orthodontic treatment in progress is an exception and benefits will end upon termination. Any balance owed will be your responsibility.

SCHEDULE OF DENTAL SERVICES FOR PLAN 706

The Covered Services specified in this Schedule of Dental Services are subject to all of the terms, conditions, limitations, and exclusions of this Certificate, and to the annual maximum indicated below.

Covered Services must be received at the Dental Center you have selected for your dental care — except for an emergency or if you have received prior written authorization from Blue Cross and Blue Shield, authorizing you to receive dental services elsewhere.

Annual Maximum

No annual maximum applies to your benefits under this Certificate.

Age Limitations

Dental Coverage excludes Orthodontic coverage. Unmarried eligible dependents are covered to age 26. Unmarried eligible dependents of sworn police or fire personnel are covered to age 26. Coverage will automatically terminate on the Dependent's birthday.

Orthodontic Coverage. Unmarried eligible dependents to age 19. Unmarried eligible dependents of sworn police or fire personnel to age 25.

Accidental Injury

There is no coverage for accidental injury. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Failed Appointments

If you fail to give your Dental Center 24-hour notice of cancellation or fail to keep your appointment, you will be responsible for any fee your Dental Center charges for failed appointments.

COVERED SERVICES

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
00120	Periodic Oral Evaluation	No Charge; $1–$40
00140	Limited Oral Evaluation - Problem Focused	No Charge; $1–$70
00150	Comprehensive Oral Evaluation	No Charge; $1–$70
00160	Detailed Extended Oral Evaluation - Problem Focused	No Charge; $1–$180
00170	Re-Evaluation - Limited Problem Focused	No Charge; $1–$50
00180	Comprehensive Periodontal Evaluation	No Charge; $1–$80
00210	Intraoral radiographs - complete series (including bitewings) once every 3 years	No Charge; $1–$100
00220	Intraoral periapical radiograph - first film	No Charge; $1–$25
00230	Intraoral periapical radiograph - each additional film	No Charge; $1–$25
00240	Intraoral occlusal film	No Charge; $1–$40
00270	Bitewing radiograph -1 film	No Charge; $1–$25
00272	Bitewing radiograph - 2 films - once per year	No Charge; $1–$40
00274	Bitewing radiograph - 4 films - once per year	No Charge; $1–$50
00277	Vertical Bitewing radiograph - 7 to 8 films	No Charge; $1–$70
00330	Panoramic film	No Charge; $1–$90
00340	Cephalometric film	No Charge; $1–$110

ADA CODE	DIAGNOSTIC AND PREVENTIVE CARE SERVICES	COPAYMENT AMOUNT
01110	Prophylaxis (adult) - 2 per year [unless prescribed more frequently]	No Charge; $1–$70
01120	Prophylaxis (child) - 2 per year [unless prescribed more frequently]	No Charge; $1–$50
01201	Topical application of fluoride including prophylaxis (child) - once per year to age [19 - 27]	No Charge; $1–$80
01203	Topical application of fluoride excluding prophylaxis (child) - once per year to age [19 - 27]	No Charge; $1–$40
01310	Nutritional counseling - control dental of disease	No Charge; $1–$50
01330	Oral hygiene instructions	No Charge; $1–$70

ADA CODE	MISCELLANEOUS SERVICES	COPAYMENT AMOUNT
00460	Pulp vitality tests	No Charge; $1–$50
00470	Diagnostic casts	No Charge; $1–$90
01351	Sealant - per tooth [(individual to age [19 - 27])]	No Charge; $1–$50
01510	Space Maintainer - fixed - unilateral	No Charge; $1–$300
01515	Space Maintainer - fixed - bilateral	No Charge; $1–$350
01520	Space Maintainer - removable - unilateral	No Charge; $1–$350
01525	Space Maintainer - removable - bilateral	No Charge; $1–$450
01550	Recementation of Space Maintainer	No Charge; $1–$70
09110	Palliative (emergency) treatment -dental pain -minor procedure	No Charge; $1–$90

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
02140	Amalgam - one surface, primary or permanent	No Charge; $1–$110
02150	Amalgam - two surfaces, primary or permanent	No Charge; $1–$130
02160	Amalgam - three surfaces, primary or permanent	No Charge; $1–$170
02161	Amalgam - four or more surfaces, primary or permanent	No Charge; $1–$200
02330	Resin - one surface, anterior	No Charge; $1–$120
02331	Resin - two surfaces, anterior	No Charge; $1–$140
02332	Resin - three surfaces, anterior	No Charge; $1–$170
02335	Resin - four or more surfaces or involving incisal angle (anterior)	No Charge; $1–$200
02390	Resin - crown (anterior)	No Charge; $1–$220
02391	Resin - one surface, posterior	No Charge; $1–$130
02392	Resin - two surfaces, posterior	No Charge; $1–$170
02393	Resin - three surfaces, posterior	No Charge; $1–$220
02394	Resin - four or more surfaces, posterior	No Charge; $1–$250
02940	Sedative filling	No Charge; $1–$80
02951	Pin retention - per tooth, in addition to restoration	No Charge; $1–$50

ADA CODE	RESTORATIVE SERVICES (includes indirect pulp capping, bases, liners, acid etching procedures and treatment under local anesthetic)	COPAYMENT AMOUNT
07111	Coronal remnants - deciduous tooth	No Charge; $1–$90
07140	Extraction - erupted tooth or exposed root	No Charge; $1–$120

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
02930	Prefabricated stainless steel crown - primary	No Charge; $1–$220
02931	Prefabricated stainless steel crown - permanent	No Charge; $1–$240
02932	Prefabricated resin crown	No Charge; $1–$260
02933	Prefabricated stainless steel crown with resin window	No Charge; $1–$300
02934	Prefabricated esthetic coated stainless steel crown - primary	No Charge; $1–$300
09210	Local anesthesia - not in conjunction with operative or surgical procedure	No Charge; $1–$40
09211	Regional block anesthesia	No Charge; $1–$50
09212	Trigeminal division block anesthesia	No Charge; $1–$80
09215	Local anesthesia	No Charge; $1–$50
09220	Deep sedation - general anesthesia - first 30 minutes (SEE EXCLUSIONS)	No Charge; $1–$350
09221	Deep sedation - general anesthesia - each additional 15 minutes (SEE EXCLUSIONS)	No Charge; $1–$140
09241	Intravenous conscious sedation - analgesia - first 30 minutes (SEE EXCLUSIONS)	No Charge; $1–$260

ADA CODE	GENERAL SERVICES	COPAYMENT AMOUNT
09242	Intravenous conscious sedation - analgesia - each additional 15 minutes (SEE EXCLUSIONS)	No Charge; $1–$110
09248	Non-intravenous conscious sedation (SEE EXCLUSIONS)	No Charge; $1–$60
09430	Office visit for observation (regular hours) - no other services performed	No Charge; $1–$70
09440	Office visit (after regular hours)	No Charge; $1–$100
09450	Case presentation - detailed and extensive treatment planning	No Charge; $1–$50
09951	Occlusal adjustment – limited	No Charge; $1–$120
09952	Occlusal adjustment – complete	No Charge; $1–$650

ADA CODE	ENDODONTICS (includes postoperative evaluation and treatment under local anesthetic)	COPAYMENT AMOUNT
03110	Pulp capping - direct (excluding final restoration)	No Charge; $1–$60
03120	Pulp capping - indirect (excluding final restoration)	No Charge; $1–$50
03220	Therapeutic Pulpotomy (excluding final restoration)	No Charge; $1–$130
03221	Pulpal debridement - primary and permanent teeth	No Charge; $1–$140
03230	Pulpal therapy (resorbable fill) anterior primary tooth	No Charge; $1–$130
03240	Pulpal therapy (resorbable fill) posterior primary tooth	No Charge; $1–$140
03310	Root canal - anterior (excluding final restoration)	No Charge; $1–$600
03320	Root canal - bicuspid (excluding final restoration)	No Charge; $1–$650

ADA CODE	ENDODONTICS (includes postoperative evaluation and treatment under local anesthetic)	COPAYMENT AMOUNT
03330	Root canal - molar (excluding final restoration)	No Charge; $1–$800
03332	Incomplete endodontics therapy; inoperable/fractured tooth	No Charge; $1–$430
03346	Retreatment of previous root canal therapy - anterior	No Charge; $1–$700
03347	Retreatment of previous root canal therapy - bicuspid	No Charge; $1–$800
03348	Retreatment of previous root canal therapy - molar	No Charge; $1–$950
03351	Apexification/recalcification - initial visit	No Charge; $1–$350
03352	Apexification/recalcification - interim medication replacement	No Charge; $1–$150
03353	Apexification/recalcification - final visit	No Charge; $1–$430
03410	Apicoectomy/periradicular surgery - anterior	No Charge; $1–$650
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Charge; $1–$630
03425	Apicoectomy/periradicular surgery - molar (first root)	No Charge; $1–$700
03426	Apicoectomy/periradicular surgery (each additional root)	No Charge; $1–$250
03430	Retrograde filling - per root	No Charge; $1–$200
03450	Root amputation - per root	No Charge; $1–$400
03920	Hemisection (including root removal) not including root canal therapy	No Charge; $1–$300

ADA CODE	PERIODONTICS (includes postoperative evaluations, treatment under local anesthetic and biologic materials to aid in soft and osseous tissue regeneration)	COPAYMENT AMOUNT
04210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	No Charge; $1–$500
04211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	No Charge; $1–$250
04240	Gingival flap procedure including root planing - four or more teeth per quadrant	No Charge; $1–$550
04241	Gingival flap procedure including root planing - one to three teeth per quadrant	No Charge; $1–$300
04249	Clinical crown lengthening - hard tissue	No Charge; $1–$650
04260	Osseous surgery, including flap entry and closure - four or more teeth per quadrant	No Charge; $1–$900
04261	Osseous surgery, including flap entry and closure - one to three teeth per quadrant	No Charge; $1–$500
04270	Pedicle soft tissue graft procedure	No Charge; $1–$650
04271	Free soft tissue graft procedure (including donor site surgery)	No Charge; $1–$700
04273	Subepithelial connective tissue graft procedure	No Charge; $1–$700
04274	Distal or proximal wedge procedure	No Charge; $1–$250
04276	Combined connective tissue and double pedicle graft	No Charge; $1–$800
04341	Periodontal scaling and root planing - four or more teeth per quadrant [(4 quadrants per year)]	No Charge; $1–$200
04342	Periodontal scaling and root planing - one to three teeth per quadrant [(4 quadrants per year)]	No Charge; $1–$100

ADA CODE	PERIODONTICS (includes postoperative evaluations, treatment under local anesthetic and biologic materials to aid in soft and osseous tissue regeneration)	COPAYMENT AMOUNT
04355	Full mouth debridement - enable periodontal evaluation and diagnosis	No Charge; $1–$130
04910	Periodontal maintenance procedure following active therapy [(limit one)]	No Charge; $1–$100

ADA CODE	ORAL SURGERY (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07210	Surgical removal of erupted tooth	No Charge; $1–$200
07220	Surgical removal of tooth - soft tissue impaction	No Charge; $1–$300
07230	Surgical removal of tooth - partial bony impaction	No Charge; $1–$400
07240	Surgical removal of tooth - complete bony impaction	No Charge; $1–$450
07241	Surgical removal of tooth - complete bony impaction (unusual complication)	No Charge; $1–$550
07250	Surgical removal of residual tooth roots (cutting procedure)	No Charge; $1–$250
07280	Surgical access of an unerupted tooth	No Charge; $1–$550
07310	Alveoloplasty - in conjunction with extractions - per quadrant	No Charge; $1–$250
07311	Alveoloplasty - in conjunction with extractions - one to three teeth per quadrant	No Charge; $1–$250
07320	Alveoloplasty - not in conjunction with extractions - per quadrant	No Charge; $1–$1100
07321	Alveoloplasty - not in conjunction with extractions - one to three teeth per quadrant	No Charge; $1–$1100

ADA CODE	ORAL SURGERY (includes postoperative evaluations and treatment under local anesthetic)	COPAYMENT AMOUNT
07450	Removal of benign odontogenic cyst, tumor or lesion (less than 1.25 cm)	No Charge; $1–$750
07451	Removal of benign odontogenic cyst, tumor or lesion (1.25 cm or larger)	No Charge; $1–$1150
07510	Incision and drainage of abscess - intraoral soft tissue	No Charge; $1–$250
07511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	No Charge; $1–$250
07960	Frenulectomy or Frenectomy (separate procedures)	No Charge; $1–$600
07963	Frenuloplasty	No Charge; $1–$600
07970	Excision of hyperplastic tissue (per arch)	No Charge; $1–$600
07971	Excision of pericoronal gingiva	No Charge; $1–$200

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02510	Inlay - metallic, one surface	No Charge; $1–$600
02520	Inlay - metallic, two surfaces	No Charge; $1–$650
02530	Inlay - metallic, three or more surfaces	No Charge; $1–$700
02542	Onlay - metallic, two surfaces	No Charge; $1–$650
02543	Onlay - metallic, three surfaces	No Charge; $1–$700
02544	Onlay - metallic, four or more surfaces	No Charge; $1–$750

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02610	Inlay - porcelain/ceramic - one surface	No Charge; $1–$650
02620	Inlay - porcelain/ceramic - two surfaces	No Charge; $1–$630
02630	Inlay - porcelain/ceramic - three or more surfaces	No Charge; $1–$700
02642	Onlay porcelain/ceramic - two surfaces	No Charge; $1–$670
02643	Onlay porcelain/ceramic - three surfaces	No Charge; $1–$800
02644	Onlay porcelain/ceramic - four or more surfaces	No Charge; $1–$750
02650	Inlay - resin - one surface	No Charge; $1–$400
02651	Inlay - resin - two surfaces	No Charge; $1–$500
02652	Inlay - resin - three or more surfaces	No Charge; $1–$500
02662	Onlay - resin - two surfaces	No Charge; $1–$450
02663	Onlay - resin - three surfaces	No Charge; $1–$500
02664	Onlay - resin - four or more surfaces	No Charge; $1–$550
02710	Crown - resin	No Charge; $1–$350
02712	Crown - 3/4 resin-based composite (indirect)	No Charge; $1–$350
02720	Crown - resin fused to high noble metal	No Charge; $1–$800
02721	Crown - resin fused to predominantly base metal	No Charge; $1–$750
02722	Crown - resin fused to noble metal	No Charge; $1–$750
02740	Crown - porcelain/ceramic substrate	No Charge; $1–$800

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02750	Crown - porcelain fused to high noble metal	No Charge; $1–$800
02751	Crown - porcelain fused to predominantly base metal	No Charge; $1–$700
02752	Crown - porcelain fused to noble metal	No Charge; $1–$750
02780	Crown - 3/4 cast high noble metal	No Charge; $1–$750
02781	Crown - 3/4 cast predominantly base metal	No Charge; $1–$700
02782	Crown - 3/4 cast noble metal	No Charge; $1–$750
02783	Crown - 3/4 porcelain/ceramic	No Charge; $1–$750
02790	Crown - full cast high noble metal	No Charge; $1–$750
02791	Crown - full cast predominantly base metal	No Charge; $1–$700
02792	Crown - full cast noble metal	No Charge; $1–$700
02794	Crown - titanium	No Charge; $1–$750
02799	Provisional crown	No Charge; $1–$350
02910	Recement inlay, onlay or partial coverage restoration [(See Limitations)]	No Charge; $1–$80
02915	Recement - cast or prefabricated post and core [(See Limitations)]	No Charge; $1–$80
02920	Recement crown [(See Limitations)]	No Charge; $1–$80
02950	Core build-up, including any pins	No Charge; $1–$200
02952	Cast post and core, in addition to crown	No Charge; $1–$350
02953	Each additional cast post (same tooth)	No Charge; $1–$200

ADA CODE	CROWNS, INLAYS/ONLAYS SERVICES	COPAYMENT AMOUNT
02954	Prefabricated post and core, in addition to crown	No Charge; $1–$250
02957	Each additional prefabricated post (same tooth)	No Charge; $1–$150
02980	Crown repair by report	No Charge; $1–$130

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05110	Complete denture - maxillary	No Charge; $1–$1150
05120	Complete denture - mandibular	No Charge; $1–$1150
05130	Immediate denture - maxillary	No Charge; $1–$1200
05140	Immediate denture - mandibular	No Charge; $1–$1200
05211	Maxillary partial denture - resin base (clasp/rests)	No Charge; $1–$900
05212	Mandibular partial denture - resin base (clasp/rests)	No Charge; $1–$1050
05213	Maxillary partial denture - metal frame with resin base	No Charge; $1–$1200
05214	Mandibular partial denture - metal frame with resin base	No Charge; $1–$1200
05225	Maxillary partial denture - flexible base (clasp/rests)	No Charge; $1–$1100
05226	Mandibular partial denture - flexible base (clasp/rests)	No Charge; $1–$1200
05281	Removable unilateral partial denture - one piece metal (with resin base)	No Charge; $1–$700
05410	Adjust complete denture - maxillary	No Charge; $1–$70
05411	Adjust complete denture - mandibular	No Charge; $1–$70

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05421	Adjust partial denture - maxillary	No Charge; $1–$70
05422	Adjust partial denture - mandibular	No Charge; $1–$70
05510	Repair broken complete denture base	No Charge; $1–$130
05520	Replace missing/broken teeth - complete denture - per tooth	No Charge; $1–$120
05610	Repair resin denture base	No Charge; $1–$150
05620	Repair cast framework, partial denture	No Charge; $1–$150
05630	Repair or replace broken clasp, partial denture	No Charge; $1–$180
05640	Replace broken teeth - partial denture - per tooth	No Charge; $1–$130
05650	Add tooth to existing partial denture	No Charge; $1–$160
05660	Add clasp to existing partial denture	No Charge; $1–$200
05670	Replace all teeth and acrylic cast metal framework - maxillary	No Charge; $1–$430
05671	Replace all teeth and acrylic cast metal framework - mandibular	No Charge; $1–$430
05710	Rebase complete maxillary denture	No Charge; $1–$450
05711	Rebase complete mandibular denture	No Charge; $1–$450
05720	Rebase partial denture - maxillary	No Charge; $1–$450
05721	Rebase partial denture - mandibular	No Charge; $1–$450
05730	Reline complete denture - maxillary (chairside)	No Charge; $1–$250
05731	Reline complete denture - mandibular (chairside)	No Charge; $1–$250

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
05740	Reline partial denture - maxillary (chairside)	No Charge; $1–$230
05741	Reline partial denture - mandibular (chairside)	No Charge; $1–$230
05750	Reline complete denture - maxillary (laboratory)	No Charge; $1–$350
05751	Reline complete denture - mandibular (laboratory)	No Charge; $1–$350
05760	Reline partial denture - maxillary (laboratory)	No Charge; $1–$330
05761	Reline partial denture - mandibular (laboratory)	No Charge; $1–$330
05860	Overdenture - complete	No Charge; $1–$1150 SEE LIMITATIONS
05861	Overdenture - partial	No Charge; $1–$1200 SEE LIMITATIONS
06205	Pontic - indirect resin based composite	No Charge; $1–$350
06210	Pontic - cast high noble metal	No Charge; $1–$700
06211	Pontic - cast predominantly base metal	No Charge; $1–$650
06212	Pontic - cast noble metal	No Charge; $1–$700
06214	Pontic - titanium	No Charge; $1–$700
06240	Pontic - porcelain fused to high noble metal	No Charge; $1–$700
06241	Pontic - porcelain fused to predominantly base metal	No Charge; $1–$650
06242	Pontic - porcelain fused to noble metal	No Charge; $1–$700

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06245	Pontic - porcelain/ceramic	No Charge; $1–$750
06250	Pontic - resin fused to high noble metal	No Charge; $1–$700
06251	Pontic - resin fused to predominantly base metal	No Charge; $1–$650
06252	Pontic - resin fused to noble metal	No Charge; $1–$650
06253	Provisional Pontic	No Charge; $1–$300
06545	Retainer - cast metal - resin bonded fixed prosthesis	No Charge; $1–$300
06548	Retainer - porcelain/ceramic - resin bonded fixed prosthesis	No Charge; $1–$350
06600	Inlay - porcelain/ceramic - two surfaces	No Charge; $1–$600
06601	Inlay - porcelain/ceramic - three or more surfaces	No Charge; $1–$650
06602	Inlay - cast high noble metal - two surfaces	No Charge; $1–$600
06603	Inlay - cast high noble metal - three or more surfaces	No Charge; $1–$700
06604	Inlay - cast fused to predominantly base metal - two surfaces	No Charge; $1–$600
06605	Inlay - cast fused to predominantly base metal - three or more surfaces	No Charge; $1–$630
06606	Inlay - cast noble metal - two surfaces	No Charge; $1–$600
06607	Inlay - cast noble metal - three or more surfaces	No Charge; $1–$650
06608	Onlay - porcelain/ceramic - two surfaces	No Charge; $1–$630
06609	Onlay - porcelain/ceramic - three or more surfaces	No Charge; $1–$650
06610	Onlay - cast high noble metal - two surfaces	No Charge; $1–$650

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06611	Onlay - cast high noble metal - three or more surfaces	No Charge; $1–$750
06612	Onlay - cast fused to predominantly base metal - two surfaces	No Charge; $1–$650
06613	Onlay - cast fused to predominantly base metal - three or more surfaces	No Charge; $1–$700
06614	Onlay - cast noble metal - two surfaces	No Charge; $1–$650
06615	Onlay - cast noble metal - three or more surfaces	No Charge; $1–$670
06624	Inlay - titanium	No Charge; $1–$700
06634	Onlay - titanium	No Charge; $1–$750
06710	Crown - indirect resin based composite	No Charge; $1–$350
06720	Crown - resin fused to high noble metal	No Charge; $1–$750
06721	Crown - resin fused to predominantly base metal	No Charge; $1–$700
06722	Crown - resin fused to noble metal	No Charge; $1–$730
06740	Crown - porcelain/ceramic	No Charge; $1–$800
06750	Crown - porcelain fused to high noble metal	No Charge; $1–$800
06751	Crown - porcelain fused to predominantly base metal	No Charge; $1–$750
06752	Crown - porcelain fused to noble metal	No Charge; $1–$750
06780	Crown - 3/4 cast high noble metal	No Charge; $1–$730
06781	Crown - 3/4 cast fused to predominantly base metal	No Charge; $1–$730
06782	Crown - 3/4 cast fused to noble metal	No Charge; $1–$700

ADA CODE	PROSTHODONTIC SERVICES	COPAYMENT AMOUNT
06783	Crown - 3/4 porcelain/ceramic	No Charge; $1–$750
06790	Crown - full cast high noble metal	No Charge; $1–$730
06791	Crown - full cast predominantly base metal	No Charge; $1–$700
06792	Crown - full cast noble metal	No Charge; $1–$730
06793	Crown - provisional	No Charge; $1–$350
06794	Crown - titanium	No Charge; $1–$800
06930	Recement fixed partial denture [(See Limitations)]	No Charge; $1–$100
06970	Cast post and core/addition to bridge retainer	No Charge; $1–$300
06971	Cast post as part of bridge retainer	No Charge; $1–$250
06972	Prefabricated post and core in addition to bridge retainer	No Charge; $1–$230
06973	Core build up for retainer, including any pins	No Charge; $1–$180
06976	Each additional cast post - same tooth	No Charge; $1–$120
06977	Each additional prefabricated post - same tooth	No Charge; $1–$150
06980	Fixed partial denture repair by report	No Charge; $1–$120
06985	Fixed partial denture - pediatric	No Charge; $1–$350
09942	Repair and/or reline of occlusal guard	No Charge; $1–$200

	ORTHODONTICS	COPAYMENT AMOUNT
Dependent Orthodontics		
	Orthodontic benefits for a dependent child **Full Course of Treatment**	$1,800
Orthodontic benefits for the treatment to correct malocclusions are limited to one Phase II Course of Treatment and Retention. Benefits include consultation, office records, comprehensive full banding and/or bonding of the dentition, the initial retention appliances and office visits for retention. The benefit period for treatment and retention will not exceed 24 months and will begin with the initial banding and/or bonding of the particular case as reported by the participating dentist. Should your coverage terminate during a course of orthodontic treatment, the balance of payments would be your responsibility.		

SPECIAL LIMITATIONS

Your dental benefits under this Certificate will be subject to the special conditions and limitations stated below.

Prosthodontics (Prosthetic appliances such as bridges, partial and full dentures)

A prosthetic appliance will be provided only once in every 4-year period. However, your existing appliance must be unserviceable or not functional (as determined by your dentist). The 4-year period will begin on the date on which the existing appliance was last supplied. The term "existing" means an appliance that was in place on and before the 4-year period begins.

The following appliances will be covered as indicated below:

1. **Fixed versus Removable Appliance.** If there are multiple spaces in the same arch, benefits will be provided for a removable appliance. If one or more missing teeth in the same arch can be replaced using a maximum of 4 units (a combination of retainers and pontics), benefits will be provided for a fixed bridge. If more than 4 units are required, benefits will be provided for a removable appliance.
2. **Recementation.** Recementation of inlays, crowns, bridges and Maryland bridges initially placed by your Dental Center will not be charged to you (within the first 12 (twelve) months). Recementation of pre-existing inlays, crowns, bridges and Maryland bridges not placed by your Dental Center will be provided according to the actual fee-for-service normally charged.
3. **Partial Dentures**. Benefits for a removable appliance will be provided if a satisfactory result can be achieved by a standard cast chrome and/or acrylic partial denture, but if you and your dentist select a more personal appliance or one involving special techniques, benefits under this Certificate will be limited to the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will be your responsibility.
4. **Complete Dentures.** If a satisfactory result can be achieved by using standard procedures and materials, but you and your dentist select a more personal appliance or one which may involve a special technique, benefits under this Certificate will be limited to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of your cost will be your responsibility.
5. **Overdenture.** If an overdenture is the treatment you choose, benefits will be provided to the limits of a standard denture. All other related services or procedures will not be covered.
6. **Temporary Full or Partial Dentures.** If you decide to have a temporary appliance instead of the conventional prosthesis, your copayment will be the same as that applicable to the conventional prosthesis (and you will have used the benefit available for the 4-year period).

7. **Prosthetic Appliances.** Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Crowns, Inlays/Onlays (Silver or tooth colored fillings, inlays, porcelain, metal, or porcelain to metal crowns)

1. Inlays, porcelain, metals, or porcelain to metal crowns. If a tooth can be restored with amalgam or composite resins, these materials will be used to restore the tooth. The judgment will be up to the dentist providing the service.
2. Restorations for abrasion, erosion and attrition will be covered only when a clinical recommendation has been made by your dentist.
3. Crowns, bridges, partial and complete dentures placed over an implant are covered at the standard benefit level and copayment listed.

Mouth Rehabilitation

If you and your dentist agree to select a course of mouth rehabilitation, your benefits under this Certificate will be limited to covering only those procedures necessary to eliminate oral disease and replace missing teeth. The balance of the cost of your treatment, including costs to increase vertical dimension or restore the occlusion, will be your responsibility.

Referrals to Specialists

Benefits, excluding emergency care, will be provided for services received from a specialist only when the referral has been made by your primary dentist.

EXCLUSIONS

The following treatments, procedures or costs are not covered under this Certificate.

General Exclusions

1. Services not specifically mentioned in this Certificate.
2. Procedures which were begun but not completed prior to coverage under this Certificate, except for Orthodontics.
3. Dental treatment for cosmetic purposes.
4. Dental service performed in a hospital, including any related hospital fee, unless you have received written authorization.
5. Procedures deemed experimental by prevailing dental standards.
6. Treatment of congenital malformation, including but not limited to cleft palate, anodontia, mandibular prognathism and enamel hypoplasia in the absence of dental carries.
7. Treatment which, in the professional judgment of the attending dentist, will not produce a satisfactory result.
8. Major restorative work caused by orthodontic treatment.
9. Dental implants, transplants or augmentation and any diagnostic or definitive treatment related to implants, transplants or augmentations.
10. Accidental injury, except as provided under palliative emergency treatment.
11. The cost of services received from physicians, dentists, oral surgeons or dental offices outside of your selected Dental Center, unless you have received written authorization from your Dental Center (or as indicated under the Emergency Treatment provisions of this Certificate).
12. Treatment for any condition to the extent to which benefits are recovered or found to be recoverable, whether by adjudication or settlement under any Workers Compensation, Occupational Disease or other law, even though you or your dependents fail to claim the right to such benefits.
13. Diagnostic procedures related to non-covered services.
14. Treatment for any disease, condition, or injuries received as a result of war, declared or undeclared, or if caused by atomic explosion, whether or not the result of war.
15. Treatment obtained from, or which payment is made by, any federal, state, county, municipal, or other governmental agency, including any foreign government.
16. Temporomandibular joint (TMJ) disorders or dysfunctions and related services.

17. General anesthesia and IV sedation without documented medical necessity. Allergy to local anesthesia must be documented by a licensed physician following testing procedures. If you decide to have general anesthesia or IV sedation without obtaining medical documentation and this requires a referral to a dental office not affiliated with the Network, or a referral to a dental office affiliated with the Network but not responsible for providing the covered services specified in the Schedule of Dental Services, benefits will not be provided for these services.

Orthodontic Exclusions

1. Retreatment of a prior orthodontic cases.
2. Patients with severe medical disabilities which may prevent satisfactory orthodontic results.
3. Any charge made by an orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient which was lost or broken through no fault of the orthodontist.
4. Orthognathic surgery.
5. Removal of asymptomatic erupted teeth associated with Orthodontics (unless you have received written authorization). This exclusion does not apply to the removal of third molars.

COORDINATION OF BENEFITS

If you should receive payment under another group policy, certificate or agreement providing the same kind of dental benefits that this Certificate provides, Blue Cross and Blue Shield or your Dental Center shall have the right to recover such payments from you, to the extent such recovery is consistent with the priority of benefit applications indicated in this section.

When the total value of benefits or services you are entitled to under this Certificate and under any other group contract exceeds your actual expense (including the premiums), Blue Cross and Blue Shield or your Dental Center reserves the right to reduce the total benefits and services provided under this Certificate so that the benefits will not exceed the total expense for the covered services received.

If any other group contract contains provisions establishing similar rules as those stated below, then the benefits under this Certificate and the other group contract will be determined by applying the following rules:

1. The benefits of the group contract which covers the person with the claim as an Insured rather than as a dependent will be determined before the benefits of the group contract which covers that person as a dependent.

2. The benefits of the group contract which covers a dependent as the *Relative* (that is, a person who is entitled to benefits under this Certificate because of a connection or relationship to the Insured) of a person whose date of birth (but not year of birth) occurs earlier in a calendar year will be determined before the benefits under any other group contract which covers that dependent as a Relative of a person whose date of birth (but not year of birth) occurs later in the calendar year. If the dependent's Relatives have the same date of birth (but not year of birth), the benefits under the group contract covering the dependent as a Relative of the person whose group policy has been in effect for the longer period of time will be determined first – except that if the claim is for a dependent child, the following rules will apply:

   (i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the group contract which covers the child as a dependent of the parent without custody.

   (ii) when the parents are divorced and the parent with custody of the child has remarried, the benefits of the group contract which covers the child as a dependent of the parent with custody will be determined before the benefits of the group contract which covers that child as a dependent of the stepparent and the benefits of the group contract which covers the child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Despite the provisions stated above, if there is a court decree which establishes financial responsibility for the dental care expenses of the child, the benefits of the group contract which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of the group contract which covers the child as a dependent child.

3. When the rules stated above do not establish an order of benefit determination, the benefits of the group contract which has been in effect for the longer period of time will decide, provided that:

   (i) the benefits of the group contract covering the person with the claim as a laid-off or retired employee or as the dependent of a laid-off or retired employee will be determined after the benefits of the group contract covering such person as an employee who is not laid off or retired; and

   (ii) if any group contract does not have a provision regarding laid-off or retired employees and the group contract determines its benefits after this contract, then the provisions of (i) above will not apply.

If the other group contract does not contain provisions establishing the same rules as set forth in this section, then the benefits under the other group contract will be determined before the benefits under this Certificate.

CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Law)

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the former spouse of or former party to a Civil Union with the Insured who has died or from whom you have been divorced or from whom your Civil Union has been dissolved. The provisions described in Article B will apply if you are the dependent child of the Insured who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided in Article A.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: **Continuation of Coverage if you are the former spouse of the Insured or spouse of a retired Insured**

If the coverage of the spouse of the Insured should terminate because of the death of the Insured, a divorce from the Insured, dissolution of a Civil Union from the Insured, or the retirement of an Insured, the former spouse or retired Insured's spouse if at least 55 years of age will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Insured or spouse of a retired Insured only if you provide the employer of the Insured with written notice of the dissolution of marriage, or Civil Union, the death or retirement of the Insured within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage to or Civil Union with the Insured, the death of the Insured or the retirement of the Insured as well as notice of your address. Such notice will include the Group Number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

c. instructions for returning the election form by certified mail, return receipt requested, within 30 days after the date of mailing receipt of such instruction by Blue Cross and Blue Shield.

3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Insured under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Insured. Your right to continuation of coverage will then be forfeited.

4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.

5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Insured, with Individual or Family Coverage, as the case may be, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

   Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

   If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

c. the date on which you remarry or enter another Civil Union.

d. the date on which you become an insured employee under any other group health plan.

e. the expiration of 2 years from the date your continued coverage under this Certificate began.

8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

   a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).

   b. on the date coverage would otherwise terminate, except due to the retirement of the Insured, under this Certificate if you were still married to or in a Civil Union with the Insured; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Insured's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Insured, except in the event this entire Certificate is modified or terminated.

   c. the date on which you remarry or enter another Civil Union.

   d. the date on which you become an insured employee under any other group health plan.

   e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

9. If you exercise the right to continuation of coverage under this Certificate you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.

10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE B: **Continuation of Coverage if you are the dependent child of the Insured**

If the coverage of a dependent child should terminate because of the death of the Insured and the dependent child is not eligible to continue coverage under ARTICLE A or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Insured only if you, or a responsible adult acting on your behalf as the dependent

child, provide the employer of the Insured with written notice of the death of the Insured within 30 days of the date the coverage terminates.

2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Insured with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

3. Within 15 days of receipt of such notice, the employer of the Insured will give written notice to Blue Cross and Blue Shield of the death of the Insured or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Insured's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Insured, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:

   a. a form for election to continue coverage under this Certificate.

   b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

   c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.

4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Insured under this Certificate as a result of the death of the Insured or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.

5. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Insureds under this Certificate.

6. The monthly charge will be computed as follows:

   a. an amount, if any, that would be charged to you if you were an Insured, plus

   b. an amount, if any, that the employer would contribute toward the charge if you were the Insured under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
    a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
    b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Insured.
    c. the date on which you become an insured employee, after the date of election, under any other group health plan.
    d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Insured covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a ''direct pay'' basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this provision of your Certificate is to explain the options available for temporarily continuing your coverage after termination if you are covered under this Certificate as the party to a Civil Union with the Insured or as the dependent child of a party to a Civil Union. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Certificate.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA provision does not apply to your dependent who is a party to a Civil Union and their children, or to your Domestic Partner and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Plan Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

GENERAL PROVISIONS

1. This Certificate, including any endorsement attached to it, is the entire agreement between you and Blue Cross and Blue Shield. Your dental benefits will be provided in accordance with the terms and conditions described in this Certificate. No statement you make in your application shall void this Certificate or be used in any legal proceedings unless your application, or an exact copy of it, is attached to this Certificate.
2. No agent of Blue Cross and Blue Shield has authority to change this Certificate or to waive any of its provisions. No change shall be valid unless it has been approved by an officer of Blue Cross and Blue Shield and such approval is endorsed and attached to this Certificate.
3. The Dental Center you select will be solely responsible for all dental advice and services performed or prescribed. Neither Blue Cross and Blue Shield, its agents, nor any employer shall be liable for injuries, damages or expenses resulting from negligence, malfeasance, nonfeasance or malpractice on the part of any officer or employee or agent of Blue Cross and Blue Shield. Neither shall Blue Cross and Blue Shield be responsible for such acts on the part of any person, organization or entity rendering services to you or your family members under this Certificate. You agree and acknowledge that Blue Cross and Blue Shield does not practice dentistry or medicine. Dentists are not employees or agents of Blue Cross and Blue Shield. The relationship between Blue Cross and Blue Shield and the dentists is that of purchaser and seller of dental services.
4. The dental services described in this Certificate are personal to you and your family and are not assignable.
5. All Copayments and additional fees or charges specified in this Certificate are due to the Dental Center. Neither Blue Cross and Blue Shield nor your Group will have any liability for the collection of such fees or charges.
6. All dental services rendered to you must be performed at the Dental Center you have selected. You may select a personal dentist from those on staff at the Dental Center you have chosen. You have the right to transfer to another Dental Center at any time. Changes submitted by the 20th of the month will become effective the 1st of the following month.
7. Payments will not be made to you for any dental services described in this Certificate unless such payment is for emergency treatment or reimbursement for payments you made to a dentist or specialist after receiving written authorization from Blue Cross and Blue Shield.

BlueCross BlueShield of Illinois

GB-17 HCSC
Plan ID: DHMO0706
www.bcbsil.com

City of Chicago

Vision

- Plan A
- Plan B

What does the Plan pay?

The Plan will pay up to the following amounts for services received at an out-of-network provider:

Service	Maximum Allowance
Eye Examination	$35
Single Vision Lens	$35 per pair
Bifocal Lens	$50 per pair
Trifocal Lens	$60 per pair
Lenticular Lens	$60 per pair
Contact Lens	Up to $105 (per pair or per total dispense)
Frames	$50

At Visionworks family of store locations:
Frames $110

What doesn't the Plan cover?

EXCLUSIONS:

This program does not cover:

1. More than one eye examination, pair of lenses (with frames) or pair of contact lenses for each covered person during any 12 consecutive months.

2. Non-prescription sunglasses.

3. Safety eyeglasses.

4. Any loss or expense caused by, incurred for or resulting from:

a. Medical or surgical treatment of eye disease or injury
b. Orthoptics, vision therapy or aniseikonia

5. Any charge incurred for a covered expense not recommended or performed by a physician or legally-licensed optometrist or optician.

6. Accidental injury or sickness arising out of, or in the course of, any work for pay or profit, or for which you or your dependent are entitled to benefits under any Worker's Compensation law, or any similar law.

7. Charges made for treatment paid for by any Federal agency or by any state agency, or provided through a hospital run by government agency (Federal, state or local) unless you or your dependent legally must pay charges.

Information about Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Mail Order Contact Lenses:

Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Website for details.

When will I receive my eyewear?

Your eyewear will be sent to your provider from the laboratory generally within five business days. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions or non "Collection" frames are selected.

May I use the benefit at different times?

If you wish, you may receive your eye examination, eyeglasses or contact lenses at different time periods. You may not split the benefit between a network and an out-of-network provider. Remember, you are eligible for an eye examination, frame and spectacle lenses or contact lenses once every 12 months.

Coordination of benefits

The plan is designed to prevent payment of benefits which exceed expenses. COB applies when you or a dependent is eligible for benefits under any other vision care policy. When other coverage exists, the plan pays only the amount which provides 100% of reasonable and customary expenses when it is added to the benefits available from all other plans. COB applies whether or not a claim is filed under the other plans.

Who should I contact with questions?

You may call Davis Vision at 1-888-456-8758 with any general questions about the plan or visit the web site at **www.davisvision.com**. If you have comments or concerns about the service received you may call or write to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attn: Quality Management Team

All correspondence will be researched and responded to within 48 hours of receipt.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of your Rights and Responsibilities as a Patient or to obtain a copy of Davis Vision's Privacy Practices Notice, please visit Davis Vision's website at:**www.davisvision.com** or call 1.800.999.5431.

Vision Care Plan Benefit Description

Sponsored by, and administered on behalf of the members and dependents of

City of Chicago

Plan A

For information prior to enrolling visit Davis Vision's website at: **www.davisvision.com**, select the member option and enter client code **7683** or call **1.877.923.2847** (toll free).

Once enrolled, please visit Davis Vision's website: **www.davisvision.com**, or call **1.888.456.8758** with questions.

City of Chicago - Plan A
Vision Care Plan

The Vision Care plan for all enrollees and their eligible dependents provides two options for vision care services. Davis Vision, the plan administrator, has established a panel of network providers who provide vision examinations at no charge, and if needed, eyeglasses or contact lenses at fixed copayment schedules or in certain instances, at no charge. Alternatively, you may go to an out-of-network provider and be reimbursed up to the amounts in the schedule of maximum allowances listed later. You select the option you wish to use each time you receive services.

Who is Davis Vision?

Davis Vision has been selected by the City to administer its vision plan for all enrollees. Davis Vision, located in New York, provides vision care services to over 35 million people across the United States. Because Davis Vision operates its own laboratory network, they are able to produce quality eyewear at reasonable costs. Davis Vision has established a network of vision care providers who meet stringent standards for examinations, testing equipment and referrals for other health problems.

Who is eligible for coverage under the plan?

You are eligible for vision care benefits if you are enrolled in the PPO or HMO medical plan sponsored by the City. Your eligible dependents become eligible when you do or when they are added to your coverage, whichever is later.

Coverage will terminate when your employment terminates, or when required premiums are not paid. Coverage for your dependents will terminate when they reach the limiting age or when your coverage terminates.

What services are included in the plan?

Covered enrollees and dependents can receive an eye examination and one pair of eyeglass frames and lenses (if required) every 12 months based on last date of service. Contact lenses may be selected in lieu of eyeglasses. There must be at least one full year between examinations.

Using a network provider:

They are licensed providers who provide routine vision examinations for no out of pocket cost. Each provider will offer you an extensive selection of frames. When you enter the provider's office, you will notice a collection of frames identified as the Davis Vision "Collection". Fashion, Designer, and Premier frames in "The Collection" are available for no additional cost.

If you choose a frame outside of "The Collection" you will receive a $50 credit, plus 20% discount on the overage to go toward your purchase and will be required to pay any additional costs. If you choose a frame at any Visionworks family of store locations you will receive a $110 credit, plus 20% discount on the overage to go toward your purchase and will be required to pay any additional costs.

Included at no additional cost are plastic or glass single vision, bifocal or trifocal lenses, glass grey #3 prescription lenses (fashion, sun or gradient tint), and post-cataract lenses. Scratch resistant coating, ultraviolet coating, photochromic lenses, blended invisible bifocals, and oversize frames and lenses are also available for no additional cost. If you select a frame from the provider's private collection there will be an additional charge.

Davis Vision offers a one year warranty against breakage on eyeglasses if you use a network provider and select Plan materials. If the frame or lenses break during normal use, simply return them to the provider for repair at no cost to you (excluding lost eyewear and scratched lenses).

If you use a network provider, you are also able to receive a discount for additional purchases such as frames, lenses and contact lenses for fixed, discounted charges (up to 20%) that are much less than the usual charges.

Obtaining services from a network provider:

When you or a covered family member need vision services, call one of the network providers. Give the employee's Member Identification Number and the name and date of birth of any dependent for whom you are requesting service. The provider will obtain the necessary authorization from Davis Vision. Claim forms are not required. If you decide to utilize a different provider after scheduling an appointment, please notify Davis Vision at 1-888-456-8758.

Are contact lenses included?

Contact lenses may be selected in lieu of eyeglasses. No copayment applies toward Plan covered contact lenses (standard, soft, daily-wear; disposable** or planned replacement**). A care kit for proper cleaning and sterilization of your lenses will be provided as are all visits necessary to obtain a proper fit. Visually required contact lenses are covered in full with prior approval at a network location. Replacement lenses and contact lens insurance are not included in the plan. Once you have selected contact lenses and the lenses are fitted, they may not be exchanged for eyeglasses. If you select contact lenses other than plan contact lenses, you will receive a $105 credit, plus 15% discount on the overage to go toward their purchase and be required to pay any additional costs. A 15% discount is available for evaluation, fitting and follow up care.

*** Disposable contact lens wearers will receive eight multi-packs of lenses. Planned replacement contact lens wearers will receive four multi-packs of lenses.*

What if I use an out-of-network provider?

If you obtain services from a provider who is not part of the network you will have to submit an itemized receipt and a claim form. Claim forms are available by visiting the web site at www.davisvision.com or by calling 1-888-456-8758.

Give the claim form to your provider at the time you receive services and ask them to complete the appropriate sections. Submit your completed claim form and your itemized receipt to:

Davis Vision Claim Processing Unit
P.O. Box 1525
Latham, NY 12110

Your claim will be reviewed and, if you were eligible for services when you received them, you will be reimbursed up to the amounts in the following schedule. If you want to be sure that you are eligible for services before you use an out-of-network provider, call Davis Vision at 1-888-456-8758, or visit the web site at **www.davisvision.com** to verify your eligibility before you schedule your appointment.

Are there any optional lens types or coatings available?

When you order your eyeglasses, you may choose optional items. You are responsible for paying the amounts shown directly to the provider.

Item	Copayment
Intermediate Vision Lenses	$25
Scratch-resistant	Included
Single Vision Scratch Protection	$20
Multifocal Scratch Protection	$40
ARC (anti-reflective coating)	
Standard	$31
Premium	$43
Ultra	$60
Progressive Addition Multifocals**	
Standard	$45
Premium	$80
Ultra	$130
Polycarbonate Lenses***	$27
High Index Plastic Lenses	$50
Polarized Lenses	$68
Plastic Photosensitive Lenses	$59

** Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive addition lenses; however, the copayment will not be refunded.

*** No charge for dependent children, monocular patients and patients with Rx +/-6.00 or greater.

What does the Plan pay?

The Plan will pay up to the following amounts for services received at an out-of-network provider:

Service	Maximum Allowance
Eye Examination	$35
Single Vision Lens	$35 per pair
Bifocal Lens	$50 per pair
Trifocal Lens	$60 per pair
Lenticular Lens	$60 per pair
Contact Lens	Up to $105 (per pair or per total dispense)
Frames	$50
At Visionworks family of store locations: Frames	$110

What doesn't the Plan cover?

EXCLUSIONS:

This program does not cover:

1. More than one eye examination, pair of lenses (with frames) or pair of contact lenses for each covered person during any 12 consecutive months.

2. Non-prescription sunglasses.

3. Safety eyeglasses.

4. Any loss or expense caused by, incurred for or resulting from:

a. Medical or surgical treatment of eye disease or injury
b. Orthoptics, vision therapy or aniseikonia

5. Any charge incurred for a covered expense not recommended or performed by a physician or legally-licensed optometrist or optician.

6. Accidental injury or sickness arising out of, or in the course of, any work for pay or profit, or for which you or your dependent are entitled to benefits under any Worker's Compensation law, or any similar law.

7. Charges made for treatment paid for by any Federal agency or by any state agency, or provided through a hospital run by government agency (Federal, state or local) unless you or your dependent legally must pay charges.

Information about Laser Vision Correction Services:

Davis Vision is pleased to provide you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (please note that some providers have flat fees equivalent to these discounts). For more information, please visit Davis Vision's web site at **www.davisvision.com** or call **1-888-456-8758**.

Mail Order Contact Lenses:

Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Website for details.

When will I receive my eyewear?

Your eyewear will be sent to your provider from the laboratory generally within five business days. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions or non "Collection" frames are selected.

May I use the benefit at different times?

If you wish, you may receive your eye examination, eyeglasses or contact lenses at different time periods. You may not split the benefit between a network and an out-of-network provider. Remember, you are eligible for an eye examination, frame and spectacle lenses or contact lenses once every 12 months.

Coordination of benefits

The plan is designed to prevent payment of benefits which exceed expenses. COB applies when you or a dependent is eligible for benefits under any other vision care policy. When other coverage exists, the plan pays only the amount which provides 100% of reasonable and customary expenses when it is added to the benefits available from all other plans. COB applies whether or not a claim is filed under the other plans.

Who should I contact with questions?

You may call Davis Vision at 1-888-456-8758 with any general questions about the plan or visit the web site at **www.davisvision.com**. If you have comments or concerns about the service received you may call or write to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attn: Quality Management Team

All correspondence will be researched and responded to within 48 hours of receipt.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of your Rights and Responsibilities as a Patient or to obtain a copy of Davis Vision's Privacy Practices Notice, please visit Davis Vision's website at:**www.davisvision.com** or call 1.800.999.5431.

Vision Care Plan Benefit Description

Sponsored by, and administered on behalf of the members and dependents of

City of Chicago

Fraternal Order of Police

For information prior to enrolling visit Davis Vision's website at: **www.davisvision.com**, select the member option and enter client code **4176** or call **1.877.923.2847** (toll free).

Once enrolled, please visit Davis Vision's website: **www.davisvision.com**, or call **1.888.456.8758** with questions.

City of Chicago - Fraternal Order of Police Vision Care Plan

The Vision Care plan for all enrollees and their eligible dependents provides two options for vision care services. Davis Vision, the plan administrator, has established a panel of network providers who provide vision examinations at no charge, and if needed, eyeglasses or contact lenses at fixed copayment schedules or in certain instances, at no charge. Alternatively, you may go to an out-of-network provider and be reimbursed up to the amounts in the schedule of maximum allowances listed later. You select the option you wish to use each time you receive services.

Who is Davis Vision?

Davis Vision has been selected by the City to administer its vision plan for all enrollees. Davis Vision, located in New York, provides vision care services to over 35 million people across the United States. Because Davis Vision operates its own laboratory network, they are able to produce quality eyewear at reasonable costs. Davis Vision has established a network of vision care providers who meet stringent standards for examinations, testing equipment and referrals for other health problems.

Who is eligible for coverage under the plan?

You are eligible for vision care benefits if you are enrolled in the PPO or HMO medical plan sponsored by the City. Your eligible dependents become eligible when you do or when they are added to your coverage, whichever is later.

Coverage will terminate when your employment terminates, or when required premiums are not paid. Coverage for your dependents will terminate when they reach the limiting age or when your coverage terminates.

What services are included in the plan?

Covered enrollees and dependents can receive an eye examination and one pair of eyeglass frames and lenses (if required) every 12 months based on last date of service. Contact lenses may be selected in lieu of eyeglasses. There must be at least one full year between examinations.

Using a network provider:

They are licensed providers who provide routine vision examinations for no out of pocket cost. Each provider will offer you an extensive selection of frames. When you enter the provider's office, you will notice a collection of frames identified as the Davis Vision "Collection". Fashion, Designer, and Premier frames in "The Collection" are available for no additional cost.

If you choose a frame outside of "The Collection" you will receive a $50 credit toward your purchase and will be required to pay any additional costs. If you choose a frame at any Visionworks family of store locations you will receive a $110 credit toward your purchase and will be required to pay any additional costs.

Included at no additional cost are plastic or glass single vision, bifocal or trifocal lenses, glass grey #3 prescription lenses (fashion, sun or gradient tint), and post-cataract lenses. Ultraviolet coating, photochromic lenses, blended invisible bifocals, and oversize frames and lenses are also available for no additional cost. If you select a frame from the provider's private collection there will be an additional charge.

Davis Vision offers a one year warranty against breakage on eyeglasses if you use a network provider and select Plan materials. If the frame or lenses break during normal use, simply return them to the provider for repair at no cost to you (excluding lost eyewear and scratched lenses).

If you use a network provider, you are also able to receive a discount for additional purchases such as frames, lenses and contact lenses for fixed, discounted charges (up to 20%) that are much less than the usual charges.

Obtaining services from a network provider:

When you or a covered family member need vision services, call one of the network providers. Give the employee's Member Identification Number and the name and date of birth of any dependent for whom you are requesting service. The provider will obtain the necessary authorization from Davis Vision. Claim forms are not required. If you decide to utilize a different provider after scheduling an appointment, please notify Davis Vision at 1-888-456-8758.

Are contact lenses included?

Contact lenses may be selected in lieu of eyeglasses. No copayment applies toward Plan covered contact lenses (standard, soft, daily-wear; disposable** or planned replacement**). A care kit for proper cleaning and sterilization of your lenses will be provided as are all visits necessary to obtain a proper fit. Visually required contact lenses are covered in full with prior approval at a network location. Replacement lenses and contact lens insurance are not included in the plan. Once you have selected contact lenses and the lenses are fitted, they may not be exchanged for eyeglasses. If you select contact lenses other than plan contact lenses, you will receive a $105 credit toward their purchase and be required to pay any additional costs.

*** Disposable contact lens wearers will receive eight multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.*

What if I use an out-of-network provider?

If you obtain services from a provider who is not part of the network you will have to submit an itemized receipt and a claim form. Claim forms are available by visiting the web site at www.davisvision.com or by calling 1-888-456-8758.

Give the claim form to your provider at the time you receive services and ask them to complete the appropriate sections. Submit your completed claim form and your itemized receipt to:

Davis Vision Claim Processing Unit
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Your claim will be reviewed and, if you were eligible for services when you received them, you will be reimbursed up to the amounts in the following schedule. If you want to be sure that you are eligible for services before you use an out-of-network provider, call Davis Vision at 1-888-456-8758, or visit the web site at **www.davisvision.com** to verify your eligibility before you schedule your appointment.

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When you order your eyeglasses, you may choose optional items. You are responsible for paying the amounts shown directly to the provider.

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Ultra	$60
Progressive Addition Multifocals**	
Standard	$45
Premium	$80
Ultra	$130
Polycarbonate Lenses***	$27
High Index Plastic Lenses	$50
Polarized Lenses	$68
Plastic Photosensitive Lenses	$59

** Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive addition lenses; however, the copayment will not be refunded.

*** No charge for dependent children, monocular patients and patients with Rx +/-6.00 or greater.

City of Chicago Insurance Requirements

The following pages contain the City of Chicago's insurance requirements for:

- Medical PPO
- Medical HMO
- Dental PPO
- Dental HMO
- Vision
- Medical Review Services

INSURANCE REQUIREMENTS
Chicago Benefits Office

Medical PPO Program

PPO must provide and maintain at PPO's own expense, during the term of the Agreement and during the time period following expiration if PPO is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,500,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $2,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of PPO's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of PPO's acts or omissions, whether such liability is attributable to the PPO or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. PPO's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the PPO with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $8,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

PPO may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any program manager/administrator or any other professional consultants perform services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Blanket Crime

Blanket Commercial Crime coverage or equivalent covering all loss or damage by employee dishonesty, robbery, burglary, theft, destruction, or disappearance, computer fraud, credit card forgery, and other related crime risks. The policy limit must be written to cover losses in the amount of maximum monies collected, received and in the possession of PPO at any given time. The City must be named as a loss payee. Coverage must include, but not limited to, third party fidelity coverage, including coverage for loss due to theft and must not contain a requirement for an arrest and/or conviction.

7) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $10,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

8) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $10,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date

must coincide with, or precede commencement of services by the PPO under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B. Additional Requirements

Evidence of Insurance. PPO must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. PPO must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from PPO, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. PPO must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect PPO for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

Failure to Maintain Insurance. Failure of the PPO to comply with required coverage and terms and conditions outlined herein will not limit PPO's liability or responsibility nor does it relieve PPO of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

Notice of Material Change, Cancellation or Non-Renewal. PPO must provide for sixty (60) days prior written notice to be given to the City in the event coverage is substantially changed, canceled or non-renewed and ten (10) days prior written notice for non-payment of premium.

Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by PPO.

Waiver of Subrogation. PPO hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. PPO agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for PPO's insurer(s).

No Limitation as to PPO's Liabilities. The coverages and limits furnished by PPO in no way limit the PPO's liabilities and responsibilities specified within the Agreement or by law.
No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by PPO under this Agreement.

PPO Insurance Primary. All insurance required of PPO under this Agreement shall be endorsed to state that PPO's insurance policy is primary and not contributory with any insurance PPO by the City.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If PPO maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or broader coverage maintained by PPO. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

Joint Venture or Limited Liability Company. If PPO is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Other Insurance obtained by PPO. If PPO desires additional coverages, the PPO will be responsible for the acquisition and cost.

Insurance required of Subcontractors. PPO shall name the Subcontractor(s) as a named insured(s) under PPO's insurance or PPO will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Worker's Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A, Insurance Required. The limits of coverage will be determined by PPO. PPO shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A, Insurance Required. PPO is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. PPO is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, PPO must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit PPO's liability or responsibility.

City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

INSURANCE REQUIREMENTS
Chicago Benefits Office

Medical HMO Program

HMO must provide and maintain at HMO's own expense, during the term of the Agreement and during the time period following expiration if HMO is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,000,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $2,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of Contractor's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of Contractor's acts or omissions, whether such liability is attributable to the HMO or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. HMO's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the HMO with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $8,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

HMO may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any program manager/administrator or any other professional consultants perform services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Blanket Crime

Blanket Commercial Crime coverage or equivalent covering all loss or damage by employee dishonesty, robbery, burglary, theft, destruction, or disappearance, computer fraud, credit card forgery, and other related crime risks. The policy limit must be written to cover losses in the amount of maximum monies collected, received and in the possession of HMO at any given time. The City must be named as a loss payee. Coverage must include, but not limited to, third party fidelity coverage, including coverage for loss due to theft and must not contain a requirement for an arrest and/or conviction.

7) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $10,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

8) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $10,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date

must coincide with, or precede commencement of services by the PPO under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B. Additional Requirements

Evidence of Insurance. HMO must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. HMO must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from HMO, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. HMO must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect HMO for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

Failure to Maintain Insurance. Failure of the HMO to comply with required coverage and terms and conditions outlined herein will not limit HMO's liability or responsibility nor does it relieve HMO of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

Notice of Material Change, Cancellation or Non-Renewal. HMO must provide for sixty (60) days prior written notice to be given to the City in the event coverage is substantially changed, canceled or non-renewed and ten (10) days prior written notice for non-payment of premium.

Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by HMO.

Waiver of Subrogation. HMO hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. HMO agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for HMO's insurer(s).

No Limitation as to HMO's Liabilities. The coverages and limits furnished by HMO in no way limit the HMO's liabilities and responsibilities specified within the Agreement or by law.

No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by HMO under this Agreement.

HMO Insurance Primary. All insurance required of HMO under this Agreement shall be endorsed to state that HMO's insurance policy is primary and not contributory with any insurance HMO by the City.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If HMO maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or broader coverage maintained by HMO. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

Joint Venture or Limited Liability Company. If HMO is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Other Insurance obtained by HMO. If HMO desires additional coverages, the HMO will be responsible for the acquisition and cost.

Insurance required of Subcontractors. HMO shall name the Subcontractor(s) as a named insured(s) under HMO's insurance or HMO will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Worker's Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A, Insurance Required. The limits of coverage will be determined by HMO. HMO shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A, Insurance Required. HMO is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. HMO is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, HMO must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit HMO's liability or responsibility.

City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

INSURANCE REQUIREMENTS
Chicago Benefits Office

Dental PPO Program

PPO must provide and maintain at PPO's own expense, during the term of the Agreement and during the time period following expiration if PPO is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,000,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $2,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of PPO's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of PPO's acts or omissions, whether such liability is attributable to the PPO or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. PPO's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the PPO with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

PPO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $8,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

PPO may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any program manager/administrator or any other professional consultants perform services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Blanket Crime

Blanket Commercial Crime coverage or equivalent covering all loss or damage by employee dishonesty, robbery, burglary, theft, destruction, or disappearance, computer fraud, credit card forgery, and other related crime risks. The policy limit must be written to cover losses in the amount of maximum monies collected, received and in the possession of PPO at any given time. The City must be named as a loss payee. Coverage must include, but not limited to, third party fidelity coverage, including coverage for loss due to theft and must not contain a requirement for an arrest and/or conviction.

7) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $10,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as

an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

9) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $10,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date

must coincide with, or precede commencement of services by the PPO under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B. Additional Requirements

Evidence of Insurance. PPO must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. PPO must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from PPO, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. PPO must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect PPO for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

Failure to Maintain Insurance. Failure of the PPO to comply with required coverage and terms and conditions outlined herein will not limit PPO's liability or responsibility nor does it relieve PPO of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

Notice of Material Change, Cancellation or Non-Renewal. PPO must provide for sixty (60) days prior written notice to be given to the City in the event coverage is substantially changed, canceled or non-renewed and ten (10) days prior written notice for non-payment of premium.

Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by PPO.

Waiver of Subrogation. PPO hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. PPO agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for PPO's insurer(s).

No Limitation as to PPO's Liabilities. The coverages and limits furnished by PPO in no way limit the PPO's liabilities and responsibilities specified within the Agreement or by law.
No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by PPO under this Agreement.

PPO Insurance Primary. All insurance required of PPO under this Agreement shall be endorsed to state that PPO's insurance policy is primary and not contributory with any insurance PPO by the City.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If PPO maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or broader coverage maintained by PPO. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

Joint Venture or Limited Liability Company. If PPO is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Other Insurance obtained by PPO. If PPO desires additional coverages, the PPO will be responsible for the acquisition and cost.

Insurance required of Subcontractors. PPO shall name the Subcontractor(s) as a named insured(s) under PPO's insurance or PPO will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Worker's Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A, Insurance Required. The limits of coverage will be determined by PPO. PPO shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A, Insurance Required. PPO is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. PPO is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, PPO must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit PPO's liability or responsibility.

City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

INSURANCE REQUIREMENTS
Chicago Benefits Office

Dental HMO Program

HMO must provide and maintain at HMO's own expense, during the term of the Agreement and during the time period following expiration if HMO is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,000,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $2,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of Contractor's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of Contractor's acts or omissions, whether such liability is attributable to the HMO or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. HMO's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the HMO with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

HMO may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $8,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

HMO may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any program manager/administrator or any other professional consultants perform services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Blanket Crime

Blanket Commercial Crime coverage or equivalent covering all loss or damage by employee dishonesty, robbery, burglary, theft, destruction, or disappearance, computer fraud, credit card forgery, and other related crime risks. The policy limit must be written to cover losses in the amount of maximum monies collected, received and in the possession of HMO at any given time. The City must be named as a loss payee. Coverage must include, but not limited to, third party fidelity coverage, including coverage for loss due to theft and must not contain a requirement for an arrest and/or conviction.

7) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $10,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

8) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $10,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date

must coincide with, or precede commencement of services by the PPO under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B. Additional Requirements

Evidence of Insurance. HMO must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. HMO must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from HMO, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. HMO must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect HMO for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

Failure to Maintain Insurance. Failure of the HMO to comply with required coverage and terms and conditions outlined herein will not limit HMO's liability or responsibility nor does it relieve HMO of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

Notice of Material Change, Cancellation or Non-Renewal. HMO must provide for sixty (60) days prior written notice to be given to the City in the event coverage is substantially changed, canceled or non-renewed and ten (10) days prior written notice for non-payment of premium.

Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by HMO.

Waiver of Subrogation. HMO hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. HMO agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for HMO's insurer(s).

No Limitation as to HMO's Liabilities. The coverages and limits furnished by HMO in no way limit the HMO's liabilities and responsibilities specified within the Agreement or by law.

No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by HMO under this Agreement.

HMO Insurance Primary. All insurance required of HMO under this Agreement shall be endorsed to state that HMO's insurance policy is primary and not contributory with any insurance HMO by the City.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If HMO maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or broader coverage maintained by HMO. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

Joint Venture or Limited Liability Company. If HMO is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Other Insurance obtained by HMO. If HMO desires additional coverages, the HMO will be responsible for the acquisition and cost.

Insurance required of Subcontractors. HMO shall name the Subcontractor(s) as a named insured(s) under HMO's insurance or HMO will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Worker's Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A, Insurance Required. The limits of coverage will be determined by HMO. HMO shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A, Insurance Required. HMO is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. HMO is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, HMO must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit HMO's liability or responsibility.

City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

INSURANCE REQUIREMENTS
Chicago Benefits Office

Vision Benefits Program

Contractor must provide and maintain at Contractor's own expense, during the term of the Agreement and during the time period following expiration if Contractor is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,000,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of Contractor's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. Contractor's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the Contractor with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $9,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

Contractor may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any program manager/administrator or any other professional consultants perform professional services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $5,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

7) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $5,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede commencement of services by the Contractor under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B**. Additional Requirements**

Evidence of Insurance. Contractor must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604-3978, original certificates of insurance and additional insured endorsement, or other evidence of

insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Contractor must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from Contractor, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. Contractor must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect Contractor for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

Failure to Maintain Insurance. Failure of the Contractor to comply with required coverage and terms and conditions outlined herein will not limit Contractor's liability or responsibility nor does it relieve Contractor of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

Notice of Material Change, Cancellation or Non-Renewal. Contractor must provide for sixty (60) days prior written notice to be given to the City in the event coverage is substantially changed, canceled or non-renewed and ten (10) days prior written notice for non-payment of premium.

Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by Contractor.

Waiver of Subrogation. Contractor hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for Contractor's insurer(s).

Contractor Insurance Primary. All insurance required of Contractor under this Agreement shall be endorsed to state that Contractor's insurance policy is primary and not contributory with any insurance carrier by the City.

No Limitation as to Contractor's Liabilities. The coverages and limits furnished by Contractor in no way limit the Contractor's liabilities and responsibilities specified within the Agreement or by law.

No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by Contractor under this Agreement.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If Contractor maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or

broader coverage maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

Joint Venture or Limited Liability Company. If Contractor is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Other Insurance obtained by Contractor. If Contractor desires additional coverages, the Contractor will be responsible for the acquisition and cost.

Insurance required of Subcontractors. Contractor shall name the Subcontractor(s) as a named insured(s) under Contractor's insurance or Contractor will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Worker's Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A, Insurance Required. The limits of coverage will be determined by Contractor. Contractor shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A, Insurance Required. Contractor is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. Contractor is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, Contractor must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit Contractor's liability or responsibility.

City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

Professional Services Insurance Requirements
Chicago Benefits Office

Medical Review Services

Contractor must provide and maintain at Contractor's own expense, during the term of the Agreement and during the time period following expiration if Contractor is required to return and perform any work, services, or operations, the insurance coverages and requirements specified below, insuring all work, services, or operations related to the Agreement.

A. Insurance Required

1) Workers Compensation and Employers Liability (Primary and Umbrella)
Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $1,000,000 each accident; $1,000,000 disease-policy limit and $1,000,000 disease-each employee, or the full per occurrence limits of the policy, whichever is greater.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

2) Commercial General Liability (Primary and Umbrella)
Commercial General Liability Insurance or equivalent must be maintained with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury, personal injury, and property damage liability. Coverages must include but not be limited to the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent).

The City must be provided additional insured status with respect to liability arising out of Contractor's work, services or operations performed on behalf of the City. The City's additional insured status must apply to liability and defense of suits arising out of Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the City on an additional insured endorsement form acceptable to the City. The full policy limits and scope of protection also will apply to the City as an additional insured, even if they exceed the City's minimum limits required herein. Contractor's liability insurance must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

3) Automobile Liability (Primary and Umbrella)
When any motor vehicles (owned, non-owned and hired) are used in connection with work, services, or operations to be performed, Automobile Liability Insurance must be maintained by the Contractor with limits of not less than $1,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater, for bodily injury and property damage and covering the ownership, maintenance, or use of any auto whether owned, leased, non-owned or hired used in the performance of the work or services. The City is to be added as an additional insureds on a primary, non-contributory basis.

Contractor may use a combination of primary and excess/umbrella policy/policies to satisfy the limits of liability required herein. The excess/umbrella policy/policies must provide the same coverages/follow form as the underlying policy/policies.

4) Excess/Umbrella

Excess/Umbrella Liability Insurance must be maintained with limits of not less than $9,000,000 per occurrence, or the full per occurrence limits of the policy, whichever is greater. The policy/policies must provide the same coverages/follow form as the underlying Commercial General Liability, Automobile Liability, Employers Liability and Completed Operations coverage required herein and expressly provide that the excess or umbrella policy/policies will drop down over reduced and/or exhausted aggregate limit, if any, of the underlying insurance. The Excess/Umbrella policy/policies must be primary without right of contribution by any other insurance or self-insurance maintained by or available to the City.

Contractor may use a combination of primary and excess/umbrella policies to satisfy the limits of liability required in sections A.1, A.2, A.3 and A.4 herein.

5) Errors & Omissions/Professional Liability

When any medical review professionals/administrators or any other professional consultants perform professional services in connection with this Agreement, Professional Liability Insurance must be maintained covering acts, errors, or omissions with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of work or services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

6) Cyber Liability

Cyber Liability Insurance must be maintained with limits of mot less than $5,000,000 for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The City must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the City.

7) Directors and Officers Liability

Directors and Officers Liability Insurance must be maintained in connection with this Agreement with limits of not less than $5,000,000. Coverage must include any actual or alleged acts, errors or omissions by directors or officers while acting in their individual or collective capacity. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede commencement of services by the PPO under this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

B. Additional Requirements

Evidence of Insurance. Contractor must furnish the City of Chicago, Department of Finance, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL. 60604-3978, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of Insurance

and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Contractor must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from Contractor, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. Contractor must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect Contractor for liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

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Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions on referenced insurance coverages must be borne by Contractor.

Waiver of Subrogation. Contractor hereby waives its rights and its insurer(s)' rights of and agrees to require their insurers to waive their rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for Contractor's insurer(s).

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No Contribution by City. Any insurance or self-insurance programs maintained by the City do not contribute with insurance provided by Contractor under this Agreement.

Insurance not Limited by Indemnification. The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

Insurance and Limits Maintained. If Contractor maintains higher limits and/or broader coverage than the minimums shown herein, the City requires and shall be entitled the higher limits and/or broader coverage maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

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City's Right to Modify. Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements.

City of Chicago

Economic Disclosure Statement (EDS)

And

Documents for Compliance with
Minority Business Enterprise / Women Business Enterprise Requirements
(MBE / WBE Requirements)

Below is a link to the City's website where you can obtain the required forms.

https://www.cityofchicago.org/city/en/depts/dps/provdrs/contract/svcs/forms_and_standardagreements.html

MBE / WBE

At the link above you will see groups of links under the headings “Schedule Ds” and “Schedule Cs”. Under the Schedule Ds heading choose Schedule D-1 MBE/WBE Utilization Non-Construction.

Under Schedules C's you will be selecting a Schedule C-1. There are two; choose the one entitled MBE/WBE Letter of Intent to Perform as a Sub, Supplier, Consultant.

You also have the ability to request a temporary waiver if you have difficulty securing MBE/WBE vendors. You will see that document on the screen as well.

Complete the documents and submit them with your RFP response.

EDS

At this same link locate the search window near the upper right corner. Search on the term Economic Disclosure to be provided access to the page with EDS Instructions, EDS forms and EDS rules. From that page you will also have the ability to complete the EDS application online, and print it for submission with your RFP response. The order of the links changes from time to time as does the title of the link, but it is usually one of the first four links; it is generally entitled Economic Disclosure, Affidavit, Online EDS.

SAMPLE PROFESSIONAL SERVICES AGREEMENT

BETWEEN

THE CITY OF CHICAGO

AND

[MEDICAL PARTICIPATING PROVIDER ORGANIZATION (PPO) ADMINISTRATION SERVICES, MEDICAL HEALTH MAINTENANCE ORGANIZATION (HMO) SERVICES, DENTAL PPO ADMINISTRATION SERVICES, DENTAL HMO ADMINISTRATION SERVICES, VISION BENEFITS SERVICES, AND UTILIZATION REVIEW SERVICES]

LORI LIGHTFOOT
MAYOR

SAMPLE PROFESSIONAL SERVICES AGREEMENT

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Page numbers will be updated in final agreement

AGREEMENT

This Agreement is entered into as of the _____ day of _____, _____ ("**Effective Date**") by and between _____, a _____ corporation ("**Contractor**"), and the City of Chicago, a municipal corporation and home rule unit of local government existing under the Constitution of the State of Illinois, acting through its Department of Finance ("**City**"), at Chicago, Illinois. The City and Contractor agree as follows:

TERMS AND CONDITIONS

ARTICLE 1. DEFINITIONS

1.1 Definitions

Whenever words or a group of words that are defined terms under the Plan are used in this Agreement, whether capitalized or not such words or combination of them have the same meaning given to them in the Plan. In addition, the following words and phrases have the following meanings for purposes of this Agreement:

"Additional Services" means those Services which are within the general scope of Services of this Agreement, but beyond the description of services required under Section 2.1, and all services reasonably necessary to complete the Additional Services to the standards of performance required by this Agreement. Any Additional Services requested by the Department require the approval of the City in a written amendment under Section 9.3 of this Agreement before the City becomes obligated to pay for those Additional Services.

"Affiliate" means a person or entity that directly (or indirectly through one or more intermediaries) controls, is controlled by, or is under common control with, Contractor. A person or entity will be deemed to be controlled by another person or entity if it is controlled in any manner whatsoever that results in control in fact by that other person or entity (either acting individually or acting jointly or in concert with others) whether directly or indirectly and whether through share ownership, a trust, a contract or otherwise.

"Agreement" means this Professional Services Agreement, including all exhibits attached to it and incorporated in it by reference, and all amendments, modifications or revisions made in accordance with its terms.

"Annuitant Plan" means collectively the Non-Medicare Eligible Annuitant Settlement Healthcare Plans and the Medicare Supplement Annuitant Settlement Healthcare Plan, sponsored by the City of Chicago, effective as of September 1, 2003, and as amended from time to time, and the Medicare Supplement Retiree Healthcare Plans and the Non-Medicare Eligible Retiree Healthcare Plan sponsored by the City, effective July 1, 2013, all attached as part of Exhibit 1-A and administered by Contractor.

"Benefits" means the coverages for medical services, dental care services, and vision care services, supplies, and equipment to which Covered Persons are entitled as, and to the extent, provided for by the respective Plan.

"Benefits Management Office" means the Benefits Management Office of the Department of Finance of the City which is under the direction of the Comptroller.

"Benefits Manager" means the Benefits Manager of the City or any representative duly authorized in writing to act on her behalf.

"Chief Procurement Officer" means the Chief Procurement Officer of the City and any representative duly authorized in writing to act on his behalf.

"Claim(s)" means notification in a form acceptable to the Contractor that a service or item has been rendered or furnished to a Covered Person in accordance with the respective Plan.

"Comptroller" means the Comptroller of the City and any representative duly authorized to act on his or her behalf.

"Copayment" means a specified flat dollar amount that a Covered Person is required to pay toward a Covered Service.

"Covered Annuitant" means a former employee of the City or the spouse or Dependent of a deceased annuitant who is receiving an age and service annuity from one of the City's four pension funds (Firemen's Annuity & Benefit Fund, Policemen's Annuity & Benefit Fund, Municipal Employees' Annuity & Benefit Fund, and Laborers' and Retirement Board Employees' Annuity & Benefit Fund), and who is eligible and elects to receive Benefits in accordance with the Annuitant Plan.

"Covered Employee" means an employee of the City who is eligible under the terms of and elects to participate in the Medical PPO Plan, the Medical HMO Plan, the Dental Plan, or the Vision Plan. Covered Employee also includes a City Fire or Police Department retiree who is eligible and elects to participate in the Medical PPO Plan or Medical HMO plan for active employees.

"Covered Person" means a Covered Annuitant, Covered Employee, or a Dependent. The City is responsible for and makes all determinations of eligibility as to Covered Persons except to the extent it has expressly delegated this authority to another entity.

"Covered Service" means a service, supply or equipment specified in the applicable Plan to be provided to Covered Persons under and to the level specified in the applicable Plan.

"Deductible" means the amount specified in a Plan as the "Deductible"

"Dental Plan" means the dental care PPO Plan and/or dental care HMO Plan sponsored by the City and administered by the Contractor, as amended from time to time at the direction of the City, pursuant to collective bargaining agreements or in accordance with any statute, law ordinance, or court order, as more fully described in Exhibit 1-A.

"Department" means the City Department of Finance.

"Dependent" means an individual who meets the eligibility requirements for a dependent as set forth in any applicable collective bargaining agreement covering City employees or as otherwise established by the City from time to time under the applicable Plan, and who is enrolled in and entitled to coverage under the applicable Plan as provided in such Plan.

"Facility" or **"Facilities"** means the site or location where health care services, dental care services, or vision care services are performed, including but not limited to, Hospitals, rehabilitation centers, licensed ambulatory surgery centers, skilled nursing homes, and dental care facilities.

"HMO Plan" means the medical or dental health maintenance organization plan sponsored by the City and administered by Contractor, pursuant to collective bargaining agreements or in accordance with any statute, law ordinance, or court order, as more fully described in Exhibit 1-A.

"HMO Services" means the HMO Plan duties and responsibilities of Contractor described in this Agreement, and any and all functions necessary to complete them or carry them out fully and to the standards of performance required in this Agreement.

"Hospital" means a duly licensed institution for the care of the sick or injured, which provides service under the care of a physician including the regular provision of bedside nursing by registered nurses. The term "Hospital" does not include health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

"Inpatient" means the Covered Person is a registered bed patient and treated as such in a health care Facility.

"Medical PPO Plan" means the medical care plan sponsored by the City and administered by the Contractor, as amended from time to time at the direction of the City, pursuant to collective bargaining agreements or in accordance with any statute, law ordinance, or court order, as more fully described in Exhibit 1-A. Additionally, for purposes of this Agreement, any reference to Medical PPO Plan includes the annuitant Plan as set forth in Exhibit 1-A..

The following Other Hospitals Network definition would only be included if Proposer has proposed administering such an arrangement:

"Other Hospitals Network" includes health care Facilities that have a discounted contract arrangement with Contractor but have not contracted with Contractor under the Medical PPO Plan.

"Participating Network" means the Participating Provider physician, Hospital and ancillary health services network to be organized, maintained and administered by Contractor in accordance with the terms of this Agreement.

"Participating Provider" means a Hospital or Provider which has or has had a written agreement with the Contractor to provide services to participants in a PPO Plan or a Facility or Provider which has been designated so by Contractor as a Participating Provider.

"Participant" means an individual identified by the City to be eligible for prescription drug benefits under the Plan as set forth in the City's eligibility file or otherwise communicated by the City in a format acceptable to Contractor.

"Plan(s)" means the Medical PPO Plan, Medical HMO Plan, Dental PPO and/or Dental HMO Plan, and/or Vision Plan, and/or Annuitant Plan, each as amended or restated from time to time at the direction of the City, whether pursuant to collective bargaining agreements or in accordance with any statute, law ordinance, or otherwise.

"PPO Plan" means a medical or dental preferred provider organization (PPO) Plan(s) sponsored by the City and administered by Contractor, as amended or restated from time to time at the direction of the City, or court order.

"PPO Services" means the PPO Plan duties and responsibilities of Contractor described in this Agreement, and any and all functions necessary to complete them or carry them out fully and to the standards of performance required in this Agreement.

"Protected Information" means all data provided by the City to Contractor or encountered by Contractor in the performance of the services to the City, including, without limitation, all data sent to Contractor by the City and/or stored by Contractor on its servers. Protected Information includes, but is not limited to, employment records, medical and health records, personal financial records (or other personally identifiable information), research data, and classified government information. To the extent there is any uncertainty as to whether any data constitutes Protected Information, the data in question shall be treated as Protected Information.

"Provider" means any health care Facility (for example, a Hospital or skilled nursing Facility) or person (for example, a physician or dentist) or entity duly licensed to render and which renders Covered Services to a Covered Person.

"**Services**" means, collectively, the services, duties, and responsibilities described in Exhibit 1 of this Agreement and any and all work necessary to complete them or carry them out fully and to the standard of performance required in this Agreement.

"**Subcontractor**" means any person or entity with whom Contractor contracts to provide any part of the Services, including subcontractors and subconsultants of any tier, suppliers, and materials providers, whether or not in privity with Contractor.

"Utilization Review" means the evaluation of the Medical Necessity, appropriateness and efficiency of the use of health care services, procedures, and Facilities, in accordance with the terms of the applicable Plan.

"Vision Plan" means the vision care plan sponsored by the City and administered by the Contractor, as amended from time to time at the direction of the City, pursuant to collective

bargaining agreements or in accordance with any statute, law ordinance, or court order, as more fully described in Exhibit 1-A.

1.2 Interpretation

(a) The order of precedence of the component contract parts will be as follows:

- Standard provisions and form provisions relating to this procurement type
- Scope of services and detailed specifications
- Task order (if applicable)
- All other parts of this Agreement

Provided, however, in the event of an inconsistency between terms set out among different component parts of the Agreement, or terms set out within a part of the Agreement, notwithstanding the order of precedence noted above, the term that is most favorable to the City controls, unless expressly stated otherwise.

(b) The term "include" (in all its forms) means "include, without limitation" unless the context clearly states otherwise.

(c) All references in this Agreement to Articles, Sections or Exhibits, unless otherwise expressed or indicated are to the Articles, Sections or Exhibits of this Agreement.

(d) Words importing persons include firms, associations, partnerships, trusts, corporations and other legal entities, including public bodies, as well as natural persons.

(e) Any headings preceding the text of the Articles and Sections of this Agreement, and any table of contents or marginal notes appended to it, are solely for convenience or reference and do not constitute a part of this Agreement, nor do they affect the meaning, construction or effect of this Agreement.

(f) Words importing the singular include the plural and vice versa. Words of the masculine gender include the correlative words of the feminine and neuter genders.

(g) All references to a number of days mean calendar days, unless indicated otherwise.

(h) Unless a contrary meaning is specifically noted elsewhere, the phrases "as required," "as directed," "as permitted," and similar words mean the requirements, directions, and permissions of the Department or City, as applicable. Similarly, the words "approved," "acceptable," "satisfactory," and similar words mean approved by, acceptable to, or satisfactory to the Department or the City, as applicable.

(i) The words "necessary," "proper," or similar words used with respect to the nature or extent of work or services mean that work or those services must be conducted in a manner or be of a character which is necessary or proper for the type of work or services being provided in the opinion of the Department and the City, as applicable. The judgment of the Department and the City in such matters will be considered final.

(j) Wherever the imperative form of address is used, such as "provide equipment required" it will be understood and agreed that such address is directed to the Contractor unless the provision expressly states that the City will be responsible for the action.

1.3 Incorporation of Exhibits

The following attached Exhibits are made a part of this Agreement:

Exhibit 1	Scope of Services and Time Limits for Performance
Exhibit 1-A	Plan Documents
Exhibit 2	Schedule of Compensation
Exhibit 3	Special Conditions for Minority Business Enterprises and Women's Business Enterprises, including Schedules C-1 and D-1
Exhibit 4	Economic Disclosure Statement and Affidavit
Exhibit 5	Insurance Requirements and Certificates of Insurance
Exhibit 6	Business Associate Agreement
Exhibit 7	List of Key Personnel
Exhibit 8	Performance Guarantees
Exhibit 9	Sexual Harassment Policy Affidavit

ARTICLE 2. DUTIES AND RESPONSIBILITIES OF CONTRACTOR

2.1 Scope of Services

This description of Services is intended to be general in nature and is neither a complete description of Contractor's Services nor a limitation on the Services that Contractor is to provide under this Agreement. Contractor must provide the Services in accordance with the standards of performance set forth in Section 2.3. The Services that Contractor must provide are described in Exhibit 1, Scope of Services and Time Limits for Performance.

2.2 Deliverables

In carrying out its Services, Contractor must prepare or provide to the City various reports, information, and data (collectively "Deliverables"). "**Deliverables**" include work product, such as written reviews, recommendations, reports, information, data, and analyses, produced by Contractor for the City.

The City may reject Deliverables that do not include relevant information or data, or do not include all documents or other materials specified in this Agreement or reasonably necessary for the purpose for which the City made this Agreement or for which the Deliverables are intended. If the City determines that Contractor has failed to comply with the foregoing standards, it will notify Contractor of its failure. If there is such a failure, and Contractor does not correct the failure, if it is possible to do so, within 30 days after receipt of notice from the City specifying the failure, then the City, by written notice, may treat the failure as a default of this Agreement under Section 8.1.

Partial or incomplete Deliverables may be accepted for review only when required for a specific and well-defined purpose for the benefit of the City and when consented to in advance by the City. Such Deliverables will not be considered as satisfying the requirements of this Agreement and partial or incomplete Deliverables in no way relieve Contractor of its obligations under this Agreement.

2.3 Standard of Performance

Contractor must perform all Services required of it under this Agreement, such that payment of Benefits and administration of Claims (including application of any pre-certification/prior authorization requirements) are made in accordance with the respective Plan, and the provisions of this Agreement, and with respect to Services for which neither the Plan nor this Agreement provides for a performance level, with that degree of skill, care and diligence normally shown by a professional performing services of a scope and purpose and magnitude comparable with the nature of the Services to be provided under this Agreement. Contractor agrees for itself and to cause its Key Personnel as set forth in Exhibit 7, and Subcontractors to devote the time, attention, skill, knowledge and professional ability to perform all Services effectively, efficiently and in a timely manner consistent with the terms of this Agreement. At no additional cost to the City, Contractor must retain and utilize sufficient staff to ensure the effective and efficient performance of Services such that payment for Benefits and administration of Plan Claims are made in accordance with the respective Plans, and the provisions of this Agreement.

Contractor acknowledges that it is entrusted with or has access to valuable and confidential information and records of the City and the City's employees, and with respect to that information, Contractor agrees to be held to the standard of care of a fiduciary.

Contractor must provide its commercially reasonable skill and judgment and cooperate with the officials, employees and agents of the City in performing Services under this Agreement and furnishing efficient business administration and supervision to perform its obligations in an expeditious and economical manner in accordance with the terms of this Agreement and all applicable laws.

Contractor must ensure that all Services that require the exercise of professional skill or judgment are accomplished by medical or other professionals qualified and competent in and appropriately licensed to practice in the applicable professional discipline and acting within the scope of such license, as required by law. Contractor must exercise skill, care and diligence in ensuring performance of all Services required under this Agreement by professional and technically competent personnel, whether by the Contractor or its Subcontractors, and, to the extent within its control, in including Participating Providers in accordance with Contractor's terms of participation. Contractor remains responsible for the accuracy of all Services or Deliverables furnished by it and its Subcontractors.

Any review, approval, acceptance of Services or Deliverables or payment for any of the Services by the City does not relieve Contractor of its responsibility for the professional skill and care and technical accuracy of all of the Services and Deliverables furnished under this Agreement, unless the technical inaccuracy or error was caused by inaccurate information being

supplied by the City. This provision in no way limits the City's rights or remedies against Contractor under this Agreement, at law or in equity.

2.4 Timeliness of Performance

(a) Contractor must provide the Services and Deliverables within the time limits required under any request for services. Further, Contractor acknowledges that time is of the essence and that the failure of Contractor to comply with the required time limits may result in economic or other losses to the City.

(b) Neither Contractor nor Contractor's agents, employees or Subcontractors, are entitled to any damages from the City, nor is any party entitled to be reimbursed by the City, for damages, charges or other losses or expenses incurred by Contractor by reason of delays or hindrances in the performance of the Services, whether or not caused by the City.

2.5 Personnel

(a) Adequate Staffing

Contractor must, upon receiving a fully executed copy of this Agreement, assign and maintain during the term of this Agreement and any extension of it an adequate staff of competent personnel that is fully equipped, licensed as appropriate, available as needed, and qualified to perform the Services. Contractor must include among its staff the Key Personnel and positions as identified below. The level of staffing may be revised from time to time by notice in writing from Contractor to the City and with prior written consent of the City.

(b) Key Personnel

In selecting the Contractor for this Contract, the City relied on the qualifications and experience of those persons identified by Contractor by name as performing the Services. Contractor must not reassign or replace Key Personnel without the written consent of the City. "**Key Personnel**" means those job titles and the persons assigned to those positions in accordance with the provisions of this Section 2.5(b). The Department may at any time in writing notify Contractor that the City will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice, Contractor must promptly suspend the key person or persons from performing Services under this Agreement and must replace him, her, or them in accordance with the terms of this Agreement. Key Personnel are identified in Exhibit 7.

(c) Salaries and Wages

Contractor and Subcontractors must pay all salaries and wages due all employees performing Services under this Agreement unconditionally and at least once a month without deduction or rebate on any account, except only for those payroll deductions that are mandatory by law or are permitted under applicable law and regulations. If in the performance of this Agreement Contractor underpays any such salaries or wages, the Comptroller for the City may withhold, out of payments due to Contractor, an amount sufficient to pay to employees underpaid the difference between the salaries or wages required to be paid under this Agreement and the

salaries or wages actually paid these employees for the total number of hours worked. The amounts withheld may be disbursed by the Comptroller for and on account of Contractor to the respective employees to whom they are due. The parties acknowledge that this Section 2.5(c) is solely for the benefit of the City and that it does not grant any third party beneficiary rights.

2.6 Minority and Women's Business Enterprises Commitment

In the performance of this Agreement, Contractor must abide by the minority and women's business enterprise commitment requirements of the Municipal Code of Chicago (**"Municipal Code"**), §2-92-420 *et seq.* (1990), except to the extent waived by the City and the Special Conditions Regarding MBE/WBE Commitment set forth in Exhibit 3. Contractor's completed Schedules C-1 and D-1 in Exhibit 3, evidencing its compliance with this requirement, are a part of this Agreement, upon acceptance by the City. Contractor must utilize minority and women's business enterprises at the greater of the amounts listed in those Schedules C-1 and D-1 or the percentages listed in them as applied to all fees received from the City.

2.7 Insurance

Contractor must provide and maintain at Contractor's own expense, during the term of this Agreement and any time period following expiration if Contractor is required to return and perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified in Exhibit 5 of this Agreement, insuring all operations related to this Agreement.

2.8 Indemnification

(a) Contractor must defend, indemnify, and hold harmless the City, its officers, representatives, elected and appointed officials, agents and employees (the "Indemnified Parties") from and against any and all Losses, including those related to:

(i) injury, death or damage of or to any person or property;

(ii) any infringement or violation of any property right (including any patent, trademark or copyright);

(iii) Contractor's failure to perform or cause to be performed Contractor's promises and obligations as and when required under this Agreement, including Contractor's failure to perform its obligations to any Subcontractor;

(iv) the City's exercise of its rights and remedies under Section 8.2 of this Agreement; and

(v) injuries to or death of any employee of Contractor or any Subcontractor under any workers' compensation statute.

(b) **"Losses"** means, individually and collectively, liabilities of every kind, including losses, damages and reasonable costs, payments and expenses (such as, but not limited to, court costs and reasonable attorneys' fees and disbursements), claims, demands, actions, suits,

proceedings, judgments or settlements, any or all of which in any way arise out of or relate to Contractor's breach of this Agreement or to Contractor's negligent or otherwise wrongful acts or omissions or those of its officers, agents, employees, consultants, Subcontractors or licensees.

(c) The Contractor will promptly provide, or cause to be provided, to the Department and the City Corporation Counsel copies of such notices as Contractor may receive of any claims, actions, or suits as may be given or filed in connection with the Contractor's performance or the performance of any Subcontractor and for which the Indemnified Parties are entitled to indemnification hereunder.

(d) At the City Corporation Counsel's option, Contractor must defend all suits brought upon all such Losses and must pay all costs and expenses incidental to them, including, without limitation, claims by employees, Subcontractors, agents, or servants of Contractor even though the claimant may allege that the Indemnified Parties were in charge of the work or service performed under the Agreement, that the claim involves equipment owned or furnished by the Indemnified Parties, or alleged negligence on the part of the Indemnified Parties; however, the City has the right, at its option, to participate, at its own cost, in the defense of any suit, without relieving Contractor of any of its obligations under this Agreement. The City will have the right to require Contractor to provide the City with a separate defense of any such suit. Any settlement must be made only with the prior written consent of the City Corporation Counsel, if the settlement requires any action on the part of the City.

(e) To the extent permissible by law, Contractor waives any limits to the amount of its obligations to defend, indemnify, hold harmless, or contribute to any sums due under any Losses, including any claim by any employee of Contractor that may be subject to the Workers Compensation Act, 820 ILCS 305/1 *et seq*. or any other related law or judicial decision (such as, *Kotecki v. Cyclops Welding Corporation*, 146 Ill. 2d 155 (1991)). The City, however, does not waive any limitations it may have on its liability under the Illinois Workers Compensation Act, the Illinois Pension Code, or any other statute or judicial decision.

(f) The indemnities in this section survive expiration or termination of this Agreement for matters occurring or arising during the term of this Agreement or as the result of or during Contractor's performance of Services beyond the term. Contractor acknowledges that the requirements set forth in this section to defend, indemnify, and hold harmless the City are apart from and not limited by the Contractor's duties under this Agreement, including the insurance requirements in Exhibit 5 of this Agreement.

2.9 Ownership of Documents

Except as otherwise agreed to in advance by the City in writing, all Deliverables, data, findings or information in any form prepared, assembled or encountered by or provided to Contractor under this Agreement are property of the City, including, as further described in Section 2.10 below, all copyrights inherent in them or their preparation. During performance of its Services, Contractor is responsible for any loss or damage to the Deliverables, data, findings or information while in Contractor's or any Subcontractor's possession. Any such lost or damaged Deliverables, data, findings or information must be restored at the expense of Contractor. If not restorable, Contractor must bear the cost of replacement and of any loss

suffered by the City on account of the destruction, as provided in Section 2.8. Notwithstanding the foregoing, Contractor shall retain all rights to its standard details and specifications and proprietary software, and nothing in this section shall be construed to be a transfer of rights which are not owned by Contractor.

2.10 Copyright Ownership and Other Intellectual Property

Contractor and the City intend that, to the extent permitted by law, the Deliverables to be produced by Contractor at the City's instance and expense under this Agreement are conclusively deemed "**works made for hire**" within the meaning and purview of Section 101 of the United States Copyright Act, 17 U.S.C. §101 *et seq.*, and that the City will be the sole copyright owner of the Deliverables and of all aspects, elements and components of them in which copyright can subsist, and of all rights to apply for copyright registration or prosecute any claim of infringement.

To the extent that any Deliverable does not qualify as a "work made for hire," Contractor hereby irrevocably grants, conveys, bargains, sells, assigns, transfers and delivers to the City, its successors and assigns, all right, title and interest in and to the copyrights and all U.S. and foreign copyright registrations, copyright applications and copyright renewals for them, and other intangible, intellectual property embodied in or pertaining to the Deliverables prepared for the City under this Agreement, and all goodwill relating to them, free and clear of any liens, claims or other encumbrances, to the fullest extent permitted by law. Notwithstanding the foregoing, Contractor shall retain all rights to its standard details and specifications and proprietary software, and nothing in this section shall be construed as a transfer of rights, which are not owned by Contractor. Contractor shall have no liability or duty whatsoever for any modification or change of the Deliverables or work, without Contractor's direct involvement and consent.

Contractor will, and will cause all of its Subcontractors, employees, agents and other persons within its control to, execute all documents and perform all acts that the City may reasonably request in order to assist the City in perfecting its rights in and to the copyrights relating to the Deliverables, at the sole expense of the City. Contractor warrants to the City, its successors and assigns, that on the date of transfer Contractor is the lawful owner of good and marketable title in and to the copyrights for the Deliverables and has the legal rights to fully assign them. Contractor further warrants that it has not assigned and will not assign any copyrights and that it has not granted and will not grant any licenses, exclusive or nonexclusive, to any other party, and that it is not a party to any other agreements or subject to any other restrictions with respect to the Deliverables. Contractor warrants that the Deliverables are complete, entire and comprehensive, and that the Deliverables constitute a work of original authorship.

(a) Patents

If any invention, improvement, or discovery of the Contractor or its Subcontractors is conceived or first actually reduced to practice during performance of or under this Agreement, and that invention, improvement, or discovery is patentable under the laws of the United States of America or any foreign country, the Contractor must notify the City immediately and provide

the City a detailed report regarding such invention, improvement, or discovery. If the City determines that patent protection for such invention, improvement, or discovery should be sought, Contractor agrees to seek patent protection for such invention, improvement, or discovery and to fully cooperate with the City throughout the patent process. The Contractor must transfer to the City, at no cost, the patent in any invention, improvement, or discovery developed under this Agreement and any patent rights to which the Contractor purchases ownership with funds provided to it under this Agreement.

(b) Indemnity

Without limiting any of its other obligations under this Agreement and in addition to any other obligations to indemnity under this Agreement, Contractor must, upon request by the City, indemnify, save, and hold harmless the City, and its officers, representatives, elected and appointed officials, agents, and employees acting within the scope of their original duties against any liability, including costs and expenses, resulting from any willful or intentional violation by the Contractor of proprietary rights, copyrights, or right of privacy, arising out of the publication, translation, reproduction, delivery, use or disposition of any Deliverables furnished under the Agreement. The Contractor is not required to indemnify the City for any such liability arising out of the wrongful acts of employees or agents of the City.

2.11 Records and Audits

(a) **Records**

(i) Contractor must deliver or cause to be delivered to the City all documents, including all Deliverables prepared for the City under the terms of this Agreement, promptly in accordance with the time limits prescribed in this Agreement, and if no time limit is specified, then upon reasonable demand for them or upon termination or completion of the Services under this Agreement. If Contractor fails to make such delivery upon demand, then Contractor must pay to the City any damages the City may sustain by reason of Contractor's failure.

(ii) Contractor must maintain any such records including Deliverables not delivered to the City or demanded by the City and including records of all assets and transactions (including contributions and claims payments) for a period that is the longer of (A) ten years after the final payment made in connection with this Agreement (or, with respect to any records that are required to be maintained pursuant to the Contractor's obligations under Exhibit 6 and the regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), specifically 45 C.F.R. § 164.530(j)), six years from the date last effective; or (B) as directed by the Local Records Act (50 ILCS 205) and relevant records retention schedule. Contractor must not dispose of such records following the expiration of the relevant period without notification of and written approval from the City in accordance with Article 10.

In addition to the records to be stored by Contractor, all records that are possessed by Contractor in its service to the City to perform a governmental function are public records of the City pursuant to the Illinois Freedom of Information Act ("FOIA"), unless the records are exempt under the Act. FOIA requires that the City produce records in a very short period of

time. If the Contractor receives a request from the City to produce records, the Contractor shall do so within 72 hours of the notice.

(b) **Audits**

(i) Contractor and any of Contractor's Subcontractors or Participating Providers must furnish the Department with all information that may be requested pertaining to the performance and cost of the Services. To the extent this Agreement allows Contractor to bill on a time basis or to charge City for certain expenses, Contractor must maintain records showing actual time devoted and costs incurred. Contractor must keep books, documents, papers, records and accounts in connection with the Services open to audit, inspection, copying, abstracting and transcription and must make these records available to the City and any other interested governmental agency, at reasonable times during the performance of its Services.

(ii) To the extent that Contractor conducts any business operations separate and apart from the Services required under this Agreement using, for example, personnel, equipment, supplies or facilities also used in connection with this Agreement, then Contractor must maintain and make similarly available to the City detailed records supporting Contractor's allocation to this Agreement (if any) of the costs and expenses attributable to any such shared usages.

(iii) Contractor must maintain its books, records, documents and other evidence and adopt accounting procedures and practices sufficient to reflect properly all costs of whatever nature claimed to have been incurred and anticipated to be incurred for or in connection with the performance of this Agreement. This system of accounting must be in accordance with generally accepted accounting principles and practices, consistently applied throughout.

(iv) No provision in this Agreement granting the City a right of access to records and documents is intended to impair, limit or affect any right of access to such records and documents which the City would have had in the absence of such provisions.

(v) The City may in its sole discretion audit the records of Contractor or its Subcontractors, or both, at any time during the term of this Agreement or within six years after the Agreement ends, in connection with the goods, work, or Services provided under this Agreement. Each calendar year or partial calendar year is considered an "audited period." If, as a result of any such audit, it is determined that Contractor or any of its Subcontractors has overcharged the City in the audited period, the City will notify Contractor. Contractor must then promptly reimburse the City for any amounts the City has paid Contractor due to the overcharges and also some or all of the cost of the audit, as follows:

A. If the audit has revealed overcharges to the City representing less than 5% of the total that should have been charged, based on the Agreement prices, of the goods, work, or Services provided in the audited period, then the Contractor must reimburse the City for 50% of the cost of the audit and 50% of the cost of each subsequent audit that the City conducts;

B. If, however, the audit has revealed overcharges to the City representing 5% or more of the total value, based on the Agreement prices, of the goods, work, or Services provided in the audited period, then Contractor must reimburse the City for the full cost of the audit and of each subsequent audit.

C. If the audit reveals that the Contractor was not paid the full amount required under the Agreement, the City will pay to the Contractor the sum equal to the amount of the deficiency.

Failure of Contractor to reimburse the City in accordance with subsection A or B above is an event of default under Section 8.1 of this Agreement, and Contractor will be liable for all of the City's costs of collection, including any court costs and attorneys' fees.

2.12 Confidentiality

(a) All Deliverables and reports, data, findings or information in any form prepared, assembled or encountered by or provided by Contractor under this Agreement are property of the City and are confidential, except as specifically authorized in this Agreement or as may be required by law. Contractor must not allow the Deliverables to be made available to any other individual or organization without the prior written consent of the City. Further, all documents and other information provided to Contractor by the City are confidential and must not be made available to any other individual or organization without the prior written consent of the City. Contractor must implement such measures as may be necessary to ensure that its staff and its Subcontractors are bound by the confidentiality provisions in this Agreement.

(b) Contractor must not issue any publicity news releases or grant press interviews, and except as may be required by law during or after the performance of this Agreement, disseminate any information regarding its Services or the project to which the Services pertain without the prior written consent of the Commissioner.

(c) If Contractor is presented with a request for documents by any administrative agency or with a subpoena duces tecum regarding any records, data or documents which may be in Contractor's possession by reason of this Agreement, Contractor must immediately give notice to the Commissioner and the Corporation Counsel for the City with the understanding that the City will have the opportunity to contest such process by any means available to it before the records, data or documents are submitted to a court or other third party. Contractor, however, is not obligated to withhold the delivery beyond the time ordered by a court or administrative agency, unless the subpoena or request is quashed or the time to produce is otherwise extended.

(d) To the extent not defined herein, the capitalized terms in this Agreement and in Exhibit 6 will have the same meaning as set forth in the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act and their implementing regulations (collectively "HIPAA"). See 45 CFR parts 160, 162 and 164. Contractor and all its Subcontractors must comply with HIPAA and all rules and regulations applicable to it or them. Contractor must also comply with the Illinois AIDS Confidentiality Act (410 ILCS 305/1 through 16) and the rules and regulations of the Illinois

Department of Public Health promulgated under it. If Contractor fails to comply with the applicable provisions under HIPAA or the Illinois AIDS Confidentiality Act, such failure will constitute an event of default under this Agreement for which no opportunity for cure will be provided.

Additionally, Contractor must comply with all requirements of HIPAA applicable to business associates, including the provisions contained in Exhibit 6.

2.13 Assignments and Subcontracts

(a) Contractor must not assign, delegate or otherwise transfer all or any part of its rights or obligations under this Agreement: (i) unless otherwise provided for elsewhere in this Agreement; or (ii) without the express written consent of the Department. The absence of such a provision or written consent voids the attempted assignment, delegation or transfer and is of no effect as to the Services or this Agreement. No approvals given by the Department, including approvals for the use of any Subcontractors, operate to relieve Contractor of any of its obligations or liabilities under this Agreement.

(b) All Subcontractors are subject to the prior approval of the Department, but in no case will such approval relieve the Contractor from its obligations or change the terms of the Agreement. Further, substitution of a previously approved Subcontractor without the prior written consent of the City is not permitted. The Contractor must notify the Department of the names of all Subcontractors to be used and shall not employ any that the Department has not approved. Prior to proposing the use of a certain Subcontractor, the Contractor must verify that neither the Subcontractor nor any of its owners is debarred from or otherwise ineligible to participate on City contracts. This information can be found on the City's website: http://www.cityofchicago.org/city/en/depts/dps/provdrs/comp/svcs/debarred_firms_list.html

(c) The Contractor will only subcontract with competent and responsible Subcontractors. If, in the judgment of the Department or the City, any Subcontractor is careless, incompetent, violates safety or security rules, obstructs the progress of the Services or work, acts contrary to instructions, acts improperly, is not responsible, is unfit, is incompetent, violates any laws applicable to this Agreement, or fails to follow the requirements of this Agreement, then the Contractor will, immediately upon notice from the Department or the City, discharge or otherwise remove such Subcontractor and propose an acceptable substitute for Chief Procurement Officer approval. Removal and substitution must be in compliance with any applicable requirements of the MBE/WBE or DBE program.

(d) Approval for the use of any Subcontractor in performance of the Services is conditioned upon performance by the Subcontractor in accordance with the terms and conditions of this Agreement. If any Subcontractor fails to perform the Services in accordance with the terms and conditions of this Agreement to the satisfaction of the Department, the City has the absolute right upon written notification to immediately rescind approval and to require the performance of this Agreement by Contractor personally or through any other City-approved Subcontractor. Any approval for the use of Subcontractors in the performance of the Services under this Agreement under no circumstances operates to relieve Contractor of any of its obligations or liabilities under this Agreement.

(e) Contractor, upon entering into any agreement with a Subcontractor, must furnish upon request of the Department a copy of its agreement. Contractor must ensure that all subcontracts contain provisions that require the Services be performed in strict accordance with the requirements of this Agreement as they relate to the Subcontractors themselves, provide that the Subcontractors are subject to all the terms of this Agreement and are subject to the approval of the Department. If the agreements do not prejudice any of the City's rights under this Agreement, such agreements may contain different provisions than are provided in this Agreement with respect to extensions of schedule, time of completion, payments, guarantees and matters not affecting the quality of the Services.

(f) Contractor must not transfer or assign any funds or claims due or to become due under this Agreement without the prior written approval of the Department. The attempted transfer or assignment of any funds, either in whole or in part, or any interest in them, which are due or to become due to Contractor under this Agreement, without such prior written approval, has no effect upon the City.

(g) Under §2-92-245 of the Municipal Code, the Chief Procurement Officer may make direct payments to Subcontractors for Services performed under this Agreement. Any such payment has the same effect as if the City had paid Contractor that amount directly. Such payment by the City to Contractor's Subcontractor under no circumstances operates to relieve Contractor of any of its obligations or liabilities under this Agreement. This section is solely for the benefit of the City and does not grant any third party beneficiary rights.

(h) The City reserves the right to assign or otherwise transfer all or any part of its interests under this Agreement to any successor.

2.14 Data Protection

(a) General. Notwithstanding any other obligation of Contractor under this Agreement, Contractor agrees that it will not lose, alter, or delete, either intentionally or unintentionally, any Protected Information, except to the extent that the City directs the Contractor in writing to do so and that it is responsible for the safe-keeping of all such information.

(b) Minimum Standard for Data at Rest and Data in Motion. Contractor must, at a minimum, comply in its treatment of Protected Information with National Institute of Standards and Technology ("NIST") Special Publication 800-53 Moderate Level Control. Notwithstanding this requirement, Contractor acknowledges that it must fully comply with each additional obligation contained in this policy.

(c) Protected Health Information. If data is protected health information or electronic protected health information, as defined in HIPAA/HITECH and regulations implementing these Acts (see 45 CFR Parts 160 and 164), it must be secured in accordance with "Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals," available on the United States Department of Health and Human Services (HHS) website http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html, or at

Volume 74 of the Federal Register, beginning at page 42742. That guidance from the HHS states that valid encryption processes for protected health information data at rest (e.g., protected health information resting on a server), must be consistent with the NIST Special Publication 800-111, Guide for Storage Encryption Technologies for End User Devices. Valid encryption processes for protected health information data in motion (e.g., transmitted through a network) are those which comply with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security Implementation; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.

(d) Where Data is to be Stored. All data must be stored only on computer systems located in the continental United States.

(e) Requirement to Maintain Security Program. Contractor acknowledges that the City has implemented an information security program to protect the City's information assets, which Program is available on the City website at http://www.cityofchicago.org/city/en/depts/doit/supp_info/is-and-it-policies.html ("City Program"). Contractor shall be responsible for establishing and maintaining an information security program that is designed to: (i) ensure the security and confidentiality of Protected Information; (ii) protect against any anticipated threats or hazards to the security or integrity of Protected Information; (iii) protect against unauthorized access to or use of Protected Information; (iv) ensure the proper disposal of Protected Information; and, (v) ensure that all Subcontractors, if any, comply with all of the foregoing.

(f) Undertaking by Contractor. Without limiting Contractor's obligation of confidentiality as further described herein, in no case shall the safeguards of Contractor's information security program be less stringent than the information security safeguards used by the City Program.

(g) Right of Audit by the City of Chicago. The City shall have the right to review Contractor's information security program prior to the commencement of Services and from time to time during the term of this Agreement. During the performance of the Services, from time to time and without notice, the City, at its own expense, shall be entitled to perform, or to have performed, an on-site audit of Contractor's information security program. In lieu of an on-site audit, upon request by the City, Contractor agrees to complete, within forty-five (45 days) of receipt, an audit questionnaire provided by the City or the City's designee regarding Contractor's information security program.

(h) Audit by Contractor. No less than annually, Contractor shall conduct an independent third-party audit of its information security program and provide such audit findings to the City, all at the Contractor's sole expense.

(i) Audit Findings. Contractor shall implement at its sole expense any remedial actions as identified by the City as a result of the audit.

(j) ***Can be deleted if n/a to the services at issue:*** Demonstrate Compliance - PCI. No less than annually, as defined by the City and where applicable, the

Contractor agrees to demonstrate compliance with PCI DSS (Payment Card Industry Data Security Standard). Upon City's request, Contractor must be prepared to demonstrate compliance of any system or component used to process, store, or transmit cardholder data that is operated by the Contractor as part of its service. Similarly, upon City's request, Contractor must demonstrate the compliance of any third party it has sub-contracted as part of the service offering. As evidence of compliance, the Contractor shall provide upon request a current attestation of compliance signed by a PCI QSA (Qualified Security Assessor).

(k) Data Confidentiality. Contractor shall implement appropriate measures designed to ensure the confidentiality and security of Protected Information, protect against any anticipated hazards or threats to the integrity or security of such information, protect against unauthorized access or disclosure of information, and prevent any other action that could result in substantial harm to the City or an individual identified with the data or information in Contractor's custody.

(l) Limitation of Access. Contractor will not knowingly permit any Contractor personnel to have access to any City facility or any records or data of the City if the person has been convicted of a crime in connection with (i) a dishonest act, breach of trust, or money laundering, or (ii) a felony. Contractor must, to the extent permitted by law, conduct a check of public records in all of the employee's states of residence and employment for at least the last five years in order to verity the above. Contractor shall assure that all contracts with subcontractors impose these obligations on the subcontractors and shall monitor the subcontractors' compliance with such obligations.

(m) Data Re-Use. Contractor agrees that any and all data exchanged shall be used expressly and solely for the purposes enumerated in the Agreement. Data shall not be distributed, repurposed or shared across other applications, environments, or business units of Contractor. As required by Federal law, Contractor further agrees that no City data of any kind shall be revealed, transmitted, exchanged or otherwise passed to other Contractors or interested parties except on a case-by-case basis as specifically agreed to in writing by an officer of the City with designated data, security, or signature authority.

(n) Safekeeping and Security. Contractor will be responsible for safekeeping all keys, access codes, passwords, combinations, access cards, personal identification numbers and similar security codes and identifiers issued to Contractor's employees, agents or subcontractors. Contractor agrees to require its employees to promptly report a lost or stolen access device or information to their primary business contact and to the City of Chicago Information Security Office.

(o) Mandatory Disclosure of Protected Information. If Contractor is compelled by law or regulation to disclose any Protected Information, the Contractor will provide to the City prompt written notice so that the City may seek an appropriate protective order or other remedy. If a remedy acceptable to the City is not obtained by the date that the Contractor must comply with the request, the Contractor will furnish only that portion of the Protected Information that it is legally required to furnish, and the Contractor shall require any recipient of the Protected Information to exercise commercially reasonable efforts to keep the Protected Information confidential.

(p) Data Breach. Contractor agrees to comply with all laws and regulations relating to data breach, including without limitation, the Illinois Personal Information Protection Act and other applicable Illinois breach disclosure laws and regulations. Data breaches of protected health information and electronic protected health information shall be governed by the provisions regarding HIPAA/HITECH and the regulations implementing those Acts, as well as the Contractor's Business Associate Agreement with the City, attached hereto as Exhibit 6. Contractor will immediately notify the City if security of any Protected Information has been breached, and will provide information as to that breach in such detail as requested by the City. Contractor will, if requested by the City, notify any affected individuals of such breach at the sole cost of the Contractor.

(q) Data Sanitization and Safe Disposal. All physical and electronic records must be retained per federal, state, and local laws and regulations, including the Local Records Act. Where disposal is approved by City and permitted by law, the Contractor agrees that prior to disposal or reuse of all magnetic and/or removable media which may have contained City data shall be submitted to a data sanitization process which meets or exceeds DoD 5220.28-M 3-pass specifications. Certification of the completion of data sanitization shall be provided to the City within 10 days of completion. Acceptance of Certification of Data Sanitization by the Information Security Office of the City is required prior to media reuse or disposal. All other materials which contain data shall be physically destroyed and shredded in accordance to NIST Special Publication 800-88, Guidelines for Media Sanitization, specifications.

(r) End of Agreement Data Handling. The Contractor agrees that upon termination of this Agreement it shall return all data to the City in a useable electronic form, unless disposal is approved, in which case, it shall erase, destroy, and render unreadable all data in its entirety in accordance to the prior stated Data Sanitization and Safe Disposal provisions. Data must be rendered in a manner that prevents its physical reconstruction through the use of commonly available file restoration utilities. Certification in writing that these actions have been completed must be provided within 30 days of the termination of this Agreement or within seven days of a request of an agent of the City, whichever shall come first.

2.15 Participation by Other Government Agencies

Other Sister Agencies (defined by illustration below) may be eligible to participate in this Agreement if (a) such agencies are authorized, by law or their governing bodies, to so participate, (b) such authorization is consented to by the City, and (c) such participation has no net adverse effect on the City and results in no diminished services from the Contractor to the Department.

Examples of such Sister Agencies are: the Chicago Board of Education, Chicago Park District, City Colleges of Chicago, Chicago Transit Authority, Chicago Housing Authority, Chicago Board of Elections, Metropolitan Pier and Exposition Authority (McCormick Place, Navy Pier), and the Municipal Courts.

2.16 Continuity of Medical PPO/HMO Services

If a Covered Person is hospitalized on the date that the Covered Person's coverage under the Medical PPO Plan or Medical HMO Plan is terminated, Contractor must continue to provide PPO Services and HMO Services required under this Agreement to the Covered Person during the hospitalization, and the City will pay to Contractor such fees associated with the Covered Person during the hospitalization period beyond the effective date of coverage that the City otherwise would be obligated to pay under this Agreement if it were to continue in place during such period.

In the event that a Covered Person is in active treatment for services provided under the Dental PPO Plan due to significant dental disease (for example, major services: crown, bridge, denture) at the time of a transition to a new service provider, the Contractor must cooperate with the City and all of the City's other service providers and the new service provider to ensure a smooth transition at the time of transition, with no interruption of Dental PPO Services for the Covered Person, and no greater financial risk to the Covered Person during such transition than the Covered Person would have had if the Contractor continued to provide Services.

2.17 Non-Liability to Providers

Except as otherwise expressly authorized by the Agreement, neither Contractor nor any Provider under contract with Contractor, whether a Participating Provider, a Provider that is part of the Other Hospital Network, or otherwise (a "**Contracted Provider**"), has any recourse against and must not bill, charge, or seek compensation from any Covered Person for a Covered Service. Contractor agrees to accept as full compensation for providing Services under the Agreement those payments from the City to which it is entitled under the Agreement. Contractor will hold all Covered Persons harmless against any monetary claims of any nature by Contracted Providers (not including Copayments, Deductibles and other amounts under the Plans which are the responsibility of the Covered Person) for Covered Services. Contractor insures and warrants the same obligations on behalf of its Contracted Providers. Contractor insures and warrants that all Contracted Providers will comply with the terms of this Section 2.17. This provision is for the benefit of Covered Persons and the City, and will survive expiration or termination of the Agreement regardless of the nature of the termination.

2.18 Change in PPO Participating Provider Rates

Contractor must continue to provide notice to the City of any change in a Participating Provider's rates that a reasonable financial analysis would show has an effect on the City's annual costs under the Agreement of one half of one percent, over or under the annual cost estimate provided by Contractor to the City for budgetary purposes.

2.19 Ownership of Documents and Other Property

All Deliverables, data, findings or information in any form prepared, assembled or encountered by or provided to Contractor under this Agreement are property of the City, including, but not limited to, all copyrights inherent in them or their preparation. During performance of its Services, Contractor is responsible for any loss or damage to the Deliverables, data, findings or information while in Contractor's or any Subcontractor's possession. Any such

lost or damaged Deliverables, data, findings or information must be restored at the expense of Contractor. If not restorable, Contractor must bear the cost of replacement and of any loss suffered by the City on account of the destruction.

Accordingly, the Deliverables, data, findings or information retained by the Contractor or its Subcontractors must be retained in such a manner that complies with the applicable provisions of the Local Records Act and that allows the City access, through the Contractor or a Subcontractor, to such information so that the City may comply with applicable law, such as the Freedom of Information Act, to the extent required.

ARTICLE 3. DURATION OF AGREEMENT

3.1 Term of Performance

This Agreement takes effect as of the Effective Date and continues, except as provided under Section 4.4 or Article 8, until _____, as that date may be extended under Section 3.2. *[City is seeking proposals for 3 year and 5 year initial terms.]*

3.2 Agreement Extension Option

The City may at any time before this Agreement expires elect to extend this Agreement for up to two *[three]* years, under the same terms and conditions as this original Agreement, by notice in writing to Contractor. *[If City selects 5 year term, the number of option years will be 3]*.

3.3 Notification of Renewal Terms

Contractor must provide City all renewal information, including information as to costs and services, at least 180 days prior to the expiration of the term of this Agreement.

3.4 Early Termination

In addition to other termination provisions set forth under this Agreement, the City may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by a notice in writing from the City to Contractor. The City will give notice to Contractor in accordance with the provisions of Article 10. The effective date of termination will be the date the notice is received by Contractor or the date stated in the notice, whichever is later. If the City elects to terminate this Agreement in full, all Services to be provided under it must cease and all materials that may have been accumulated in performing this Agreement, whether completed or in the process, must be delivered to the City effective ten days after the date the notice is considered received as provided under Article 10 of this Agreement (if no date is given) or upon the effective date stated in the notice.

After the notice is received, Contractor must restrict its activities, and those of its Subcontractors, to winding down any reports, analyses, or other activities previously begun. No costs incurred after the effective date of the termination are allowed except as set forth below in this Section 3.4. Payment for any Services actually and satisfactorily performed before the effective date of the termination is on the same basis as set forth in Article 4, but if any compensation is described or provided for on the basis of a period longer than ten days, then the

compensation must be prorated accordingly. No amount of compensation, however, is permitted for anticipated profits on unperformed Services. The City and Contractor must attempt to agree on the amount of compensation to be paid to Contractor, but if not agreed on, the dispute must be settled in accordance with Article 5 of this Agreement. The payment so made to Contractor is in full settlement for all Services satisfactorily performed under this Agreement.

Contractor must include in its contracts with Subcontractors an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the City arising from termination of subcontracts after the early termination. Contractor will not be entitled to make any early termination claims against the City resulting from any Subcontractor's claims against Contractor or the City.

If the City's election to terminate this Agreement for default under Sections 8.1 and 8.2 is determined in a court of competent jurisdiction to have been wrongful, then such termination will be considered to be an early termination under this Section 3.3.

3.5 Transition Assistance

Upon termination, the Parties agree that Contractor shall have no further duty or responsibility to provide services to the City under this Agreement except as provided in Section 3.3 above. However, Contractor will use reasonable efforts to cooperate in good faith with a successor service provider and to transfer all relevant non-proprietary information concerning the Program that City deems necessary for future operations, in Contractor's standard format, to City or to a successor service provider and to forward to the successor any claims received thereafter, at no charge to the City if sent in Contractor's standard format. If the successor claims are to be sent in a format requiring development work by Contractor, the City agrees to pay the reasonable fees associated with the development work required. The City agrees that Contractor may charge reasonable fees for the provision of requested reports that Contractor previously provided.

ARTICLE 4. COMPENSATION

4.1 Payment

The City will pay Contractor according to the Schedule of Compensation in the attached Exhibit 2 for the completion of the Services in accordance with this Agreement, including the standard of performance in Section 2.3.

The City will process payment within 60 calendar days after receipt of invoices and all supporting documentation necessary for the City to verify the satisfactory delivery of work, services or goods to be provided under this Agreement.

Contractor may be paid, at the City's option, by electronic payment method. If the City elects to make payment through this method, it will so notify the Contractor, and Contractor agrees to cooperate to facilitate such payments by executing the City's electronic funds transfer form, available for download from the City's website at: http://www.cityofchicago.org/content/dam/city/depts/fin/supp_info/DirectDepositCityVendor.pdf.

The City reserves the right to offset mistaken or wrong payments against future payments. The City will not be obligated to pay for any work, services or goods that were not ordered or that are non-compliant with the terms and conditions of the Agreement. Any goods, work, or services which fail tests, audits, and/or inspections are subject to correction, exchange or replacement at the cost of the Contractor.

4.2 Improper Benefits Payments

Contractor must reimburse the City for any improper payments for Benefits for which payment has been made by Contractor, including any payments made or Benefits provided to individuals who are not Covered Persons or for which a Covered Person is not eligible under the PPO Plan (unless the payment resulted from faulty information provided by the City) or to which Contractor is not entitled to make payments to under the terms of this Agreement. Contractor is not entitled to any reimbursement by the City for payments made to Providers for Benefits provided to which the recipient was not entitled unless the Benefits are furnished as a result of incorrect information provided by the City.

4.3 Invoicing

Contractor shall issue City an invoice for all service fees on a monthly basis. The invoices must be in such detail as the City requests. City shall pay Contractor all invoiced amounts for Claims and service fees within 60 calendar days after City receives an invoice (including all supporting documentation reasonably requested by City) from Contractor except for those amounts that are disputed in good faith, provided that Contractor is notified of the dispute and City has provided a detailed description justifying the dispute. Contractor and City agree to actively work to resolve any dispute as outlined herein.

The Contractor will cooperate in good faith with the City in implementing electronic ordering and invoicing, including but not limited to price lists/catalogs, purchase orders, releases and invoices. The electronic ordering and invoice documents will be in a format specified by the City and transmitted by an electronic means specified by the City. Such electronic means may include, but are not limited to, disks, flash drives, e-mail, EDI, FTP, web sites, and third party electronic services. The City reserves the right to change the document format and/or the means of transmission upon written notice to the Contractor. Contractor will ensure that the essential information, as determined by the City, in the electronic document, corresponds to that information submitted by the Contractor in its paper documents. The electronic documents will be in addition to paper documents required by this Agreement, however, by written notice to the Contractor, the City may deem any or all of the electronic ordering and invoice documents the official documents and/or eliminate the requirement for paper ordering and invoice documents.

A Claims Paid and Expense Experience Report with respect to medical, dental, and vision Claims for the invoiced month must accompany each invoice (i.e., an invoice for June must be accompanied by a June report).

At a minimum, invoices must contain the following information:

(i) The time period being invoiced;

(ii) All group and section numbers, unless certain groups and sections are invoiced separately; and

(iii) The amount payable by the City.

All Claims Paid and Expense Experience Reports must contain the following information:

(i) Gross Claims for each group number and section and type of Claim (i.e., medical, dental, or vision);

(ii) Description (Name) for each group;

(iv) Discounts;

(v) Net Claims;

(vi) Count of Covered Employees and Covered Annuitants;

(vii) Total administrative/access fee;

(viii) Total access fees;

(ix) Total net claims plus administrative/access fees; and

(x) The Claims experience and any fees payable by enrollment must be available via electronic file transfer or in electronic media and must agree with the amount invoiced.

If Contractor has more than one contract with the City, separate invoices must be prepared for each contract in lieu of combining items from different contracts under the same invoice. Invoice quantities, item descriptions, units of measure and pricing information must correspond to the terms of this Agreement.

4.4 Funding

The source(s) of funds for payments under this Agreement is/are fund number(s) _____. Funding for this Agreement is subject to the availability of funds and their appropriation by the Chicago City Council.

4.5 Non-Appropriation

Pursuant to 65 ILCS 5/8-1-7, any contract for the expenditure of funds made by a municipality without the proper appropriation is null and void.

If no funds or insufficient funds are appropriated and budgeted in any fiscal period of the City for payments to be made under this Agreement, then the City will notify Contractor in writing of that occurrence, and this Agreement will terminate on the earlier of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for

payment under this Agreement are exhausted. Payments for Services completed to the date of notification will be made to Contractor except that no payments will be made or due to Contractor under this Agreement beyond those amounts appropriated and budgeted by the City to fund payments under this Agreement.

4.6 Price Reduction

If at any time during the term of this Agreement, Contractor makes a general price reduction in the price of services to other customers, the equivalent price reduction based on similar quantities, size, and scope of Services and/or considerations shall apply to this Agreement for the duration of the term of this Agreement. For purposes of this Section 4.6, a general price reduction shall include reductions in the effective price charged by Contractor by reason of rebates, financial incentives, discounts, value points, or other benefits with respect to the Services. Such price reductions shall be effective at the same time and in the same manner as the reduction Contractor makes in the price of the services to its other customers and prospective customers generally.

4.7 Subcontractor Payment Reports

To the extent applicable to this Agreement under City procurement rules, the Contractor must report payments to Subcontractors on a monthly basis in the form of an electronic report. Upon the first payment issued by the City to the Contractor for services performed, on the first day of each month and every month thereafter, email and/or fax notifications will be sent to the Contractor with instructions to report payments to Subcontractors that have been made in the prior month. This information must be entered into the Certification and Compliance Monitoring System (C2), or whatever reporting system is currently in place, on or before the 15th day of each month.

Once the Contractor has reported payments made to each Subcontractor, including zero dollar amount payments, the Subcontractor will receive an email and/or fax notification requesting that it log into the system and confirm payments received. All monthly confirmations must be reported on or before the 20th day of each month. Contractor and Subcontractor reporting to the C2 system must be completed by the 25th of each month or payments may be withheld. All contracts between the Contractor and its Subcontractors must contain language requiring the Subcontractors to respond to email and/or fax notifications from the City requiring them to report payments received from the Contractor. Access to the C2 system can be found at: https://chicago.mwdbe.com

(Note: This site works for reporting all Subcontractor payments regardless of whether they are MBE/WBE/DBE or non-certified entities.)

If a Subcontractor has satisfactorily performed in accordance with the requirements of the Agreement, Contractor must pay Subcontractor for such work, services, or materials within seven calendar days of Contractor receiving payment from the City. Failure to comply with the foregoing will be deemed an event of default.

4.8 Prompt Payment to Subcontractors

(a) Incorporation of Prompt Payment Language in Subcontracts

To the extent applicable to this Agreement under City procurement rules, Contractor must state the requirements of these prompt payment provisions in all subcontracts and purchase orders and must comply with such requirements. If Contractor fails to incorporate these provisions in all subcontracts and purchase orders, the provisions of this Section are deemed to be incorporated in all subcontracts and purchase orders. Contractor and the Subcontractors have a continuing obligation to make prompt payment to their respective Subcontractors.

(b) Payment to Subcontractors Within Seven Days

The Contractor must make payment to its Subcontractors within seven days of receipt of payment from the City for each invoice, provided, however, that the Subcontractor's performance has met the terms of the contract, and that Subcontractor has submitted its request for payment to the Contractor with such documentation as is reasonably necessary to substantiate such performance, the Contractor shall bill the City for such performance when the Contractor is first authorized under the Agreement to submit an invoice to the City for such performance. Contractor may only invoice the City at the rates contained in the Agreement.

(c) Reporting Failures to Promptly Pay

The City posts payments to prime contractors at: http://webapps.cityofchicago.org/VCSearchWeb/org/cityofchicago/vcsearch/controller/payments/begin.do?agencyId=city. If the Contractor, without reasonable cause, fails to make any payment to its Subcontractors and material suppliers within seven days after receipt of payment under a City contract, the Contractor shall pay to its Subcontractors and material suppliers, in addition to the payment due them, interest in the amount of 2% per month, calculated from the expiration of the seven-day period until fully paid. In the event that a Contractor fails to make payment to a Subcontractor within the seven-day period required above, the Subcontractor may notify the City by submitting a report form that may be downloaded from the DPS website at: http://www.cityofchicago.org/content/dam/city/depts/dps/ContractAdministration/StandardFormsAgreements/Failure_to_Promtly_Pay_Fillable_Form_3_2013.pdf.

The report will require the Subcontractor to affirm that (i) its invoice to the Contractor was included in the payment request submitted by the contractor to the City and (ii) Subcontractor has not, at the time of the report, received payment from the contractor for that invoice. The report must reference the payment (voucher) number posted on-line by the City in the notice of the payment to the contractor.

Per Chapters 1-21, "False Statements," and 1-22, "False Claims," of the Municipal Code of Chicago, making false statements or claims to the City are violations of law and subject to a range of penalties including fines and debarment.

(d) Whistleblower Protection

Contractor shall not take any retaliatory action against any Subcontractor for reporting non-payment pursuant to this subsection 4.8(d). Any such retaliatory action is an event of default under this Agreement and is subject to the remedies set forth in Section 8.2, including termination. In addition to those remedies, any retaliatory action by Contractor may result in Contractor being deemed non-responsible for future City contracts or, if, in the sole judgment of the Chief Procurement Officer, such retaliatory action is egregious, the Chief Procurement Officer may initiate debarment proceedings against the Contractor. Any such debarment shall be for a period of not less than one year.

(e) Liquidated Damages for Failure to Promptly Pay

Much of the City's economic vitality derives from the success of its small businesses. The failure by Contractor to pay its Subcontractors in a timely manner, therefore, is clearly detrimental to the City. Inasmuch as the actual damages to the City due to such failure are uncertain in amount and difficult to prove, Contractor and City agree that the City may assess liquidated damages against Contractor if it fails to meet the prompt payment requirements. Such liquidated damages shall be assessed to compensate the City for any and all damage incurred due to the failure of the Contractor to promptly pay its subcontractors and does not constitute a penalty. Any and all such liquidated damages collected by the City shall be used to improve the administration and outreach efforts of the City's Small Business Program.

(f) Action by the City

Upon receipt of a report of a failure to pay, the City will issue notice to the Contractor, and provide the contractor with an opportunity to demonstrate reasonable cause for failing to make payment within applicable period set forth in the Agreement. The Chief Procurement Officer, in his or her sole judgment, shall determine whether any cause for nonpayment provided by a contractor is reasonable. In the event that the contractor fails to demonstrate reasonable cause for failure to make payment, the City shall notify the contractor that it will assess liquidated damages. Any such liquidated damages will be assessed according to the following schedule:

First Unexcused Report: $50

Second Unexcused Report: $100

Third Unexcused Report: $250

Fourth Unexcused Report: $500

(g) Direct Payment to Subcontractors By City

The City may notify the Contractor that payments to the Contractor will be suspended if the City has determined that the Contractor has failed to pay any Subcontractor, employee, or workman, for work performed. If Contractor has not cured a failure to pay a Subcontractor, employee or workman within 10 days after receipt of such notice, the City may request the Comptroller to apply any money due, or that may become due, to Contractor under the

Agreement to the payment of such Subcontractors, workmen, and employees and the effect will be the same, for purposes of payment to Contractor, as if the City had paid Contractor directly.

Further, if such action is otherwise in the City's best interests, the City may (but is not obligated to) request that the Comptroller make direct payments to Subcontractors for monies earned on contracts and the effect will be the same, for purposes of payment to Contractor, as if the City had paid Contractor directly. The City's election to exercise or not to exercise its rights under this paragraph shall not in any way affect the liability of the Contractor or its sureties to the City or to any such Subcontractor, workman, or employee upon any bond given in connection with this Agreement.

ARTICLE 5. NOTICE AND SATISFACTION, DISPUTES, MEDIATION

(a) Notice and Satisfaction

Unless specifically stated otherwise in this Agreement, the City and the Contractor agree to give one another written notice of any complaint or concern the other party may have about the performance of obligations under this Agreement, and to allow the notified party 90 days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such. This process shall include participation by executives of both parties in good faith discussions to resolve such complaint or concern, including but not limited to in-person meetings, before any further action is taken.

(b) Disputes

Any dispute arising out of or relating to this Agreement that is not resolved pursuant to Section 5(a) above, shall be resolved in accordance with the procedures specified in Sections 5(b)-(e), which shall be the sole and exclusive procedures for the resolution of any such disputes. Notwithstanding the preceding, the parties do not waive their right to bring suit in court as set forth below if a dispute cannot be resolved by the means set forth here. All negotiations pursuant to this Article 5 are confidential, except to the extent disclosure is required by law, and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

Contractor must meet with representatives of the City whenever necessary to promptly resolve any problems that occur relating to the administration or performance of the Agreement. The parties will exercise commercially reasonable efforts to resolve in good faith any such problems. All reasonable requests for information not otherwise inconsistent with the terms of this Agreement and made by one party to the other in the course of attempting to resolve disputes will be honored.

(c) Mediation

To the extent any dispute described in Sections 5(a) or (b) above cannot be resolved pursuant to Section 5(a), the parties agree to participate in good faith in non-binding mediation before any further action is taken. The parties agree to mediate within a time period that is reasonable under the facts and circumstances of the dispute. Each party will name at least two and no more than three potential mediators (complete with resume) who are located in Chicago, Illinois. If the parties cannot mutually agree on a single mediator, each party may strike all but

one of the other party's proposed mediators, leaving a total of two names. The parties then shall select a name by coin toss. The cost of the mediator shall be divided evenly by the parties whether or not the mediation results in resolution of the matters in controversy. Executives with resolution authority agree to participate in good faith in any such mediation.

(d) Optional Arbitration

To the extent the parties are unable to resolve a dispute under the mediation process described in Section 5(c) above, and only if both parties agree, the dispute will be submitted to binding arbitration in Illinois. If binding arbitration is agreed upon by both parties, the parties agree to submit the dispute to the American Arbitration Association ("AAA"). The parties shall agree on the arbitrator to hear the dispute in accordance with the AAA rules no later than 10 business days from the date on which binding arbitration is agreed to. If the parties cannot agree on the arbitrator within the specified time period, then the AAA shall select an arbitrator as soon as possible in accordance with the AAA's procedures for selection of arbitrators. The parties will seek to have the arbitrator submit a decision within 30 days after the arbitration or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. Arbitration proceedings will be governed by the rules of the AAA then in effect. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party.

(e) Exhaustion of Mandatory Dispute Resolution Provisions

If the parties have exhausted the mandatory dispute resolution provisions described in this Article 5, and do not mutually agree to pursue binding arbitration, and a dispute still remains between them, either party may pursue any remedy in a court of competent jurisdiction in Cook County, Illinois.

ARTICLE 6. COMPLIANCE WITH ALL LAWS

6.1 Compliance with All Laws Generally

(a) Contractor must observe and comply with all applicable federal, state, county and municipal laws, statutes, ordinances and executive orders, in effect now or later and whether or not they appear in this Agreement, including those set forth in this Article 6, and Contractor must pay all taxes and obtain all licenses, certificates and other authorizations required by them. Contractor must require all Subcontractors to do so, also. Contractor agrees that Contractor's failure to maintain current throughout the term and any extensions of the term, the disclosures and information pertaining to ineligibility to do business with the City under Chapter 1-23 of the Municipal Code, as such is required under Sec. 2-154-020, shall constitute an event of default.

Provisions required by law, ordinances, rules, regulations, or executive orders to be inserted in the Agreement are deemed inserted in the Agreement whether or not they appear in the Agreement. Contractor must pay all taxes and obtain all licenses, certificates, and other authorizations required in connection with the performance of its obligations hereunder, and Contractor must require all Subcontractors to also do so. Failure to do so is an event of default and may result in the termination of this Agreement

(b) Notwithstanding anything in this Agreement to the contrary, references to a statute or law are considered to be a reference to (i) the statute or law as it may be amended from time to time; (ii) all regulations and rules pertaining to or promulgated pursuant to the statute or law; and (iii) all future statutes, laws, regulations, rules and executive orders pertaining to the same or similar subject matter.

(c) By entering into this Agreement with the City, Contractor certifies to the best of its knowledge and belief that it, its principals and any Subcontractors used in the performance of this Agreement, meet City requirements and have not violated any City or Sister Agency policy, codes, state, federal, or local laws, rules or regulations and have not been subject to any debarment, suspension or other disciplinary action by any government agency. Additionally, if at any time the contractor becomes aware of such information, it must immediately disclose it to the City.

(d) By entering into this Agreement, Contractor represents that it is a corporation in good standing in the state of Illinois.

6.2 Federal Affirmative Action

It is an unlawful employment practice for the Contractor (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, or the terms, conditions, or privileges of his employment, because of such individuals race, color, religion, sex, age, handicap or national origin; or (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individuals race, color, religion, sex, age, handicap or national origin.

Contractor must comply with The Civil Rights Act of 1964, 42 U.S.C. sec. 2000 et seq. (1988), as amended. Attention is called to: Exec. Order No. 11,246,30 Fed. Reg. 12,319 (1965), reprinted in 42 U.S.C. 2000(e) note, as amended by Exec. Order No. 11,375,32 Fed. Reg. 14,303 (1967) and by Exec. Order No. 12,086,43 Fed. Reg. 46,501 (1978); Age Discrimination Act, 42 U.S.C. sec. 61 01-61 06 (1988); Rehabilitation Act of 1973, 29 U.S.C. sec. 793-794 (1988); Americans with Disabilities Act, 42 U.S.C. sec. 12102 et seq.; and 41 C.F.R. Part 60 et seq. (1990); and all other applicable federal laws, rules, regulations and executive orders.

6.3 Civil Rights Act of 1964, Title VI, Compliance with Nondiscrimination Requirements

During the performance of this Agreement, the contractor, for itself, its assignees, and successors in interest agrees as follows:

(a) Compliance with Federal Nondiscrimination Requirements

The contractor will comply with federal nondiscrimination laws, regulations, and authorities, as they may be amended from time to time ("Acts and Regulations"), which include:

(i) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq., 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin);

(ii) 49 CFR part 21 (Non-discrimination in Federally-Assisted Programs of the Department of Transportation—Effectuation of Title VI of The Civil Rights Act of 1964);

(iii) Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794 et seq.), as amended (prohibits discrimination on the basis of disability); and 49 CFR part 27;

(iv) The Age Discrimination Act of 1975, as amended, (42 U.S.C. § 6101 et seq.) (prohibits discrimination on the basis of age);

(v) The Civil Rights Restoration Act of 1987, (PL 100-209) (Broadened the scope, coverage and applicability of Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, by expanding the definition of the terms "programs or activities" to include all of the programs or activities of the Federal-aid recipients, sub-recipients and contractors, whether such programs or activities are Federally funded or not);

(vi) Titles II and III of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. §§ 12131 – 12189), as implemented by Department of Transportation regulations at 49 CFR parts 37 and 38;

(vii) Executive Order 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations, which ensures non-discrimination against minority populations by discouraging programs, policies, and activities with disproportionately high and adverse human health or environmental effects on minority and low-income populations;

(viii) Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination under Title VI includes discrimination because of limited English proficiency (LEP) (70 Fed. Reg. at 74087 to 74100);

(ix) Title IX of the Education Amendments of 1972, as amended, which prohibits discrimination because of sex in education programs or activities (20 U.S.C. 1681 et seq);

(x) The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, (42 U.S.C. § 4601) (prohibits unfair treatment of persons displaced or whose property has been acquired because of Federal or Federal-aid programs and projects);

(xi) Airport and Airway Improvement Act of 1982, (49 USC § 471, Section 47123), as amended, (prohibits discrimination based on race, religion, color, national origin, or sex in any activity carried out with a grant from the FAA).

(b) Nondiscrimination

The Contractor, with regard to the work performed by it under the Agreement, will not discriminate on the grounds of race, color, or national origin in the selection and retention of Subcontractors, including procurements of materials and leases of equipment. The Contractor will not participate directly or indirectly in the discrimination prohibited by the Acts and the Regulations, including employment practices when the contract covers any activity, project, or program set forth in Appendix B of 49 CFR part 21 (Nondiscrimination in Federally-Assisted Programs of the US Department of Transportation).

(c) Solicitations for Subcontracts, Including Procurements of Materials and Equipment

In all solicitations, either by competitive bidding, or negotiation made by the Contractor for work to be performed under a subcontract, including procurements of materials, or leases of equipment, each potential subcontractor or supplier will be notified by the Contractor of the contractor's obligations under this contract and the Acts and the Regulations relative to Non-discrimination on the grounds of race, color, or national origin.

(d) Information and Reports

The contractor will provide all information and reports required by the Acts, the Regulations, and directives issued pursuant thereto and will permit access to its books, records, accounts, other sources of information, and its facilities as may be determined by the City to be pertinent to ascertain compliance with such Acts, Regulations, and instructions. Where any information required of Contractor is in the exclusive possession of another who fails or refuses to furnish the information, the Contractor will so certify to the City and will set forth what efforts it has made to obtain the information.

(e) Sanctions for Noncompliance

In the event of a Contractor's noncompliance with the Non-discrimination provisions of this Agreement, the City will impose such contract sanctions as it may determine to be appropriate, including, but not limited to:

(i) Withholding payments to the Contractor until the Contractor complies; and/or

(ii) Cancelling, terminating, or suspending the Agreement, in whole or in part.

(f) Incorporation of Provisions

The Contractor will include the provisions of Section 6.3(a) through (f) in every subcontract, including procurements of materials and leases of equipment, unless exempt by the Acts, the Regulations and directives issued pursuant thereto. The Contractor will take action with respect to any subcontract as the City may direct as a means of enforcing such provisions including sanctions for noncompliance. Provided, that if the Contractor becomes involved in, or

is threatened with litigation by a Subcontractor, or supplier because of such direction, the Contractor may request the City to enter into any litigation to protect the interests of the City.

6.4 Other Nondiscrimination Requirements

(a) Illinois Human Rights Act

(i) Generally

Contractor must comply with the Illinois Human Rights Act, 775 ILCS 5/1-1 01 et seq., as amended and any rules and regulations promulgated in accordance therewith, including, but not limited to the Equal Employment Opportunity Clause, 44 Ill. Admin. Code 750 Appendix A, and as further described below.

Contractor must comply with the Public Works Employment Discrimination Act, 775 ILCS 10/0.01 et seq., as amended; and all other applicable state laws, rules, regulations and executive orders.

(ii) State of Illinois Duties of Public Contractors (44 Ill. Admin. Code 750 et seq.)

Contractor shall comply with its obligations for public contractors under state law. These rules require that Contractor examine all its job classifications to determine whether minorities or women are underutilized, and if underutilization exists in any job classification, the contractor must take appropriate affirmative action. 44 Ill. Admin. Code 750.110. Underutilization means "having fewer minority/female workers in a particular job classification than would reasonably be expected by their availability. 44 Ill. Admin. Code 750.120.

When required by the state rules, Contractors shall develop and implement written affirmative action plans to overcome underutilization of minorities and/or women, including, at minimum, a description of the Contractor's workforce analysis and goals and timetables for recruitment efforts, per 44 Ill. Admin. Code 750.130. Contractors shall also state in all solicitations that all applicants be afforded equal employment opportunity without discrimination ("because of race, color, religion, sex, marital status, national origin or ancestry, citizenship status, age, physical or mental disability unrelated to ability, sexual orientation, military status, order of protection status or unfavorable discharge from military service," 44 Ill. Admin. Code 750.150), and advise in writing their personnel, referral sources, and labor organizations of the Contractor's obligations under state law and any affirmative action plan.

(iii) State of Illinois Equal Employment Opportunity Clause

In the event of the Contractor's non-compliance with the provisions of this Equal Employment Opportunity Clause or the Illinois Human Rights Act, the Contractor may be declared ineligible for future contracts or subcontracts with the State of Illinois or any of its political subdivisions or municipal corporations, and the Agreement may be cancelled or voided in whole or in part, and other sanctions or penalties may be imposed or remedies invoked as provided by statute or regulation. During the performance of this Agreement, the Contractor agrees as follows:

A. That Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, marital status, order of protection status, national origin or ancestry, citizenship status, age, physical or mental disability unrelated to ability, military status or an unfavorable discharge from military service; and, further, that he or she will examine all job classifications to determine if minority persons or women are underutilized and will take appropriate affirmative action to rectify any underutilization.

B. That, if Contractor hires additional employees in order to perform services under this Agreement or any portion of this Agreement, Contractor will determine the availability (in accordance with 44 Ill. Admin. Code Part 750) of minorities and women in the areas from which Contractor may reasonably recruit and Contractor will hire for each job classification for which employees are hired in a way that minorities and women are not underutilized.

C. That, in all solicitations or advertisements for employees placed, Contractor or will state that all applicants will be afforded equal opportunity without discrimination because of race, color, religion, sex, sexual orientation, marital status, order of protection status, national origin or ancestry, citizenship status, age, physical or mental disability unrelated to ability, military status or an unfavorable discharge from military service.

D. That Contractor will send to each labor organization or representative of workers with which Contractor has or is bound by a collective bargaining or other agreement or understanding, a notice advising the labor organization or representative of the Contractor's obligations under the Illinois Human Rights Act and 44 Ill. Admin. Code Part 750. If any labor organization or representative fails or refuses to cooperate with the Contractor in Contractor's efforts to comply with the Act and this Part, the Contractor will promptly notify the Illinois Department of Human Rights and the City and will recruit employees from other sources when necessary to fulfill its obligations under the contract.

E. That Contractor will submit reports as required by 44 Ill. Admin. Code Part 750, furnish all relevant information as may from time to time be requested by the Illinois Department of Human Rights or the City, and in all respects comply with the Illinois Human Rights Act and 44 Ill. Admin. Code Part 750.

F. That Contractor will permit access to all relevant books, records, accounts and work sites by personnel of the City and the Illinois Department of Human Rights for purposes of investigation to

ascertain compliance with the Illinois Human Rights Act and the Illinois Department of Human Rights' Rules and Regulations.

G. That Contractor will include verbatim or by reference the provisions of this clause in every subcontract awarded under which any portion of the Agreement obligations are undertaken or assumed, so that the provisions will be binding upon the Subcontractor. In the same manner as with other provisions of this Agreement, the Contractor will be liable for compliance with applicable provisions of this clause by Subcontractors; and further it will promptly notify the City and the Illinois Department of Human Rights in the event any Subcontractor fails or refuses to comply with the provisions. In addition, the Contractor will not utilize any Subcontractor declared by the Illinois Human Rights Commission to be ineligible for contracts or subcontracts with the State of Illinois or any of its political subdivisions or municipal corporations.

(b) Chicago Human Rights Ordinance MCC Ch. 2-160

Contractor must comply with the Chicago Human Rights Ordinance, MCC Ch. 2-160, Sect. 2-160-010 *et seq*., as amended; and all other applicable municipal code provisions, rules, regulations and executive orders.

Contractor must furnish or shall cause each of its Subcontractors to furnish such reports and information as requested by the Chicago Commission on Human Relations.

(c) Business Enterprises Owned by People With Disabilities (BEPD)

Pursuant to MCC 2-92-586, Contractor is strongly encouraged to subcontract with businesses certified as business enterprises owned or operated by people with disabilities ("BEPD") as defined in that section or MCC 2-92-337, and to use BEPD businesses as suppliers.

6.5 False Statements

False statements made in connection with this Agreement, including statements in, omissions from and failures to timely update the EDS, as well as in any other affidavits, statements or Agreement documents constitute a material breach of the Agreement. Any such misrepresentation renders the Agreement voidable at the option of the City, notwithstanding any prior review or acceptance by the City of any materials containing such a misrepresentation. In addition, the City may debar Contractor, assert any contract claims or seek other civil or criminal remedies as a result of a misrepresentation (including costs of replacing a terminated Contractor pursuant to MCC Sect. 1-21-010).

6.6 Occupational Safety and Health Administration Laws and Regulations ("OSHA")

Contractor must comply with OSHA by providing a safe and healthful workplace. In addition, Contractor must comply with the "General Duty Clause" of OSHA, which requires employers to keep their workplace free of serious recognized hazards.

6.7 Inspector General

It is the duty of any bidder, proposer or Contractor, all Subcontractors, every applicant for certification of eligibility for a City contract or program, and all officers, directors, agents, partners and employees of any bidder, proposer, Contractor, Subcontractor or such applicant to cooperate with the Legislative Inspector General or the Inspector General in any investigation or hearing, if applicable, undertaken pursuant to Chapters 2-55 or 2-56, respectively, of the Municipal Code. Contractor understands and will abide by all provisions of Chapters 2-55 and 2-56 of the Municipal Code. All subcontracts must inform Subcontractors of the provision and require understanding and compliance with it.

6.8 MacBride Ordinance

The City of Chicago through the passage of the MacBride Principles Ordinance seeks to promote fair and equal employment opportunities and labor practices for religious minorities in Northern Ireland and provide a better working environment for all citizens in Northern Ireland.

In accordance with §2-92-580 of the Municipal Code of the City of Chicago, if Contractor conducts any business operations in Northern Ireland, the Contractor must make all reasonable and good faith efforts to conduct any business operations in Northern Ireland in accordance with the MacBride Principles for Northern Ireland as defined in Illinois Public Act 85-1390 (1988 Ill. Laws 3220).

The provisions of this Section 6.8 do not apply to contracts for which the City receives funds administered by the United States Department of Transportation, except to the extent Congress has directed that the Department of Transportation not withhold funds from states and localities that choose to implement selective purchasing policies based on agreement to comply with the MacBride Principles for Northern Ireland, or to the extent that such funds are not otherwise withheld by the Department of Transportation.

6.9 City Hiring Plan Prohibitions

(a) The City is subject to the June 16, 2014 "City of Chicago Hiring Plan" (the "2014 City Hiring Plan") entered in *Shakman v. Democratic Organization of Cook County*, Case No 69 C 2145 (United States District Court for the Northern District of Illinois). Among other things, the 2014 City Hiring Plan prohibits the City from hiring persons as governmental employees in non-exempt positions on the basis of political reasons or factors.

(b) Contractor is aware that City policy prohibits City employees from directing any individual to apply for a position with Contractor, either as an employee or as a subcontractor, and from directing Contractor to hire an individual as an employee or as a Subcontractor.

Accordingly, Contractor must follow its own hiring and contracting procedures, without being influenced by City employees. Any and all personnel provided by Contractor under this Agreement are employees or Subcontractors of Contractor, not employees of the City of Chicago. This Agreement is not intended to and does not constitute, create, give rise to, or otherwise recognize an employer-employee relationship of any kind between the City and any personnel provided by Contractor.

(c) Contractor will not condition, base, or knowingly prejudice or affect any term or aspect of the employment of any personnel provided under this Agreement, or offer employment to any individual to provide services under this Agreement, based upon or because of any political reason or factor, including, without limitation, any individual's political affiliation, membership in a political organization or party, political support or activity, political financial contributions, promises of such political support, activity or financial contributions, or such individual's political sponsorship or recommendation. For purposes of this Agreement, a political organization or party is an identifiable group or entity that has as its primary purpose the support of or opposition to candidates for elected public office. Individual political activities are the activities of individual persons in support of or in opposition to political organizations or parties or candidates for elected public office.

(d) In the event of any communication to Contractor by a City employee or City official in violation of paragraph (b) above, or advocating a violation of paragraph (c) above, Contractor will, as soon as is reasonably practicable, report such communication to the Hiring Oversight Section of the City's Office of the Inspector General ("OIG Hiring Oversight"), and also to the head of the Department. Contractor also will cooperate with any inquiries by OIG Hiring Oversight.

6.10 Electronic Mail Communication

Electronic mail communication between Contractor and City employees must relate only to business matters between Contractor and the City.

6.11 Wheel Tax (City Sticker)

Contractor must pay all Wheel Tax required by Chapter 3-56 of the MCC, as amended from time to time. Contractor should take particular notice of MCC 3-56-020 and MCC 3-56-125 which relate to payment of the tax for vehicles that are used on City streets or on City property by City residents. For the purposes of Chapter 3-56, any business that owns, leases or otherwise controls a place of business within the City wherein motor vehicles or semi-trailers are stored, repaired, serviced, or loaded or unloaded in connection with the business is also considered to be a City resident.

6.12 Compliance with Environmental Laws and Related Matters

(a) Definitions

For purposes of this section, the following definitions shall apply:

Environmental Agency: An "Environmental Agency" is any governmental agency having responsibility, in whole or in part, for any matter addressed by any Environmental Law. An agency need not be responsible only for matters addressed by Environmental Law(s) to be an Environmental Agency for purposes of this Agreement.

Environmental Claim: An "Environmental Claim" is any type of assertion that Contractor or any Subcontractor is liable, or allegedly is liable, or should be held liable, under any Environmental Law, or that Contractor or any Subcontractor has or allegedly has violated or otherwise failed to comply with any Environmental Law. A non-exhaustive list of Environmental Claims includes, without limitation: demand letters, lawsuits, and citations of any kind regardless of originating source.

Environmental Law: An "Environmental Law" is any Law that in any way, directly or indirectly, in whole or in part, bears on or relates to the environment or to human health or safety. A non-exhaustive list of Environmental Laws includes without limitation the Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. 9601, *et seq*., the Resource Conservation and Recovery Act, 42 U.S.C. 6901, *et seq*., the Hazardous Materials Transportation Act, 49 U.S.C. 5101, *et seq*., the Clean Air Act, 42 U.S.C. 7401, *et seq*., the Federal Water Pollution Control Act, 33 U.S.C. 1251, *et seq*., the Occupational Safety and Health Act, 29 U.S.C. 651, *et seq*., the Illinois Environmental Protection Act, 415 ILCS 5/1, *et seq*., the Illinois Occupational Safety and Health Act, 820 ILCS 219/1, *et seq*., Chapters 7-28 and 11-4 of the Chicago Municipal Code, and all related rules and regulations.

Law(s): The word "Law" or "Laws," whether or not capitalized, is intended in the broadest possible sense, including without limitation all federal, state and local: statutes; ordinances; codes; rules; regulations; administrative and judicial orders of any kind; requirements and prohibitions of permits, licenses or other similar authorizations of any kind; court decisions; common law; and all other legal requirements and prohibitions.

Routine: As applied to reports or notices, "Routine" refers to a report or notice that must be made, submitted or filed on a regular, periodic basis (e.g., quarterly, annually, biennially) and that in no way arises from a spill or other release or any kind, or from an emergency response situation, or from any actual, possible or alleged noncompliance with any Environmental Law.

(b) Joint Ventures

If Contractor or any Subcontractor is a joint venture, then every party to every such joint venture is deemed a Subcontractor for purposes of this Section 6.12.

(c) Compliance with Environmental Laws

As part of or in addition to its obligation to observe and comply with all applicable laws, Contractor must observe and comply with all applicable Environmental Laws and ensure that all Subcontractors observe and comply with all applicable Environmental Laws.

Any noncompliance, by Contractor or any Subcontractor, with any Environmental Law during the time that this Agreement is effective is an event of default, regardless of whether the noncompliance relates to performance of this Agreement. This includes without limitation any

failure by Contractor or any Subcontractor to keep current, throughout the term of this Agreement, all insurance certificates, permits and other authorizations of any kind that are required, directly or indirectly, by any Environmental Law.

(d) Costs

Any cost arising directly or indirectly, in whole or in part, from any noncompliance, by Contractor or any Subcontractor, with any Environmental Law, will be borne by the Contractor and not by the City. This includes, but is not limited to, any cost associated with removal of waste or other material from a facility lacking any required permit. No provision of this Agreement is intended to create or constitute an exception to this provision.

(e) Proof of Noncompliance; Authority; Cure

Any adjudication, whether administrative or judicial, against Contractor or any Subcontractor, for a violation of any Environmental Law, is sufficient proof of noncompliance, and therefore of an event of default, for purposes of this Agreement

Any citation issued to/against Contractor or any Subcontractor, by any government agent or entity, alleging a violation of any Environmental Law, is sufficient proof of noncompliance for purposes of this Agreement, and therefore of an event of default, if the citation contains or is accompanied by, or the City otherwise obtains, any evidence sufficient to support a reasonable conclusion that a violation has occurred.

Any other evidence of noncompliance with any Environmental Law is sufficient proof of noncompliance for purposes of this Agreement, and therefore of an event of default, if the evidence is sufficient to support a reasonable conclusion that noncompliance has occurred.

The Chief Procurement Officer shall have the authority to determine whether noncompliance with an Environmental Law has occurred, based on any of the foregoing types of proof. Upon determining that noncompliance has occurred, s/he may in his/her discretion declare an event of default and may in his/her discretion offer Contractor an opportunity to cure the event of default, such as by taking specified actions, which may include without limitation ceasing and desisting from utilizing a Subcontractor.

The Chief Procurement Officer may consider many factors in determining whether to declare an event of default, whether to offer an opportunity to cure, and if so any requirements for cure, including without limitation: the seriousness of the noncompliance, any effects of the noncompliance, Contractor's and/or Subcontractor's history of compliance or noncompliance with the same or other Laws, Contractor's and/or Subcontractor's actions or inaction towards mitigating the noncompliance and its effects, and Contractor's or Subcontractor's actions or inaction towards preventing future noncompliance.

(f) Copies of Notices and Reports; Related Matters

If any Environmental Law requires Contractor or any Subcontractor to make, submit or file any non-Routine notice or report of any kind, to any Environmental Agency or other person, including without limitation any agency or other person having any responsibility for any type of

emergency response activity, then Contractor must deliver a complete copy of the notice or report (or, in the case of legally required telephonic or other oral notices or reports, a comprehensive written summary of same) to the Department within 24 hours of making, submitting or filing the original report.

Additionally, to the extent not already achieved by Contractor's compliance with this subsection 6.12(f), Contractor must notify the Department, within 24 hours of learning of any of the following:

(i) any release, suspected release, or threatened release of any waste or other material relating to the work performed under the Contract;

(ii) any notice of any kind received by Contractor, any Subcontractor, or any employee or agent of Contractor or any Subcontractor, from an Environmental Agency or any other person, of or relating to any release, suspected release, or threatened release of any waste or other material relating to the work performed under the Agreement.

This notification must be in writing, must be submitted by a fast method such as email, and must include, to the best of Contractor's knowledge at the time of submittal: the types and amounts of the waste or other material at issue; the location; the cause and any contributing factors; all actions taken, being taken, and intended to be taken by Contractor and any Subcontractors; and a copy of any notice received by Contractor, any Subcontractor, or any employee or agent of Contractor or any Subcontractor. Contractor must also provide written updates to the Commissioner by email or other method as indicated by the Commissioner whenever Contractor becomes aware of information that is different from or additional to the information provided in the initial notification.

The requirements of this provision apply, regardless of whether the subject matter of the required notice or report concerns performance of this Agreement.

Failure to comply with any requirement of this provision is an event of default.

(g) Requests for Documents and Information

If the Department requests documents or information of any kind that directly or indirectly relate(s) to performance of this Agreement, Contractor must obtain and provide the requested documents and/or information to the Department within five business days.

Failure to comply with any requirement of this provision is an event of default.

(h) Environmental Claims and Related Matters

Within 24 hours of receiving, or of any Subcontractor's receiving, notice of any Environmental Claim, Contractor must submit copies of all documents constituting or relating to the Environmental Claim to the Department. Thereafter, Contractor must submit copies of related documents if requested by the Department. These requirements apply, regardless of whether the Environmental Claim concerns performance of Services under this Agreement.

Failure to comply with any requirement of this provision is an event of default.

(i) Preference for Recycled Materials

To the extent practicable and economically feasible and to the extent that it does not reduce or impair the quality of any work or services, Contractor must use recycled products in performance of the Services pursuant to U.S. Environment Protection Agency (U.S. EPA) guidelines at 40 CFR Parts 247-253, which implement section 6002 of the Resource Conservation and Recovery Act, as amended, 42 USC § 6962.

(j) No Waste Disposal in Public Way MCC 11-4-1600(E)

Contractor warrants and represents that it, and to the best of its knowledge, its Subcontractors have not violated and are not in violation of the following sections of the City of Chicago Municipal Code (collectively, the "Waste Sections"):

7-28-390 Dumping on public way;

7-28-440 Dumping on real estate without permit;

11-4-1410 Disposal in waters prohibited;

11-4-1420 Ballast tank, bilge tank or other discharge;

11-4-1450 Gas manufacturing residue;

11-4-1500 Treatment and disposal of solid or liquid waste;

11-4-1530 Compliance with rules and regulations required;

11-4-1550 Operational requirements; and

11-4-1560 Screening requirements.

During the period while this Agreement is executory, Contractor's or any Subcontractor's violation of the Waste Sections, whether or not relating to the performance of this Agreement, constitutes a breach of and an event of default under this Agreement, for which the opportunity to cure, if curable, will be granted only at the sole discretion of the City. Such breach and default entitles the City to all remedies under the Agreement, at law or in equity.

This section does not limit the Contractor's and its Subcontractors' duty to comply with all applicable federal, state, county and municipal laws, statutes, ordinances and executive orders, in effect now or later, and whether or not they appear in this Agreement.

Non-compliance with these terms and conditions may be used by the City as grounds for the termination of this Agreement and may further affect the Contractor's eligibility for future contract awards.

6.13 Economic Disclosure Statement and Affidavit

Pursuant to MCC Ch. 2-154 and 65 ILCS 5/8-10-8.5 any person, business entity or agency submitting a bid or proposal to or contracting with the City will be required to complete the Disclosure of Ownership Interests in the Economic Disclosure Statement ("EDS"). Failure to provide complete or accurate disclosure will render this Agreement voidable by the City.

Contractors must complete an online EDS prior to the Bid Opening Date. Contractors are responsible for notifying the City and updating their EDS any time there is a change in circumstances that makes any information provided or certification made in an EDS inaccurate, obsolete or misleading. Failure to so notify the City and update the EDS is grounds for declaring the Contractor in default, terminating the Agreement for default, and declaring the Contractor ineligible for future contracts.

Contractor makes certain representations and certifications that the City relies on in its decision to enter into a contract. The laws and requirements that are addressed in the EDS include the following:

(a) Business Relationships with Elected Officials

Pursuant to MCC Sect. 2-156-030(b), it is illegal for any elected official, or any person acting at the direction of such official, to contact either orally or in writing any other City official or employee with respect to any matter involving any person with whom the elected official has any business relationship that creates a financial interest on the part of the official, or the domestic partner or spouse of the official, or from whom or which he has derived any income or compensation during the preceding twelve months or from whom or which he reasonably expects to derive any income or compensation in the following twelve months. In addition, no elected official may participate in any discussion in any City Council committee hearing or in any City Council meeting or vote on any matter involving the person with whom the elected official has any business relationship that creates a financial interest on the part of the official, or the domestic partner or spouse of the official, or from whom or which he has derived any income or compensation during the preceding twelve months or from whom or which he reasonably expects to derive any income or compensation in the following twelve months.

Violation of MCC § 2-156-030 by any elected official with respect to this contract will be grounds for termination of this Agreement The term financial interest is defined as set forth in MCC Chapter 2-156.

(b) MCC 1-23 and 720 ILCS 5/33E Bribery, Debts, and Debarment Certification

The Contractor or each joint venture partner, if applicable, must complete the appropriate subsections in the EDS which include: (i) certification that the Contractor or each joint venture partner, its agents, employees, officers and any subcontractors (A) have not been engaged in or been convicted of bribery or attempted bribery of a public officer or employee of the City, the State of Illinois, any agency of the federal government or any state or local government in the United States or engaged in or been convicted of bid-rigging or bid-rotation activities as defined in this section as required by the Illinois Criminal Code; (B) do not owe any debts to the State of Illinois, in accordance with 65 ILCS 5/11-42.1-1 and (C) are not presently debarred or

suspended; (ii) Certification Regarding Environmental Compliance; (iii) Certification Regarding Ethics and Inspector General; and (iv) Certification Regarding Court-Ordered Child Support Compliance.

Contractor, in performing under this Agreement shall comply with MCC Sect. 2-92-320, as follows:

No person or business entity shall be awarded a contract or sub-contract if that person or business entity: (a) has been convicted of bribery or attempting to bribe a public officer or employee of the City, the State of Illinois, or any agency of the federal government or of any state or local government in the United States, in that officers or employee's official capacity; or (b) has been convicted of agreement or collusion among bidders or prospective bidders in restraint of freedom of competition by agreement to bid a fixed price, or otherwise; or (c) has made an admission of guilt of such conduct described in (a) or (b) above which is a matter of record but has not been prosecuted for such conduct; or (d) has violated MCC Sect. 2-92-610; or (e) has violated any regulation promulgated by the Chief Procurement Officer that includes ineligibility as a consequence of its violation; or (f) has committed, within a 24-month period, three or more violations of Chapter 1-24 of the MCC; or (g) has been debarred by any local, state or federal government agency from doing business with such government agency, for any reason or offense set forth in subsections (a), (b), or (c) of this section, or substantially equivalent reason or offense, for the duration of the debarment by such government agency.

For purposes of this section, where an official, agent, or employee of a business entity has committed any offense under this section on behalf of such an entity and pursuant to the direction or authorization of a responsible official thereof, the business entity will be chargeable with the conduct.

One business entity will be chargeable with the conduct of an affiliated agency. Ineligibility under this section will continue for three years following such conviction or admission. The period of ineligibility may be reduced, suspended, or waived by the Chief Procurement Officer under certain specific circumstances. Reference is made to Section 2-92-320 for a definition of affiliated agency, and a detailed description of the conditions which would permit the Chief Procurement Officer to reduce, suspend, or waive the period of ineligibility.

6.14 Wages

Contractor must pay the highest of (1) prevailing wage/Davis-Bacon rate, if applicable; (2) minimum wage specified by Mayoral Executive Order 2014-1; "Living Wage" rate specified by MCC Sect. 2-92-610; (3) Chicago Minimum Wage rate specified by MCC Chapter 1-24, or (4) the highest applicable State or Federal minimum wage.

(a) Minimum Wage, Mayoral Executive Order 2014-1

Mayoral Executive Order 2014-1 provides for a fair and adequate minimum wage to be paid to employees of City contractors and subcontractors performing work on City contracts. Contractor must comply with Mayoral Executive Order 2014-1 and any applicable regulations issued by the Chief Procurement Officer. The minimum wage to be paid pursuant to the Order as of July 1, 2018 is $13.80 per hour. The minimum wage must be paid to:

(i) All employees regularly performing work on City property or at a City jobsite.

(ii) All employees whose regular work entails performing a service for the City under a City contract.

Each July 1st the hourly wage specified by the Executive Order shall increase in proportion to the increase, if any, in the Consumer Price Index for All Urban Consumers most recently published by the Bureau of Labor Statistics of the United States Department of Labor. Any hourly wage increase shall be rounded up to the nearest multiple of $0.05. Such increase shall remain in effect until any subsequent adjustment is made. On or before June 1st each year, the City shall make available to City concessionaires a bulletin announcing the adjusted minimum hourly wages for the upcoming year.

The minimum wage is not required to be paid to employees whose work is performed in general support of Contractors operations, does not directly relate to the services provided to the City under the Agreement, and is included in the Agreement price as overhead, unless that employee's regularly assigned work location is on City property or at a City jobsite. It is also not required to be paid by employers that are 501(c)(3) not-for-profits.

Except as further described, the minimum wage is also not required to be paid to categories of employees subject to subsection 4(a)(2), subsection 4(a)(3), subsection 4(d), subsection 4(e), or Section 6 of the Illinois Minimum Wage Law, 820 ILCS 105/1 *et seq.*, in force as of the date of this Agreement, or as amended thereafter. Nevertheless, the minimum wage is required to be paid to those workers described in subsections 4(a)(2)(A) and 4(a)(2)(B) of the Illinois Minimum Wage Law.

Additionally, the minimum wage is not required to be paid to employees subject to a collective bargaining agreement that provides for different wages than those required by Mayoral Executive Order 2014-1, if that collective bargaining agreement was in force prior to October 1, 2014 or if that collective bargaining agreement clearly and specifically waives the requirements of the order.

If the payment of a Base Wage pursuant to Municipal Code of Chicago Sect. 2-92-610 is required for work or services done under this Agreement, and the minimum wage is higher than the Base Wage, then the Contractor must pay the minimum wage. Likewise, if the payment of a prevailing wage is required and the prevailing wage is higher than the minimum wage, then the Contractor must pay the prevailing wage.

Contractors are reminded that they must comply with Municipal Code Chapter 1-24 establishing a minimum wage.

(b) Living Wage Ordinance

MCC Sect. 2-92-610 provides for a living wage for certain categories of workers employed in the performance of City contracts, specifically non-City employed security guards, parking attendants, day laborers, home and health care workers, cashiers, elevator operators, custodial workers, and clerical workers ("Covered Employees"). Accordingly, pursuant to MCC

Sect. 2-92-610 and regulations promulgated thereunder: (i) if the Contractor has 25 or more full-time employees, and (ii) if at any time during the performance of the Agreement the Contractor and/or any Subcontractor or any other entity that provides any portion of the Services (collectively "Performing Parties") uses 25 or more full-time security guards, or any number of other full-time Covered Employees, then the Contractor's obligation to pay, and to assure payment of, the Base Wage will begin at any time during the Agreement term when the conditions set forth in (1) and (2) above are met, and will continue thereafter until the end of the Agreement term.

As of July 1, 2018, the Base Wage is $12.55. The current rate can be found on the Department of Procurement Services' website. (Note that as of July 1, 2018, the wage specified by Mayoral Executive Order 2014-1 is higher than the Base Wage rate. Therefore, the higher wage specified by the Executive Order (or other applicable rule or law) must be paid.)

Each July 1st the Base Wage will be adjusted, using the most recent federal poverty guidelines for a family of four (4) as published annually by the U.S. Department of Health and Human Services, to constitute the following: the poverty guidelines for a family of four (4) divided by 2000 hours or the current base wage, whichever is higher. At all times during the term of this Agreement, Contractor and all other Performing Parties must pay the Base Wage (as adjusted in accordance with the above). If the payment of prevailing wages is required for work or services done under this Agreement, and the prevailing wages for Covered Employees are higher than the Base Wage, then the Contractor must pay the prevailing wage rates.

The Contractor must include provisions in all subcontracts requiring its Subcontractors to pay the Base Wage to Covered Employees. The Contractor agrees to provide the City with documentation acceptable to the Chief Procurement Officer demonstrating that all Covered Employees, whether employed by the Contractor or by a Subcontractor, have been paid the Base Wage, upon the City's request for such documentation. The City may independently audit the Contractor and/or Subcontractors to verify compliance herewith.

Failure to comply with the requirements of this Section will be an event of default under this Agreement, and further, failure to comply may result in ineligibility for any award of a City contract or subcontract for up to three years.

Not-for-Profit Corporations: If the Contractor is a corporation having Federal tax-exempt status under Section 501(c)(3) of the Internal Revenue Code and is recognized under Illinois not-for-profit law, then the provisions above do not apply.

(c) Chicago Paid Sick Leave Ordinance

The Paid Sick Leave Ordinance, which is published in the June 22, 2016 Council Journal, pages 27188 – 27197 and which will be codified at MCC 1-24-045, became effective July 1, 2017. Contractor understands that, to the extent that the Ordinance applies to its activities, it must comply with the Ordinance.

(d) Equal Pay

The Contractor will comply with all applicable provisions of the Equal Pay Act of 1963, 29 U.S.C. 206(d) and the Illinois Equal Pay Act of 2003, 820 ILCS 112/1, *et seq*., as amended, and all applicable related rules and regulations including but not limited to those set forth in 29 CFR Part 1620 and 56 Ill. Adm. Code Part 320.

6.15 Restrictions on Business Dealings

(a) Prohibited Interests in City Contracts

No member of the governing body of the City or other unit of government and no other officer, employee or agent of the City or other unit of government who exercises any functions or responsibilities in connection with the work or services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. No member of or delegate to the Congress of the United States or the Illinois General Assembly and no alderman of the City or City employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.

(b) Conflicts of Interest

The Contractor covenants that it, and to the best of its knowledge, its subcontractors if any, presently have no interest and will not acquire any interest, direct or indirect, in any enterprise, project or contract which would conflict in any manner or degree with the performance of the work, services or goods to be provided hereunder. The Contractor further covenants that in the performance of the Agreement no person having any such interest will be employed, either by Contractor or any Subcontractor, to perform any work or services under the Agreement or have access to confidential information.

If the City determines that the Contractor does have such a conflict of interest, the City will notify the Contractor in writing, stating the basis for its determination. The Contractor will thereafter have 30 days in which to respond with reasons why the Contractor believes a conflict of interest does not exist. If the Contractor does not respond or if the City still reasonably determines a conflict of interest to exist, the Contractor must terminate its interest in the other enterprise, project, or contract. Further, if the City in the reasonable judgment of the Department determines that any subcontractor's work or services for others conflicts with the work or services to be provided by them, upon request of the City, Contractor must require that Subcontractor to terminate such other work or services immediately.

If Contractor or any Subcontractors become aware of a conflict, they must immediately stop work on the activity causing the conflict and notify the City.

If Contractor or any Subcontractors ("Contracting Parties") assist the City in determining the advisability or feasibility of a project or in recommending, researching, preparing, drafting or issuing a request for proposals, bid specifications for a project, or other procurement solicitation document, the Contracting Parties must not participate, directly or indirectly, as a prime, subcontractor, subconsultant or joint venturer in that project or in the preparation of a proposal or bid for that project during the term of this Agreement or afterwards. The Contracting Parties may, however, assist the City in reviewing the proposals or bids for the project if none of the

Contracting Parties have a relationship with the persons or entities that submitted the proposals or bids for that project.

(c) Prohibition on Certain Contributions, Mayoral Executive Order 2011-4

No Contractor or any person or entity who directly or indirectly has an ownership or beneficial interest in Contractor of more than 7.5% ("Owners"), spouses and domestic partners of such Owners, Contractor's Subcontractors, any person or entity who directly or indirectly has an ownership or beneficial interest in any Subcontractor of more than 7.5% ("Sub-owners") and spouses and domestic partners of such Sub-owners (Contractor and all the other preceding classes of persons and entities are together, the "Identified Parties"), shall make a contribution of any amount to the Mayor of the City of Chicago (the "Mayor") or to his political fundraising committee during (i) the bid or other solicitation process for this Agreement or Other Contract, including while this Agreement or Other Contract is executory, (ii) the term of this Agreement or any Other Contract between City and Contractor, and/or (iii) any period in which an extension of this Agreement or Other Contract with the City is being sought or negotiated.

Contractor represents and warrants that since the date of public advertisement of the specification, request for qualifications, request for proposals or request for information (or any combination of those requests) or, if not competitively procured, from the date the City approached the Contractor or the date the Contractor approached the City, as applicable, regarding the formulation of this Agreement, no Identified Parties have made a contribution of any amount to the Mayor or to his political fundraising committee.

Contractor shall not: (a) coerce, compel or intimidate its employees to make a contribution of any amount to the Mayor or to the Mayor's political fundraising committee; (b) reimburse its employees for a contribution of any amount made to the Mayor or to the Mayor's political fundraising committee; or (c) bundle or solicit others to bundle contributions to the Mayor or to his political fundraising committee.

The Identified Parties must not engage in any conduct whatsoever designed to intentionally violate this provision or Mayoral Executive Order No. 2011-4 or to entice, direct or solicit others to intentionally violate this provision or Mayoral Executive Order No. 2011-4.

Violation of, non-compliance with, misrepresentation with respect to, or breach of any covenant or warranty under this provision or violation of Mayoral Executive Order No. 2011-4 constitutes a breach and default under this Agreement, and under any Other Contract for which no opportunity to cure will be granted. Such breach and default entitles the City to all remedies (including without limitation termination for default) under this Agreement, under Other Contract, at law and in equity. This provision amends any Other Contract and supersedes any inconsistent provision contained therein.

If Contractor violates this provision or Mayoral Executive Order No. 2011-4 prior to award of the Agreement resulting from this specification, the CPO may reject Contractor's bid.

For purposes of this Section 6.15:

"Other Contract" means any agreement entered into between the Contractor and the City that is (i) formed under the authority of MCC Ch. 2-92; (ii) for the purchase, sale or lease of real or personal property; or (iii) for materials, supplies, equipment or services which are approved and/or authorized by the City Council.

"Contribution" means a "political contribution" as defined in MCC Ch. 2-156, as amended.

"Political fundraising committee" means a "political fundraising committee" as defined in MCC Ch. 2-156, as amended.

6.16 Debts Owed to the City; Anti-Scofflaw, MCC Set. 2-92-380

In addition to the certifications regarding debts owed to the City in the EDS, Contractor is subject to MCC Sect. 2-92-380.

Pursuant to MCC Sect. 2-92-380 and in addition to any other rights and remedies (including set-off) available to the City under this Agreement or permitted at law or in equity, the City will be entitled to set off a portion of the Agreement price or compensation due under the Agreement, in an amount equal to the amount of the fines and penalties for each outstanding parking violation complaint and the amount of any debt owed by the contracting party to the City. For purposes of this section, outstanding parking violation complaint means a parking ticket, notice of parking violation, or parking violation complaint on which no payment has been made or appearance filed in the Circuit Court of Cook County within the time specified on the complaint, and debt means a specified sum of money owed to the City for which the period granted for payment has expired.

However, no such debt(s) or outstanding parking violation complaint(s) will be offset from the Agreement price or compensation due under the Agreement if one or more of the following conditions are met:

(i) the contracting party has entered into an agreement with the Department of Revenue, or other appropriate City department, for the payment of all outstanding parking violation complaints and debts owed to the City and the Contracting party is in compliance with the agreement; or

(ii) the contracting party is contesting liability for or the amount of the debt in a pending administrative or judicial proceeding; or the contracting party has filed a petition in bankruptcy and the debts owed the City are dischargeable in bankruptcy.

6.17 Firms Owned or Operated by Individuals with Disabilities

The City encourages consultants to use Subcontractors that are firms owned or operated by individuals with disabilities, as defined by §2-92-586 of the Municipal Code of the City of Chicago, where not otherwise prohibited by federal or state law.

6.18 Ineligibility to do Business with City.

Failure by the Contractor or any Controlling Person (defined in Section 1-23-010 of the Municipal Code) thereof to maintain eligibility to do business with the City in violation of Section 1-23-030 of the Municipal Code shall render this Agreement voidable or subject to termination, at the option of the City. Contractor agrees that Contractor's failure to maintain eligibility (or failure by Controlling Persons to maintain eligibility) to do business with the City in violation of Section 1-23-030 of the Municipal Code shall constitute an event of default.

6.19 Duty to Report Corrupt or Unlawful Activity

Pursuant to §2-156-018 of the Municipal Code, it is the duty of the Contractor to report to the Inspector General, directly and without undue delay, any and all information concerning conduct which it knows to involve corrupt activity. "Corrupt Activity" means any conduct set forth in Subparagraph (a)(1), (2) or (3) of §1-23-020 of the Municipal Code. Knowing failure to make such a report will be an event of default under this Agreement. Reports may be made to the Inspector General's toll-free hotline, 866-IG-TIPLINE (866-448-4754).

6.20 Policy Prohibiting Sexual Harassment

Contractor shall attest by affidavit that Contractor has a written policy prohibiting sexual harassment that shall include, at a minimum, the following information: (i) the illegality of sexual harassment; (ii) the definition of sexual harassment; and (iii) the legal recourse available for victims of sexual harassment. Contractor's affidavit is attached hereto in Exhibit 9.

Contractor's failure to have a written policy prohibiting sexual harassment as provided above shall constitute an event of default. In the event of default, the City shall notify Contractor of such noncompliance and may, as appropriate: (i) issue Contractor an opportunity to cure consistent with the default provisions in this Agreement; (ii) terminate the Agreement; or (iii) take any other action consistent with the default provisions in Article 8. This Section 6.20 shall not be construed to prohibit the City from prosecuting any person who knowingly makes a false statement of material fact to the City pursuant to Chapter 1-21 of the Municipal Code, or from availing itself of any other remedies under the Agreement or law.

For purposes of this Section 6.20, "sexual harassment" means any unwelcome sexual advances or requests for sexual favors or conduct of a sexual nature when (i) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; (ii) submission to or rejection of such conduct by an individual is used as the basis for any employment decision affecting the individual; or (iii) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

6.21 Policy on Nondisclosure of Salary History

Contractor shall attest by affidavit (included as Appendix C to the first Economic Disclosure Statement set forth in Exhibit 4) that Contractor has a policy that conforms to the following requirements:

(i) Contractor shall not screen job applicants based on their wage or salary history, including

A. by requiring that an applicant's prior wages, including benefits or other compensation, satisfy minimum or maximum criteria; or

B. by requesting or requiring an applicant to disclose prior wages or salary, either (a) as a condition of being interviewed, (b) as a condition of continuing to be considered for an offer of employment, (c) as a condition of an offer of employment or an offer of compensation, or (d) as a condition of employment; and

(ii) Contractor shall not seek an applicant's wage or salary history, including benefits or other compensation, from any current or former employer.

If Contractor violates the above requirements, Contractor may be deemed ineligible to contract with the City, and any contract, extension, or renewal thereof awarded in violation of the above requirements may be voidable at the option of the City; provided, however, that upon a finding of a violation by Contractor, no contract shall be voided, terminated, or revoked without consideration by the City of such action's impact on the Contractor's MBE or WBE Subcontractors.

6.22 Deemed Inclusion

Provisions required by law, ordinances, rules, regulations, or executive orders to be inserted in this Agreement are deemed inserted in this Agreement whether or not they appear in this Agreement or, upon application by either party, this Agreement will be amended to make the insertion; however, in no event will the failure to insert the provisions before or after this Agreement is signed prevent its enforcement.

6.23 Acknowledgement of Non-ERISA Status

Contractor hereby acknowledges that the City has informed Contractor that the Agreement, and any component of a City benefit plan are not subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), and that neither the Contractor nor any of its Subcontractors are to represent or act otherwise. Contractor is responsible for ensuring that its Subcontractors comply with this acknowledgement, and, if a Subcontractor does not do so, Contractor is responsible for terminating such relationship and securing the services of another Subcontractor as needed.

ARTICLE 7. SPECIAL CONDITIONS

7.1 Warranties and Representations

In connection with signing and carrying out this Agreement, Contractor warrants or represents to the City as follows:

(a) In general, Contractor:

(i) warrants that it and its Subcontractors are appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which Contractor is not appropriately licensed;

(ii) warrants that Participating Providers are available in the geographic areas specified by the City and include sufficient numbers to readily provide reasonable access to Covered Persons;

(iii) warrants that it has established and maintains written agreements with Participating Providers that require such Participating Providers to cooperate with Utilization Review programs;

(iv) warrants that it has established and maintains written agreements with Participating Providers that encourage such Participating Providers to make referrals to other Participating Providers;

(v) warrants that its written agreements with Participating Providers are in compliance with all applicable federal, state and local laws, rules and regulations;

(vi) warrants it is financially solvent; it and each of its employees, agents and Subcontractors of any tier are competent to perform the Services required under this Agreement; and Contractor is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

(vii) warrants that it will not knowingly use the services of any ineligible contractor or Subcontractor for any purpose in the performance of its Services under this Agreement;

(viii) warrants that it and its Subcontractors are not in default at the time this Agreement is signed, and have not been deemed by the City to have, within five years immediately preceding the date of this Agreement, been found to be in default on any contract awarded by the City;

(ix) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this Agreement; this Agreement is feasible of performance in accordance with all of its provisions

and requirements, and Contractor warrants it can and will perform, or cause to be performed, the Services in strict accordance with the provisions and requirements of this Agreement;

(x) represents that Contractor and, to the best of its knowledge, its Subcontractors are not in violation of the provisions of §2-92-320 of the Municipal Code, and in connection with it, and additionally in connection with the Illinois Criminal Code, 720 ILCS 5/33E as amended, and the Illinois Municipal Code, 65 ILCS 5/11-42.1-1;

(xi) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 8.2 and 8.3 of this Agreement; and

(xii) warrants and represents that neither Contractor nor an Affiliate of Contractor appears on the Specially Designated Nationals List, the Denied Persons List, the unverified List, the Entity List, or the Debarred List as maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or by the Bureau of Industry and Security of the U.S. Department of Commerce (or their successors), or on any other list of persons or entities with which the City may not do business under any applicable law, rule, regulation, order or judgment.

(b) As to Contractor's Participating Providers:

(i) Contractor has established and maintains its Participating Network for the provision of PPO Services to Covered Persons under the PPO Plan(s). The PPO Providers are geographically distributed and include sufficient numbers to readily provide reasonable access to covered medical care for Covered Persons. Contractor has contracted with specialty care physicians in sufficient quantity and with sufficient geographic dispersion to readily provide reasonable access to prevent delay in the receipt of covered medically necessary specialty care by Covered Persons. Contractor will notify City promptly of any significant changes to the Participating Network and Other Hospitals Network. Further, when commercially reasonable, Contractor contracts with the Hospital-based physicians who provide Covered Services to Covered Persons at Medical PPO Plan contracted Hospitals; Contractor will use commercially reasonable efforts to keep such contracts in force during the term of this Agreement, subject to any legal limitations to which Contractor may be subject.

(ii) Contractor has established and maintains its Other Hospitals Network for the provision of Out-of-Network Services to Covered Persons under the PPO Plan(s) if the Covered Person chooses to use such a Facility.

(iii) Contractor shall use commercially reasonable efforts to maintain the Other Hospitals Networks during the term of this Agreement so that access to covered medical care provided by Participating Providers is not materially degraded, and remains in accordance with all other terms and conditions set out in this Agreement, subject to any legal limitations to which Contractor may be subject.

(iv) Contractor has established, maintains and operates in accordance with standards, policies and procedures, subject to change from time to time, pursuant to which it monitors, evaluates and terminates Participating Providers. A copy of such policies and

procedures must be furnished to the City, which must be updated to remain in compliance with the most current version.

(v) Contractor has established and will maintain, so long as this Agreement is in effect, written agreements with any and all Providers in the Participating Network. Said written agreements must at a minimum contain terms and conditions to provide for the following:

A. The Provider will not discriminate in any manner as to treatment between Covered Persons under this Agreement and any other patients of Provider;

B. The Provider will not balance bill Covered Persons for medically necessary or any other services under this Agreement and will look only to Contractor for payment;

C. The Provider will not bill the Covered Person for services that are not medically necessary;

D. The Provider will cooperate with Utilization Review activities including, without limitation, those of the City's third party vendors;

E. The Provider will cooperate with the quality assurance, peer review, credentialing, and management activities of Contractor;

F. The Provider will cooperate fully with any complaint appeal and grievance procedure program established and maintained under the PPO Plan;

G. The Provider will give 90 days' written notice of termination of the Participating Network contract;

H. The Provider will use his/her reasonable efforts to refer Covered Persons to other Participating Network Providers for Covered Services which the Provider cannot provide; including, but not limited to, specialist care;

I. Provider shall permit Contractor or its designees, upon reasonable notice and during normal business hours, to have, without charge, access to and the right to examine, audit, excerpt and transcribe any books, documents, papers and records relating to Covered Person's medical and billing information within the possession of the Provider and to inspect the Provider's operations, which involve transactions relating to Covered Persons and as may be reasonably required by the Contractor in carrying out its responsibilities and programs, including, but not limited to,

assessing quality of care, medical necessity, appropriateness of care, and accuracy of billing and payment; and

J. Providers will agree to act in a manner substantially consistent with all applicable terms and conditions of this Agreement and the Plans as set forth in Exhibit 1-A.

(vi) Contractor agrees that it will not include in its contracts with Providers a provision allowing Provider to bill for the transfer of medical records.

(vii) Contractor warrants that it also has written agreements with the Other Hospitals Network that include the terms of (v), A. through C. above.

(viii) Contractor warrants that its written contracts with Providers will include the requirements that Provider will use best efforts to secure and maintain all Hospital-based physicians' participation in the Contractor's Participating Network and other managed care networks in which the Hospital participates, including the following physicians:

A. Radiologists;

B. Pathologists;

C. Anesthesiologists;

D. Emergency Medicine Physicians; and

E. Emergency Surgical Physicians (Trauma Surgeons)

(ix) Contractor's written agreements with Participating Providers and Other Hospitals Network Providers are in compliance with any applicable federal, state and local laws, rules and regulations and will continue to be throughout the term of this Agreement.

(x) Contractor performs ongoing monitoring of its Participating Providers and Other Hospitals Network Providers as set forth in Exhibit 1 and to the extent required to maintain the standards of the Participating Network and will take action consistent with Contractor's policies and procedures, including, when appropriate, terminating a Provider from the network if it does not meet the participation standards for the Participating Network and/or if there are excessive numbers of complaints by Covered Persons, consistently inappropriate utilization, unacceptable quality of care or billing of Covered Persons which is not in accordance with the Participating Provider and Other Hospitals Network Providers contract and Contractor will assure that such contracts have commercially reasonable termination provisions.

(xi) Contractor is and shall remain compliant with local, state and federal laws, ordinances, regulations and statutes applicable to Contractor's performance of Services under this Agreement.

(xii) Contractor warrants and ensures that at all times Services provided hereunder will be designed to encourage health care Providers to provide services to Covered

Persons enrolled in the PPO Plan in accordance with accepted medical and Hospital standards prevailing in the community at the time the services are rendered; and to encourage the provision of such services consistent with the Participating Provider's training, experience, specialization, if any, and the ethics of his/her profession and such services will be provided at such times and places as necessary for the prompt and proper delivery of medical care.

(xiii) Contractor agrees to notify the City promptly of any change in a Participating Provider's office location, telephone number, hours of operation, and/or any material change in any Participating Providers' group's ability to provide or arrange for services under this Agreement.

(xiv) Contractor further agrees to make all medical records in Contractor's possession available, at no cost and at reasonable times, for inspection by a designated representative of Covered Person and/or the City subject to pertinent laws and further subject to the audit provisions of this Agreement.

(xv) Contractor hereby states and warrants that each Participating Provider is required to be licensed to practice medicine in the state of Illinois and/or any state where services are rendered and has Hospital staff privileges in locations necessary to adequately service Covered Persons (as reasonably determined by the City) and that Contractor will make reasonable efforts to verify that each Participating Provider has complied with and remains in compliance with the requirements set forth in this subsection (xv).

(xvi) Contractor hereby states and warrants that all of Contractor's contracted Hospitals and Facilities providing any Covered Services as described in this Agreement are required to fulfill all accreditation standards of the Joint Commission or any other nationally recognized accrediting body.

(xvii) Contractor agrees to require all parties providing Covered Services as described in this Agreement, with whom Contractor has agreements, including but not limited to Participating Providers, to contract in writing with Contractor to act in a manner substantially consistent with the applicable terms of this Agreement.

(xviii) Contractor agrees to inform the City promptly of any material changes in methodology as to how Providers in Contractor's service area are compensated.

7.2 Ethics

(a) In addition to the foregoing warranties and representations, Contractor warrants:

(i) no officer, agent or employee of the City is employed by Contractor or has a financial interest directly or indirectly in this Agreement or the compensation to be paid under this Agreement except as may be permitted in writing by the Board of Ethics established under Chapter 2-156 of the Municipal Code;

(ii) no payment, gratuity or offer of employment will be made in connection with this Agreement by or on behalf of any Subcontractors to Contractor or higher tier

Subcontractors or anyone associated with them, as an inducement for the award of a subcontract or order; and

(b) Contractor will comply with Chapter 2-156 of the Municipal Code. Contractor acknowledges that any Agreement entered into, negotiated or performed in violation of any of the provisions of Chapter 2-156, including any contract entered into with any person who has retained or employed a non-registered lobbyist in violation of Section 2-156-305 of the Municipal Code is voidable as to the City.

7.3 Joint and Several Liability

If Contractor, or its successors or assigns, if any, is comprised of more than one individual or other legal entity (or a combination of them), then under this Agreement, each and without limitation every obligation or undertaking in this Agreement to be fulfilled or performed by Contractor is the joint and several obligation or undertaking of each such individual or other legal entity.

7.4 Business Documents

At the request of the City, Contractor must provide copies of its latest articles of incorporation, by-laws and resolutions, or partnership or joint venture agreement, as applicable.

7.5 Conflicts of Interest

(a) No member of the governing body of the City or other unit of government and no other officer, employee or agent of the City or other unit of government who exercises any functions or responsibilities in connection with the Services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. No member of or delegate to the Congress of the United States or the Illinois General Assembly and no alderman of the City or City employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.

(b) Contractor represents that it, and to the best of its knowledge, its Subcontractors if any (Contractor and Subcontractors will be collectively referred to in this Section 7.5 as "Contracting Parties"), presently have no direct or indirect interest and will not acquire any direct or indirect interest in any project or contract that would conflict in any manner or degree with the performance of its Services under this Agreement.

(c) Upon the request of the City, Contracting Parties must disclose to the City their past client lists and the names of any clients with whom they have an ongoing relationship. Contracting Parties are not permitted to perform any Services for the City on applications or other documents submitted to the City by any of Contracting Parties' past or present clients. If Contracting Parties become aware of a conflict, they must immediately stop work on the assignment causing the conflict and notify the City.

(d) Without limiting the foregoing, if the Contracting Parties assist the City in determining the advisability or feasibility of a project or in recommending, researching, preparing, drafting or issuing a request for proposals or bid specifications for a project, the

Contracting Parties must not participate, directly or indirectly, as a prime, subcontractor or joint venturer in that project or in the preparation of a proposal or bid for that project during the term of this Agreement or afterwards. The Contracting Parties may, however, assist the City in reviewing the proposals or bids for the project if none of the Contracting Parties have a relationship with the persons or entities that submitted the proposals or bids for that project.

(e) Further, Contracting Parties must not assign any person having any conflicting interest to perform any Services under this Agreement or have access to any confidential information, as described in Section 2.12 of this Agreement. If the City, by the Commissioner in his reasonable judgment, determines that any of Contracting Parties' services for others conflict with the Services that Contracting Parties are to render for the City under this Agreement, Contracting Parties must terminate such other services immediately upon request of the City.

(f) Furthermore, if any federal funds are to be used to compensate or reimburse Contractor under this Agreement, Contractor represents that it is and will remain in compliance with federal restrictions on lobbying set forth in Section 319 of the Department of the Interior and Related Agencies Appropriations Act for Fiscal Year 1990, 31 U.S.C. §1352, and related rules and regulations set forth at 54 Fed. Reg. 52,309 ff. (1989), as amended. If federal funds are to be used, Contractor must execute a Certification Regarding Lobbying, which is part of the EDS and incorporated by reference as if fully set forth here.

7.6 Non-Liability of Public Officials

Contractor and any assignee or Subcontractor of Contractor must not charge any official, employee or agent of the City personally with any liability or expenses of defense or hold any official, employee or agent of the City personally liable to them under any term or provision of this Agreement or because of the City's execution, attempted execution or any breach of this Agreement.

7.7 Certification Regarding Suspension and Debarment

Contractor certifies, as further evidenced in the EDS attached as Exhibit 4, by its acceptance of this Agreement that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. Contractor further agrees by executing this Agreement that it will include this clause without modification in all lower tier transactions, solicitations, proposals, contracts and subcontracts. If Contractor or any lower tier participant is unable to certify to this statement, it must attach an explanation to the Agreement.

ARTICLE 8. EVENTS OF DEFAULT, REMEDIES, TERMINATION, SUSPENSION AND RIGHT TO OFFSET

8.1 Events of Default Defined

The following constitute events of default:

(a) Any material misrepresentation, whether negligent or willful and whether in the inducement or in the performance, made by Contractor to the City.

(b) Contractor's material failure to perform any of its obligations under this Agreement including the following:

(i) Any material misrepresentation, whether negligent or willful and whether in the inducement or in the performance, made by Contractor to the City;

(ii) Failure to perform the Services with sufficient personnel and equipment or with sufficient material to ensure the timely performance of the Services;

(iii) Failure to have and maintain all professional licenses required by law to perform the Services;

(iv) Failure to timely perform the Services;

(v) Failure to perform the Services in a manner reasonably satisfactory to the City or inability to perform the Services satisfactorily as a result of insolvency, filing for bankruptcy or assignment for the benefit of creditors;

(vi) Failure to promptly re-perform, as required, within a reasonable time and at no cost to the City, Services that are rejected as erroneous or unsatisfactory;

(vii) Discontinuance of the Services for reasons within Contractor's reasonable control;

(viii) Failure to comply with Section 6.1 in the performance of the Agreement;

(ix) Failure promptly to update EDS(s) furnished in connection with this Agreement when the information or responses contained in it or them is no longer complete or accurate;

(x) Failure to comply with any other material term of this Agreement, including the provisions concerning insurance and nondiscrimination;

(xi) Any change in ownership or control of Contractor without the prior written approval of the City (when such prior approval is permissible by law), which approval the City will not unreasonably withhold;

(xii) Contractor's default under any other agreement it may presently have or may enter into with the City for the duration of this Agreement. Contractor acknowledges that in the event of a default under this Agreement the City may also declare a default under any such other agreements;

(xiii) Contractor's violation of City ordinance(s) unrelated to performance under the Agreement such that, in the opinion of the City, it indicates a willful or reckless disregard for City laws and regulations;

(xiv) Contractor's violation of, non-compliance with, misrepresentation with respect to, or breach of any covenant or warranty under Mayoral Executive Order No. 2011-4;

(xv) Contractor's use of a Subcontractor that is currently debarred by the City or otherwise ineligible to do business with the City; and

(xvi) Any other acts specifically stated in this Agreement as constituting an act of default.

8.2 Remedies

(a) Notices. The occurrence of any event of default permits the City, at the City's sole option, to declare Contractor in default. The City may in his sole discretion give Contractor an opportunity to cure the default within a certain period of time, which period of time must not exceed 30 days unless extended by the City. Whether to declare Contractor in default is within the sole discretion of the City and neither that decision nor the factual basis for it is subject to review or challenge under the Disputes provision of this Agreement.

The City will give Contractor written notice of the default, either in the form of a cure notice ("**Cure Notice**"), or, if no opportunity to cure will be granted, a default notice ("**Default Notice**"). If the City gives a Default Notice, the City will indicate whether it has any present intent to terminate this Agreement, and the decision to terminate is final and effective upon giving the notice. If the City decides not to terminate, this decision will not preclude the City from later deciding to terminate the Agreement in a later notice, which will be final and effective upon the giving of the notice or on the date set forth in the notice, whichever is later. The City may give a Default Notice if Contractor fails to effect a cure within the cure period given in a Cure Notice. When a Default Notice with intent to terminate is given as provided in this Section 8.2 and Article 10, Contractor must discontinue any Services, unless otherwise directed in the notice, and deliver all materials accumulated in the performance of this Agreement, whether completed or in the process, to the City.

(b) Exercise of Remedies. After giving a Default Notice, the City may invoke any or all of the following remedies:

(i) The right to take over and complete the Services, or any part of them, at Contractor's expense and as agent for Contractor, either directly or through others, and bill Contractor for the cost of the Services, and Contractor must pay the difference between the total amount of this bill and the amount the City would have paid Contractor under the terms and conditions of this Agreement for the Services that were assumed by the City as agent for Contractor under this Section 8.2;

(ii) The right to terminate this Agreement as to any or all of the Services yet to be performed effective at a time specified by the City;

(iii) The right of specific performance, an injunction or any other appropriate equitable remedy;

(iv) The right to money damages;

(v) The right to withhold all or any part of Contractor's compensation under this Agreement;

(vi) The right to deem Contractor non-responsible in future contracts to be awarded by the City;

(vii) The right to declare default on any other contract or agreement Contractor may have with the City.

(c) City's Reservation of Rights. If the City considers it to be in the City's best interests, it may elect not to declare default or to terminate this Agreement. The parties acknowledge that this provision is solely for the benefit of the City and that if the City permits Contractor to continue to provide the Services despite one or more events of default, Contractor is in no way relieved of any of its responsibilities, duties or obligations under this Agreement, nor does the City waive or relinquish any of its rights.

(d) Non-Exclusivity of Remedies. The remedies under the terms of this Agreement are not intended to be exclusive of any other remedies provided, but each and every such remedy is cumulative and is in addition to any other remedies, existing now or later, at law, in equity or by statute. No delay or omission to exercise any right or power accruing upon any event of default impairs any such right or power, nor is it a waiver of any event of default nor acquiescence in it, and every such right and power may be exercised from time to time and as often as the City considers expedient.

8.3 Early Termination

(a) In addition to termination under Sections 8.1 and 8.2 of this Agreement, the City may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by a notice in writing from the City to Contractor. The City will give notice to Contractor in accordance with the provisions of Article 10. The effective date of termination will be the date the notice is received by Contractor or the date stated in the notice, whichever is later. If the City elects to terminate this Agreement in full, all Services to be provided under it must cease and all materials that may have been accumulated in performing this Agreement, whether completed or in the process, must be delivered to the City effective 10 days after the date the notice is considered received as provided under Article 10 of this Agreement (if no date is given) or upon the effective date stated in the notice.

(b) After the notice is received, Contractor must restrict its activities, and those of its Subcontractors, to winding down any reports, analyses, or other activities previously begun. No costs incurred after the effective date of the termination are allowed. Payment for any Services actually and satisfactorily performed before the effective date of the termination is on the same basis as set forth in Article 4, but if any compensation is described or provided for on the basis of a period longer than 10 days, then the compensation must be prorated accordingly. No amount of compensation, however, is permitted for anticipated profits on unperformed Services. The City and Contractor must attempt to agree on the amount of compensation to be paid to Contractor, but if not agreed on, the dispute must be settled in accordance with Article 5 of this Agreement. The payment so made to Contractor is in full settlement for all Services satisfactorily performed under this Agreement.

(c) Contractor must include in its contracts with Subcontractors an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the City arising from termination of subcontracts after the early termination. Contractor will not be entitled to make any early termination claims against the City resulting from any Subcontractor's claims against Contractor or the City.

(d) If the City's election to terminate this Agreement for default under Sections 8.1 and 8.2 is determined in a court of competent jurisdiction to have been wrongful, then in that case the termination is to be considered to be an early termination under this Section 8.3.

8.4 Suspension

The City may at any time request that Contractor suspend its Services, or any part of them, by giving 15 days prior written notice to Contractor or upon informal oral, or even no notice, in the event of emergency. No costs incurred after the effective date of such suspension are allowed. Contractor must promptly resume its performance of the Services under the same terms and conditions as stated in this Agreement upon written notice by the City and such equitable extension of time as may be mutually agreed upon by the City and Contractor when necessary for continuation or completion of Services. Any additional costs or expenses actually incurred by Contractor as a result of recommencing the Services must be treated in accordance with the compensation provisions under Article 4 of this Agreement.

No suspension of this Agreement is permitted in the aggregate to exceed a period of 45 days within any one year of this Agreement. If the total number of days of suspension exceeds 45 days, Contractor by written notice to the City may treat the suspension as an early termination of this Agreement under Section 8.3.

8.5 Right to Offset

(a) In connection with Contractor's performance under this Agreement, the City may offset any incremental costs and other damages the City incurs in any or all of the following circumstances:

(i) if the City terminates this Agreement for default or any other reason resulting from Contractor's performance or non-performance;

(ii) if the City exercises any of its remedies under Section 8.2 of this Agreement;

(iii) if the City has any credits due or has made any overpayments under this Agreement.

The City may offset these incremental costs and other damages by use of any payment due for Services completed before the City terminated this Agreement or before the City exercised any remedies. If the amount offset is insufficient to cover those incremental costs and other damages, Contractor is liable for and must promptly remit to the City the balance upon written demand for it. This right to offset is in addition to and not a limitation of any other remedies available to the City.

(b) As provided under §2-92-380 of the Municipal Code, the City may set off from Contractor's compensation under this Agreement an amount equal to the amount of the fines and penalties for each *outstanding parking violation complaint* and the amount of any *debt* owed by Contractor to the City as those italicized terms are defined in the Municipal Code.

(c) In connection with any liquidated or unliquidated claims against Contractor, and without breaching this Agreement, the City may set off a portion of the price or compensation due under this Agreement in an amount equal to the amount of any liquidated or unliquidated claims that the City has against Contractor unrelated to this Agreement. When the City's claims against Contractor are finally adjudicated in a court of competent jurisdiction or otherwise resolved, the City will reimburse Contractor to the extent of the amount the City has offset against this Agreement inconsistently with such determination or resolution.

ARTICLE 9. GENERAL CONDITIONS

9.1 Entire Agreement

(a) **General**

This Agreement, and the exhibits attached to it and incorporated in it, constitute the entire agreement between the parties and no other terms, conditions, warranties, inducements, considerations, promises or interpretations are implied or impressed upon this Agreement that are not addressed in this Agreement.

(b) **No Collateral Agreements**

Contractor acknowledges that, except only for those representations, statements or promises contained in this Agreement and any exhibits attached to it and incorporated by reference in it, no representation, statement or promise, oral or in writing, of any kind whatsoever, by the City, its officials, agents or employees, has induced Contractor to enter into this Agreement or has been relied upon by Contractor, including any with reference to: (i) the meaning, correctness, suitability or completeness of any provisions or requirements of this Agreement; (ii) the nature of the Services to be performed; (iii) the nature, quantity, quality or volume of any materials, equipment, labor and other facilities needed for the performance of this Agreement; (iv) the general conditions which may in any way affect this Agreement or its performance; (v) the compensation provisions of this Agreement; or (vi) any other matters, whether similar to or different from those referred to in (i) through (vi) immediately above, affecting or having any connection with this Agreement, its negotiation, any discussions of its performance or those employed or connected or concerned with it.

(c) **No Omissions**

Contractor acknowledges that Contractor was given ample opportunity and time and was requested by the City to review thoroughly all documents forming this Agreement before signing this Agreement in order that it might request inclusion in this Agreement of any statement, representation, promise or provision that it desired or on that it wished to place reliance. Contractor did so review those documents, and either every such statement, representation, promise or provision has been included in this Agreement or else, if omitted, Contractor

relinquishes the benefit of any such omitted statement, representation, promise or provision and is willing to perform this Agreement in its entirety without claiming reliance on it or making any other claim on account of its omission.

9.2 Counterparts

This Agreement is comprised of several identical counterparts, each to be fully signed by the parties and each to be considered an original having identical legal effect.

9.3 Amendments

Except as provided in Section 3.3 of this Agreement, no changes, amendments, modifications or discharge of this Agreement, or any part of it are valid unless in writing and signed by the authorized agent of Contractor and by the Mayor or his or her respective successors and assigns. The City incurs no liability for Additional Services without a written amendment to this Agreement under this Section 9.3.

Whenever under this Agreement Contractor is required to obtain the City's prior written approval, the effect of any approval that may be granted pursuant to Contractor's request is prospective only from the later of the date approval was requested or the date on which the action for which the approval was sought is to begin. In no event is approval permitted to apply retroactively to a date before the approval was requested.

9.4 Governing Law and Jurisdiction

This Agreement is governed as to performance and interpretation in accordance with the laws of the State of Illinois without regard to choice of law principles.

Contractor irrevocably submits itself to the original jurisdiction of those courts located within the County of Cook, State of Illinois, with regard to any controversy arising out of, relating to, or in any way concerning the execution or performance of this Agreement. Service of process on Contractor may be made, at the option of the City, either by registered or certified mail addressed to the applicable office as provided for in this Agreement, by registered or certified mail addressed to the office actually maintained by Contractor, or by personal delivery on any officer, director, or managing or general agent of Contractor. If any action is brought by Contractor against the City concerning this Agreement, the action must be brought only in those courts located within the County of Cook, State of Illinois. The Contractor irrevocably waives any objection (including without limitation any objection of the laying of venue or based on the grounds of forum non conveniens) which it may now or hereafter have to the bringing of any action or proceeding with respect to this Agreement in the jurisdiction set forth above.

9.5 Severability

If any provision of this Agreement is held or deemed to be or is in fact invalid, illegal, inoperative or unenforceable as applied in any particular case in any jurisdiction or in all cases because it conflicts with any other provision or provisions of this Agreement or of any constitution, statute, ordinance, rule of law or public policy, or for any other reason, those circumstances do not have the effect of rendering the provision in question invalid, illegal,

inoperative or unenforceable in any other case or circumstances, or of rendering any other provision or provisions in this Agreement invalid, illegal, inoperative or unenforceable to any extent whatsoever. The invalidity, illegality, inoperativeness or unenforceability of any one or more phrases, sentences, clauses or sections in this Agreement does not affect the remaining portions of this Agreement or any part of it.

9.6 Assigns

All of the terms and conditions of this Agreement are binding upon and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

9.7 Cooperation

Contractor must at all times cooperate fully with the City and act in the City's best interests. If this Agreement is terminated for any reason, or if it is to expire on its own terms, Contractor must make every effort to promote an orderly transition to another provider of the Services for the Benefits, if any, orderly demobilization of its own operations in connection with the Services for the Benefits, and uninterrupted provision of Services and Benefits during any transition period, and must otherwise comply with the reasonable requests and requirements of the Benefits Manager in connection with the termination or expiration as provided by this Section.

(a) General Obligations

In connection with any expiration or termination of this Agreement or of the provision of any of the Services provided hereunder, each party must take all actions necessary to accomplish a complete and timely transition from Contractor to the City, or to any replacement providers (collectively, the "New Contractor or "NC") designated by the City of the Services being terminated (a "Transition"), without any interruption of or adverse impact on the Services or any other services provided by third parties. Each party must cooperate in a reasonable way with the other and the NC and otherwise take reasonable steps required to assist the City in effecting a complete and timely Transition. Each party must provide the other and the NC with reasonable information regarding the Services or as is otherwise needed for Transition, must provide for the prompt and orderly conclusion of all Services, as the City may direct, including completing or partial completion of Services, documentation of Services in process, and other measures to assure an orderly Transition. Contractor's obligation to provide the Services shall not cease until the later of (i) completion of a Transition reasonably satisfactory to the City, including the performance by Contractor of all obligations of Contractor provided in this Section and processing of PPO Claims incurred prior to the termination date or (ii) the expiration of the Outstanding PPO Claim Period (as defined in Section 9.7(d)(ii)). With respect to Contractor's provision of Services or files described in this Agreement or otherwise reasonably requested during a Transition, City and Contractor agree there will be no charges to the City, other than those described in this Agreement, for the Transition services and files provided that the files are in the Contractor's standard file format and layout for Transition services.

(b) Process

The Transition process shall begin on the date any termination notice is delivered, if the City elects to terminate any or all of the Services pursuant to the terms of this Agreement or whenever requested by the City prior to expiration of the Agreement. Subject to Contractor's obligation to perform Services, the City's obligation to pay fees for Services shall expire on the termination or expiration date, except, however, that Contractor will remain obligated to provide Services until the City reasonably determines that a Transition satisfactory to the City has occurred. Contractor and the City will discuss in good faith a plan for determining the nature and extent of Contractor obligations and for the transfer of Services in process, except, however, that Contractor's obligation under this Agreement to provide all Services necessary for Transition will not be lessened in any respect. Contractor will be required to perform its Transition obligations on an expedited basis as reasonably determined by the City.

(c) Specific Obligations

The Transition includes but is not limited to the performance of the following specific obligations:

(i) Full Cooperation and Information

From and after the commencement of the Transition activities, Contractor must cooperate fully with the City and the NC to facilitate a smooth transition of the Services being terminated from Contractor to the City or the NC. Such cooperation includes the provision (both before and after the cessation of Contractor's providing all or any part of the Services under this Agreement) by Contractor to the City of full, complete, detailed, and sufficient information (including all information then being utilized by Contractor) to enable the City's personnel (or that of the NC) to fully assume and continue without interruption the provision of the Services in a manner consistent with the Plan provisions, the Scope of Services set forth in Exhibit 1, and the City's role as the sponsor of the PPO Plan.

(ii) No Interruption or Adverse Impact

Contractor must cooperate with the City and all of the City's other service providers and the NC to ensure a smooth transition at the time of Transition, with no interruption of Services, no adverse impact on the provision of Services or the City's activities, no interruption of any services provided by third parties, and no adverse impact on the provision of services by third parties.

(iii) Third-Party Authorizations

Without limiting the obligations of Contractor, Contractor must, subject to the terms of any subcontracts, procure at no charge to the City any third-party authorizations necessary to grant the City and any NC the use and benefit of subcontracts between Contractor and Subcontractors used to provide the Services.

(iv) Delivery of Documentation and Data; Preparation for Transition; Complete Documentation

Contractor must deliver to the City or any NC, at the City's request, sufficient information when reasonably necessary to support any Transition of the City's Plan including all documentation, data (as provided in Section 3.8 Records and Audits), materials, business rules and logic documentation, and Claim payment and medical policies that are used in administration of the Plan to the extent not included in the City's Plan documents to enable the City, or its NC, to provide for the continuity of administrative services provided under this Agreement. If such information includes any of Contractor's Business Proprietary Information, then Contractor reserves the right to modify the format and require confidentiality protection from NC. Following Transition, upon reasonable request by the City, Contractor will provide to the City such information within Contractor's possession and control sufficient for the City's business purpose requested, subject to protection of Business Proprietary Information under this Agreement. The City shall pay reasonable charges for such services.

(v) All Necessary Cooperation and Actions

Contractor must provide all cooperation, take such additional actions, and perform such additional tasks as may be necessary to ensure a timely and orderly Transition in compliance with the provisions of this Section 10.7, including full performance, of Contractor's obligations under this Section 10.7.

(d) Outstanding Claims at Termination, Expiration, or Suspension

(i) The City acknowledges that on the date of termination, expiration, or suspension of this Agreement there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Contractor for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid or adjudicated by the Contractor. The City shall be responsible for the reimbursement to Contractor of all Claim payments made by Contractor in accordance with the applicable Plan rendered or furnished to a Covered Person prior to the date of termination, expiration, or suspension of the Agreement, whether or not Claims for such services have been submitted, as of the date of termination, expiration, or suspension including, but not limited to, payments made in accordance with Medicare Secondary Payer laws. ***The following applies to medical HMO and PPO only:*** If a Covered Person is an Inpatient at the time the Agreement terminates, expires, or is suspended, the Contractor may make payments for Benefits for Covered Services which are provided by the Hospital or other Facility Provider until the Covered Person is discharged provided that the days are medically necessary or until the Covered Services for the Covered Person are transferred to the NC, whichever occurs first. The City will reimburse the Contractor for payments made to Providers in accordance with the Agreement.

(ii) In consideration of the Contractor's continuing to make such payments and rendering these Transition services, the City will continue to reimburse Contractor for a 24-month period after the effective date of termination for proper payments made by Contractor for Claims for Benefits rendered by Providers prior to the termination date of the Agreement and paid during such 24-month period (the "Outstanding Claim Period"). ***Applicable to self insured services only:*** In addition, the City will pay Contractor an amount equal to _____% of the sum of the administrative fees charged in the 12-month period immediately preceding the

effective date of termination (the "Runout Fee"). 50% of this Runout Fee will be paid in 24 equal monthly installments during the Outstanding Claim Period; the remaining 50% will be paid within the 60-day period following the close of the Outstanding Claim Period.

(iii) At the end of the Outstanding Claim Period, Contractor will provide the City and the NC, if any, all information related to Claims for Benefits rendered prior to the termination of the Agreement but not yet paid by necessary for the processing and adjudication of such Claims by the City or the NC, if any.

(iv) A final reimbursement for Services will be made within 60 days after the last day of the Outstanding Claim Period subject to reconciliation as provided under Exhibit 3 and audit as provided under Section 3.8.

(v) This Section 9.7(d), like all payment provisions under this Agreement, shall be subject to the terms of Section ____, and to the extent that there is any contradiction between Section 9.7(d) and the terms of Section ____, Section _____ shall control.

9.8 Waiver

Nothing in this Agreement authorizes the waiver of a requirement or condition contrary to law or ordinance or that would result in or promote the violation of any federal, state or local law or ordinance.

A waiver of any breach of the Agreement shall not be held to be a waiver of any other or subsequent breach. Whenever under this Agreement the City by a proper authority waives the Contractor's performance in any respect or waives a requirement or condition to either the City's or the Contractor's performance, the waiver so granted, whether express or implied, shall only apply to the particular instance and will not be deemed a waiver forever or for subsequent instance of the performance, requirement, or condition. No such waiver shall be construed as a modification of this Agreement regardless of the number of times the City may have waived the performance, requirement, or condition.

9.9 No Third Party Beneficiaries

The Parties agree that this Agreement is solely for the benefit of the Parties and nothing herein is intended to create any third party beneficiary rights for Covered Persons, Subcontractors, or other third parties.

9.10 Independent Contractor

This Agreement is not intended to and does not constitute, create, give rise to, or otherwise recognize a joint venture, partnership, corporation or other formal business association or organization of any kind between Contractor and the City. The rights and the obligations of the parties are only those set forth in this Agreement. Contractor must perform under this Agreement as an independent contractor and not as a representative, employee, agent, or partner of the City.

This Agreement is between the City and an independent contractor and, if Contractor is an individual, nothing provided for under this Agreement constitutes or implies an employer-employee relationship such that:

The City will not be liable under or by reason of this Agreement for the payment of any workers' compensation award or damages in connection with the Contractor performing the Services required under this Agreement.

Contractor is not entitled to membership in any City pension fund, group medical insurance program, group dental program, group vision care, group life insurance program, deferred income program, vacation, sick leave, extended sick leave, or any other benefits ordinarily provided to individuals employed and paid through the regular payrolls of the City.

The City is not required to deduct or withhold any taxes, FICA or other deductions from any compensation provided to Contractor.

9.11 Approvals

Whenever Contractor is required to obtain prior written approval, the effect of any approval that may be granted pursuant to Contractor's request is prospective only from the later of the date approval was requested or the date on which the action for which the approval was sought is to begin. In no event is approval permitted to apply retroactively to a date before the approval was requested.

ARTICLE 10. NOTICES

Notices provided for in this Agreement, unless provided for otherwise in this Agreement, must be given in writing and may be delivered personally or by placing in the United States mail, first class and certified, return receipt requested, with postage prepaid and addressed as follows:

If to the City:
Chicago Benefits Office
Department of Finance
Room 700, City Hall
121 North LaSalle Street
Chicago, Illinois 60602
Attention: Benefits Manager

With Copies to:
Department of Law
Room 600, City Hall
121 North LaSalle Street
Chicago, Illinois 60602
Attention: Corporation Counsel

If to Contractor:
_____
_____
_____
Attention:_____

Changes in these addresses must be in writing and delivered in accordance with the provisions of this Article 10. Notices delivered by mail are considered received three days after mailing in accordance with this Article 10. Notices delivered personally are considered effective upon receipt. Refusal to accept delivery has the same effect as receipt.

ARTICLE 11. AUTHORITY

Contractor represents and warrants that execution of this Agreement by the Contractor is authorized, and that signature(s) of each person signing on behalf of the Contractor have been made with complete and full authority to commit the Contractor to all terms and conditions of this Agreement, including each and every representation, certification, and warranty contained herein, attached hereto and collectively incorporated by reference herein, or as may be required by the terms and conditions hereof. If other than a sole proprietorship, Contractor must provide satisfactory evidence that the execution of the Agreement is authorized in accordance with the business entity's rules and procedures.

[Signature Pages, Exhibits and Schedules follow.]

SIGNATURE PAGE(S)

SIGNED at Chicago, Illinois:

CITY OF CHICAGO

By: _____
Mayor

CONTRACTOR[1]

By: _____

Its: _____

Attest: _____

[1] If Contractor is a joint venture or other legal entity for which this signature format is inappropriate, please substitute an appropriate signature page with appropriate attestation and notarization.

EXHIBIT 1
SCOPE OF SERVICES AND TIME LIMITS FOR PERFORMANCE

EXHIBIT 2
SCHEDULE OF COMPENSATION

EXHIBIT 3
SPECIAL CONDITIONS FOR MINORITY BUSINESS ENTERPRISES AND WOMEN'S BUSINESS ENTERPRISES, INCLUDING SCHEDULES C-1 AND D-1

EXHIBIT 4
ECONOMIC DISCLOSURE STATEMENT AND AFFIDAVIT

EXHIBIT 5
INSURANCE REQUIREMENTS AND
CERTIFICATES OF INSURANCE

Contractor must provide and maintain at Contractor's own expense, during the term of the Agreement and during the time period following expiration if Contractor is required to return and perform any Services or Additional Services, the insurance coverages and requirements specified below, insuring all Services related to the Agreement.

A. INSURANCE REQUIRED FROM CONTRACTOR

[Not included in this sample professional services agreement. Please See insurance requirements exhibit]

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B. Additional Requirements

1) Evidence of Insurance.

Contractor must furnish the City of Chicago, Department of Finance, Benefits Management Office, 333 South State Street, Room 400, Chicago, IL. 60604, original certificates of insurance and additional insured endorsement, or other evidence of insurance, to be in force on the date of this Agreement, and renewal certificates of insurance and endorsement, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Contractor must submit evidence of insurance prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain, nor the City's receipt of, or failure to object to a non-complying insurance certificate, endorsement or other insurance evidence from Contractor, its insurance broker(s) and/or insurer(s) will not be construed as a waiver by the City of any of the required insurance provisions. Contractor must advise all insurers of the Agreement provisions regarding insurance. The City in no way warrants that the insurance required herein is sufficient to protect Contractor against liabilities which may arise from or relate to the Agreement. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time.

2) Failure to Maintain Insurance.

Failure of the Contractor to comply with required coverage and terms and conditions outlined herein will not limit Contractor's liability or responsibility nor does it relieve Contractor of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

3) Notice of Material Change, Cancellation or Non-Renewal.

Contractor must provide 60 days' prior written notice to the City in the event coverage is substantially changed, canceled, or non-renewed, and ten days' prior written notice for non-payment of premium.

4) Deductibles and Self-Insured Retentions.

Any deductibles or self-insured retentions on referenced insurance coverages must be borne by Contractor.

5) Waiver of Subrogation.

Contractor hereby waives its rights and agrees to require its insurer(s) to waive its rights of subrogation against the City under all required insurance herein for any loss arising from or relating to this Agreement. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City received a waiver of subrogation endorsement for Contractor's insurer(s).

6) Contractor's Insurance Primary.

All insurance required of Contractor under this Agreement shall be endorsed to state that Contractor's insurance policy is primary and not contributory with any insurance carrier by the City.

7) No Limitation as to Contractor's Liabilities.

The coverages and limits furnished by Contractor in no way limit the Contractor's liabilities and responsibilities specified within the Agreement or by law.

8) No Contribution by City.

Any insurance or self-insurance programs maintained by the City do not contribute to insurance provided by Contractor under this Agreement.

9) Insurance not Limited by Indemnification.

The insurance required to be carried under this Exhibit 5 is not limited by any limitations expressed in Section 2.7 of the Agreement or any other limitation placed on indemnification under this Agreement given as a matter of law.

10) Insurance and Limits Maintained.

If Contractor maintains higher limits and/or broader coverage than the minimums set forth in this Exhibit 5, the City requires and shall be entitled the higher limits and/or broader coverage maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

11) Joint Venture or Limited Liability Company.

If Contractor is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

12) Other Insurance obtained by Contractor.

If Contractor desires additional coverages, the Contractor will be responsible for the acquisition and cost of such coverage.

13) Insurance required of Subcontractors.

Contractor shall name any Subcontractor(s) as a named insured(s) under Contractor's insurance or Contractor will require each Subcontractor(s) to provide and maintain Commercial General Liability, Commercial Automobile Liability, Workers Compensation and Employers Liability Insurance and when applicable Excess/Umbrella Liability Insurance with coverage at least as broad as in outlined in Section A. above, Insurance Required. The limits of coverage will be determined by Contractor. Contractor shall determine if Subcontractor(s) must also provide any additional coverage or other coverage outlined in Section A. above, Insurance Required. Contractor is responsible for ensuring that each Subcontractor has named the City as an additional insured where required and name the City as an additional insured on an endorsement form at least as broad and acceptable to the City. Contractor is also responsible for ensuring that each Subcontractor has complied with the required coverage and terms and conditions outlined in this Section B, Additional Requirements. When requested by the City, Contractor must provide to the City certificates of insurance and additional insured endorsements or other evidence of insurance. The City reserves the right to obtain complete, certified copies of any required insurance policies at any time. Failure of the Subcontractor(s) to comply with required coverage and terms and conditions outlined herein will not limit Contractor's liability or responsibility under this Agreement.

14) City's Right to Modify.

Notwithstanding any provisions in the Agreement to the contrary, the City, Department of Finance, Risk Management Office maintains the right to modify, delete, alter or change these requirements. Any agreed to changes will be reflected in a signed amendment to this Agreement.

EXHIBIT 6
BUSINESS ASSOCIATE AGREEMENT

The City of Chicago ("City") and _____ ("Business Associate") agree to the following terms and conditions, which are intended to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations:

The terms below that are capitalized and in bold have the same meanings as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, which is part of the American Recovery and Reinvestment Act of 2009, and the regulations promulgated thereunder, including the privacy, security, breach, omnibus, and enforcement rules, as each may be amended from time to time (collectively, "HIPAA"). See 45 CFR parts 160 and 164.

Specifically, the following terms used in the Business Associate Agreement shall have the same meaning as in HIPAA: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Financial Remuneration, Fundraising, Health Care Operations, Individual, Marketing, Minimum Necessary, Notice of Privacy Practices, Protected Health Information ("PHI"), Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use. The term "Breach" has the meaning as set forth in HIPAA when capitalized below, but has the ordinary dictionary meaning when not capitalized below.

For purposes of this Business Associate Agreement, the term "Protected Health Information" or "PHI" includes electronic PHI, also known as ePHI.

1. Interpretation of this Business Associate Agreement. A reference in this Business Associate Agreement to HIPAA means the section in effect or as amended. If there is a dispute as to whether Business Associate is, in fact, a Business Associate, the Business Associate must provide a legal memorandum to the City indicating why the Business Associate does not fall under the definition of Business Associate in HIPAA. If the City disagrees with the legal memorandum regarding the Business Associate's conclusion that Business Associate is not a Business Associate, the City may choose to report a Breach to the Secretary or take other measures as deemed necessary to ensure the City's compliance with HIPAA. Any ambiguity or inconsistency in this Business Associate Agreement shall be resolved in favor of a meaning that permits City to comply with HIPAA.

2. Amendment of this Business Associate Agreement. The parties hereto agree to negotiate in good faith to amend this Agreement from time to time as is necessary for City to comply with the requirements of HIPAA and for Business Associate to provide services to City. However, no change, amendment, or modification of this Agreement shall be valid unless it is set forth in writing and signed by both parties.

3. Designation of HIPAA Officer(s). Business Associate agrees to designate, in writing, a HIPAA Privacy and Security Officer(s) who will communicate with the City's HIPAA Privacy and Security Officers for purposes of this Agreement. Business Associate agrees to notify the

City's HIPAA Privacy and Security Officers of such designation and the contact information of such officer(s):

Stephen Murphy	Bruce Coffing
HIPAA Privacy Officer	HIPAA Security Officer
312-747-9605	312-744-2461
hipaaprivacyofficer@cityofchicago.org	hipaasecurityofficer@cityofchicago.org

4. Uses and Disclosures of PHI. Business Associate must not use or further disclose Protected Health Information ("PHI") other than as permitted or required by this Agreement, as necessary to perform the services in this Agreement, or as required by law.

a. Business Associate will not sell PHI or use or disclose PHI for the purposes of marketing or fundraising.
b. Business Associate shall not directly or indirectly receive financial remuneration in exchange for any PHI of an individual or in exchange for making communications regarding treatment or health care operations purposes, unless otherwise allowed in this Agreement.
c. If Business Associate is authorized to use PHI to provide the City with de-identified information, Business Associate is not permitted to use or disclose the de-identified information for purposes other than those specified in the Agreement.
d. Business Associate may use PHI to provide data aggregation services to the City, relating to the health care operations of the City.
e. Business Associate may use and disclose PHI received by the Business Associate in its capacity as a Business Associate to the City, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that, as to any such disclosure, the following requirements are met:

    i. The disclosure is required by law; or
    ii. The Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been the subject of a Breach.

f. Except as otherwise limited in this Agreement, Business Associate may use and disclose PHI obtained from or on behalf of the City to perform functions, activities, or services for, or on behalf of, the City as specified in the Agreement, provided that such use or disclosure would not violate HIPAA if done by the City.

5. Minimum Necessary. Business Associate shall use, disclose, or request only the minimum necessary PHI necessary to accomplish the intended purpose of the use, disclosure, or request. Business Associate represents that the PHI used, disclosed, or requested by Business Associate is the minimum necessary to carry out purposes of the Agreement. Prior to any use or

disclosure, Business Associate shall determine whether a limited data set would be sufficient for these purposes.

6. Safeguards of PHI. Business Associate must use appropriate safeguards with respect to PHI that it creates, receives, maintains, or transmits on behalf of the City to prevent the use or disclosure of PHI other than as provided for in this Agreement. The safeguards must reasonably protect PHI from any intentional or unintentional use or disclosure in violation of HIPAA privacy regulations (45 CFR Part 164, subpart E) and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. The safeguards must also reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that Business Associate creates, receives, maintains, or transmits on the City's behalf as required by the HIPAA security regulations (45 CFR Part 164, subpart C). Where applicable, Business Associate must comply with the HIPAA security regulations (45 CFR Part 164, subpart C) with respect to electronic protected health information, to prevent the use or disclosure other than as provided for by this Agreement. Where feasible, PHI will not leave the City's facilities and will be accessed under the supervision of City employees.

7. Applicability of Business Associate Agreement to Subcontractors and Agents. Business Associate must ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits PHI on behalf of the Business Associate agrees to the same restrictions, conditions, and requirements that apply through this Agreement to Business Associate with respect to such information, by entering into a contract or other arrangement that complies with HIPAA. An agent or subcontractor of a Business Associate is not permitted to use or disclose PHI in a manner that would not be permissible if done by the Business Associate. Business Associate will ensure that its subcontractors and agents to which Business Associate is permitted by this Agreement or in writing by the City to disclose PHI agree to implement reasonable and appropriate safeguards to protect PHI. Business Associate will obtain reasonable assurances from any subcontractors and agents to which Business Associate discloses PHI that the subcontractor or agent will hold PHI in confidence and further use or disclose PHI only for the purpose for which Business Associate disclosed PHI to the subcontractor or agent or as required by law.

Business Associate will obtain reasonable assurances that any subcontractor or agent to which Business Associate discloses PHI will notify the Business Associate within 5 calendar days (who will, in turn, notify the City within 5 calendar days, as described below) of any instance in which the subcontractor or agent becomes aware of a Breach of unsecured PHI; possible Breach of unsecured PHI; any security incident of which it becomes aware, including: any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with agent or subcontractor's system operations of which agent/subcontractor becomes aware.

Agent/subcontractor is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on agent/subcontractor's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, agent/subcontractor may delay notification to Business Associate for the time period specified in

HIPAA. Agent or subcontractor's report will include the information described in 45 CFR 164.404(c) and such other information as the Business Associate or the City may reasonably request.

8. Reporting of Breaches, Potential Breaches, and Security Incidents. Business Associate must report to the City any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, as well as any Breach of Unsecured PHI; potential Breach of unsecured PHI; any security incident of which it becomes aware; any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with Business Associate's system operations of which Business Associate becomes aware.

Business Associate will make the report to the City's HIPAA Privacy and Security Officers not more than five (5) calendar days after Business Associate discovers such non-permitted use or disclosure, Breach, security incident, or other incident as described above. Business Associate shall provide any reports or notices required by HIPAA as a result of Business Associate's Breach. On behalf of the City, Business Associate will provide such reports or notices to any party or entity (including but not limited to media, Secretary, and individuals affected by the Breach) entitled by law to receive the reports or notices. Business Associate agrees to pay the costs associated with notifying individuals affected by the Breach, which may include, but are not limited to, paper, printing, and mailing costs.

Business Associate is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, Business Associate may delay notifying City for the time period specified in HIPAA. Business Associate's report will include the information described in 45 CFR 164.404(c) and such other information as the City may reasonably request.

9. Mitigation and Penalties. Business Associate must mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach or of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement. Business Associate shall take reasonable steps to put corrective measures in place to prevent future Breaches (such as retraining employees and upgrading security systems). At the City's request, Business Associate shall take reasonable steps to mitigate the harm to affected Individuals whose PHI has been or may have been compromised as a result of a Breach by Business Associate, including obtaining credit monitoring services and offering identity theft insurance. To the extent that the City incurs civil or criminal monetary penalties as a result of a Breach by the Business Associate, the Business Associate agrees to reimburse the City for such penalties.

10. Designated Record Sets - Access. If the Business Associate has PHI in a Designated Record Set, then Business Associate must provide access to or otherwise make available, at the request of the City, and in the time and manner designated by the City, PHI in a Designated

Record Set, to the City or, as directed by City, to an Individual in order to meet the requirements under 45 CFR 164.524.

11. Designated Record Sets – Amendments. If the Business Associate has PHI in a Designated Record Set, then Business Associate must make any amendments to PHI in a Designated Record Set that the City directs or agrees to pursuant to 45 CFR 164.526 at the request of City or an Individual, and in the time and manner designated by the City.

12. Internal Practices, Books, and Records. Business Associate must make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the City available to the Secretary for purposes of determining compliance with HIPAA. Business Associate also must make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, the City available to the City in a time and manner designated by the City, for purposes of the Secretary determining City's compliance with HIPAA.

13. Accounting of Disclosures - Documentation. Business Associate must document the disclosures of PHI and information relating to such disclosures as would be required for City to respond to a request by an individual for an accounting of disclosures of PHI in accordance with HIPAA, specifically 45 CFR 164.528.

14. Accounting of Disclosures – Provision of Information. Business Associate must provide to City or an individual, in time and manner designated by City, information collected which relates to the disclosure of PHI, to permit City to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. If the Business Associate receives a request for accounting of disclosures directly from the individual, the Business Associate must respond to such request for an accounting of disclosures, provide the accounting of disclosures to the individual within the time required by 45 CFR 164.528, and provide the information regarding such request to the City, in the time and manner designated by the City.

15. Survival, Termination, and Return or Destruction of PHI. Upon termination of this Agreement for any reason, the Business Associate's obligations under these contractual obligations shall survive termination and remain in effect:

a. until Business Associate has completed the return or destruction (in accordance with the US Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals) of all of the PHI provided by City to Business Associate, or created or received by Business Associate on behalf of City, and

b. to the extent that Business Associate retains any PHI.

Upon the expiration or termination of the underlying Agreement, if feasible, the Business Associate must either: (1) return all PHI received from the City, or created, maintained, or received by Business Associate on behalf of the City, which the Business Associate still maintains in any form, to the City or (2) destroy it, at the City's option (in accordance with the US Department of Health and Human Services' Guidance to Render Unsecured Protected Health

Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals). This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If it is infeasible for Business Associate to obtain, from a subcontractor or agent any PHI in the possession of the subcontractor or agent, Business Associate shall require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors' and/or agents' use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

In the event of a breach of the terms of these contractual obligations, the cure and remedies of the Agreement shall govern. HIPAA's privacy rule (45 CFR § 164.504(e)(2)) requires that the Business Associate will authorize termination of the contract by the City, if the City determines that the Business Associate has violated a material term of these contractual obligations.

16. Compliance with Obligations. To the extent the Business Associate is to carry out one or more of City's obligation(s) under Subpart E of 45 CFR Part 164, the Business Associate must comply with the requirements of Subpart E that apply to the City in the performance of such obligation(s). Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the City.

17. No Third Party Rights. The terms and conditions of this Agreement are intended for the sole benefit of Business Associate and City and do not create any third party rights.

18. Governing Law. To the extent not preempted by federal law, the Agreement shall be governed and construed in accordance with the laws of the State of Illinois.

EXHIBIT 7
LIST OF KEY PERSONNEL

Name: _____

Title: _____

Name: _____

Title: _____

EXHIBIT 8
PERFORMANCE GUARANTEES

EXHIBIT 9
SEXUAL HARASSMENT POLICY AFFIDAVIT

In accordance with requirements set forth in Section 2-92-612 of the Municipal Code, Contractor hereby attests that Contractor has a written policy prohibiting sexual harassment that includes, at a minimum, the following information:

(i) the illegality of sexual harassment;

(ii) the definition of sexual harassment; and

(iii) the legal recourse available for victims of sexual harassment.

Contractor understands that it may be required to produce records to the City to verify the information provided.

Under penalty of perjury, the person signing below: (1) warrants that he/she is authorized to execute this Affidavit on behalf of Contractor, and (2) warrants that all certifications and statements contained in this Affidavit are true, accurate, and complete as of the date of execution.

Name of Contractor: _____

Signature of Authorized Officer: _____

Title of Signatory: _____

State of: _____

County of: _____

Signed and sworn (or affirmed) to before me on _____ (date) by _____ (name/s of person/s making statement).

_____

(Signature of Notary Public)

(Seal)

Disclaimer

2019 Agency Exhibits
for Provider Proposed To Be Selected
Effective 1/1/2020 and Future Years

The 2019 documents provided in the City of Chicago's Agency Exhibit are the most recently approved documents as of the 2019 RFP publication date. Changes may occur by reason of Federal, State or local legislation or policy, or pursuant to collective bargaining agreements. Proposers must be flexible and able to adapt to all such changes.

Cook County Documents

Table of Contents

Summary of Health Benefits

Benefits	HMO Plan HMO Provider*	PPO Plan In-Network	PPO Plan Out-of-Network
PRIMARY CARE			
Primary care visit to treat an injury or illness	$15 copay/visit	$25 copay+10% coinsurance/visit	40% coinsurance/visit
Specialist visit	$20 copay/visit	$35 copay+10% coinsurance/visit	40% coinsurance/visit
Other practitioner office visit	$15 copay/visit	$25 copay+10% coinsurance/visit	40% coinsurance/visit
Preventative care/screening/ immunization	$0 copay/visit	$0	$0
OUTPATIENT SERVICES			
Diagnostic test (x-ray, blood work) and imaging (CT/PET scans, MRIs)	$0	10% coinsurance	40% coinsurance
Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	10% coinsurance	40% coinsurance
Physician/surgeon fees	$0	10% coinsurance	40% coinsurance
Maternity prenatal/postnatal care	$15 copay/visit First prenatal visit only	$25 copay/visit+10% coinsurance First prenatal visit only	40% coinsurance
Mental/behavioral health outpatient services	$15 copay/visit	$25 copay/visit+10% coinsurance	40% coinsurance
Substance use disorder outpatient services	$15 copay/visit	$25 copay/visit+10% coinsurance	40% coinsurance
EMERGENCY CARE			
Emergency room services	$75 copay/visit Waived if admitted	$75 copay/visit Waived if admitted	$75 copay/visit Waived if admitted
Emergency medical transportation	$0 Ground transportation only	10% coinsurance	10% coinsurance
Urgent care	$15 copay/visit Must be affiliated with chosen medical group or referral required	$25 copay + 10% coinsurance	$25 copay + 40% coinsurance
INPATIENT BENEFITS			
Facility fee (e.g., hospital room)	$100 copay/visit	10% coinsurance	40% coinsurance
Physician/surgeon fee	$0	10% coinsurance	40% coinsurance
Mental/behavioral health inpatient services	$100 copay/admission	10% coinsurance	40% coinsurance
Substance use disorder inpatient services	$100 copay/admission	10% coinsurance	40% coinsurance
Delivery and all maternity inpatient services	$100 copay/admission	10% coinsurance	40% coinsurance
EXTENDED CARE			
Home health care	$0	10% coinsurance	40% coinsurance
Skilled nursing care	$100 copay/admission	10% coinsurance	40% coinsurance
Hospice service	$0	10% coinsurance	40% coinsurance

*Referrals are required in the HMO plan except for primary care visits to treat injury or illness, pre- and post-natal care, and emergency room services/transportation.
You are responsible for the full cost of any charges that exceed the Schedule of Maximum Allowances (SMA), sometimes referred to as "R&C" or "reasonable and customary" amount.

Health Plans Limits and Maximums

Feature	HMO Plan	PPO Plan	
		In-Network	Out-of-Network*
Annual deductible	$0	$350 Individual $700 Family	$700 Individual $1,400 family
Out-of-Pocket (OOP) maximum	$1,600 Individual $3,200 family	$1,600 Individual $3,200 family	$3,200 Individual $6,400 family
*You are responsible for the full cost of any charges that exceed the Schedule of Maximum Allowances (SMA), sometimes referred to as "R&C" or "reasonable and customary" amount.			

Calculating Your Contributions

This chart shows your cost as a percentage of pre-tax salary based on plan selected and family members you choose to cover.

	HMO	PPO
Employee only	1.5%	2.5%
Employee + spouse	2.0%	3.0%
Employee + child(ren)	1.75%	2.75%
Employee + family	2.25%	3.25%
Employees working less than 30 hours/week may contribute at a different rate.		

Employees on an approved leave of absence remain responsible for their regular payroll contributions when billed. Employees on a personal leave of absence are responsible for paying the full County cost for continued coverage.

* The cost and benefits described here are subject to the collective bargaining process and Cook County Board approval.

Summary of Dental Plans

Item/Procedure	Dental HMO Copayment (Member Pays)	Dental PPO In-Network	Dental PPO Out-of-Network
Benefit Period Maximum	None	$1,500	
Deductible	None	$25 per Individual $100 per Family *(4 individual maximum)* Deductible does not apply to preventive and orthodontic services	$50 per Individual $200 per Family *(4 individual maximum)* Deductible does not apply to preventive and orthodontic services
PREVENTATIVE			
Dental Exams *(2 exams per benefit period)*	$0	100% of the maximum allowance	80% of the maximum allowance
Prophylaxis *(2 cleanings per benefit period)*	$0	100% of the maximum allowance	80% of the maximum allowance
Fluoride Treatment *(eligible members up to age 19)*	$0	100% of the maximum allowance	80% of the maximum allowance
PRIMARY SERVICES			
Dental X-Rays	$0	80% of the maximum allowance	60% of the maximum allowance
Space Maintainers *(eligible members up to age 19)*	$63-$96	80% of the maximum allowance	60% of the maximum allowance
RESTORATIVE			
Amalgams and Anterior Resins	$17-$44	80% of the maximum allowance	60% of the maximum allowance
Posterior Resins	$53-$105	80% of the maximum allowance	60% of the maximum allowance
Crowns and Fixed Bridges	$256 to $300 per unit	50% of the maximum allowance	50% of the maximum allowance
EMERGENCY SERVICES			
Palliative Emergency Treatment	$0	80% of the maximum allowance	80% of the maximum allowance
ENDODONTICS			
Root Canal Therapy	$109-$162	80% of the maximum allowance	60% of the maximum allowance
PERIODONTICS			
Scaling and Root Planing	$37/quadrant	80% of the maximum allowance	60% of the maximum allowance
Gingivectomy	$111/quadrant	80% of the maximum allowance	60% of the maximum allowance
Osseous Surgery	$206/quadrant	80% of the maximum allowance	60% of the maximum allowance
ORAL SURGERY			
Routine Extractions	$18 to $20	80% of the maximum allowance	60% of the maximum allowance
Removal of Impacted Teeth *(soft tissue and partial bone)*	$50-$65	80% of the maximum allowance	60% of the maximum allowance
PROSTHETICS			
Full and Partial Dentures	$383-$396	50% of the maximum allowance	50% of the maximum allowance
Denture Reline	$40-$72	50% of the maximum allowance	50% of the maximum allowance
Endosseous Implants	Not covered	50% of the maximum allowance	50% of the maximum allowance
ORTHODONTICS			
Adults *(19 or older)*	Not covered	50% of the maximum allowance	
Dependent Children *(up to age 19)*	$3,233 - $3,356 not including x-rays or orthodontic records	50% of the maximum allowance	
Lifetime Maximum	One full course of treatment for dependent children under age 19	$1,250	

Cook County EAP Scope

- Provide a member portal which is user-friendly and thorough. The portal is to be available on all devices, offer online customer service chat, and provide access to tools, resources, and apps.
- Offer a base package of services including Critical Incidence Support, Management Support, Unlimited Wellness Coaching (phone and video), and a Bank of Work-Life Training Hours (40 hours).
- Make available a minimum of three (3) counseling sessions annually. Assistance is be provided through a range of methods including digital, phone, video, and face-to-face.
- Refer concerns that cannot be adequately addressed through the EAP to appropriate health plan, private or community resources.
- Offer a broad network of licensed clinicians.
- Maintain capacity to provide on-site critical incidence support.
- May offer additional buy-up resources for financial counseling and work-life services, among others.
- Provide periodic utilization reporting as well as ad-hoc analyses.
- Provide robust employee engagement materials in print and electronic formats.
- Integrate services as requested with other County benefits vendors.
- Conduct member surveys to assess program effectiveness.

COOK COUNTY
ECONOMIC DISCLOSURE STATEMENT
AND EXECUTION DOCUMENT
INDEX

SECTION 1
INSTRUCTIONS FOR COMPLETION OF
ECONOMIC DISCLOSURE STATEMENT AND EXECUTION DOCUMENT

This Economic Disclosure Statement and Execution Document ("EDS") is to be completed and executed by every Bidder on a County contract, every Proposer responding to a Request for Proposals, and every Respondent responding to a Request for Qualifications, and others as required by the Chief Procurement Officer. The execution of the EDS shall serve as the execution of a contract awarded by the County. The Chief Procurement Officer reserves the right to request that the Bidder or Proposer, or Respondent provide an updated EDS on an annual basis.

Definitions. Terms used in this EDS and not otherwise defined herein shall have the meanings given to such terms in the Instructions to Bidders, General Conditions, Request for Proposals, Request for Qualifications, as applicable.

Affiliate means a person that directly or indirectly through one or more intermediaries, Controls is Controlled by, or is under common Control with the Person specified.

Applicant means a person who executes this EDS.

Bidder means any person who submits a Bid.

Code means the Code of Ordinances, Cook County, Illinois available on municode.com.

Contract shall include any written document to make Procurements by or on behalf of Cook County.

Contractor or *Contracting Party* means a person that enters into a Contract with the County.

Control means the unfettered authority to directly or indirectly manage governance, administration, work, and all other aspects of a business.

EDS means this complete Economic Disclosure Statement and Execution Document, including all sections listed in the Index and any attachments.

Joint Venture means an association of two or more Persons proposing to perform a for-profit business enterprise. Joint Ventures must have an agreement in writing specifying the terms and conditions of the relationship between the partners and their relationship and respective responsibility for the Contract

Lobby or lobbying means to, for compensation, attempt to influence a County official or County employee with respect to any County matter.

Lobbyist means any person who lobbies.

Person or *Persons* means any individual, corporation, partnership, Joint Venture, trust, association, Limited Liability Company, sole proprietorship or other legal entity.

Prohibited Acts means any of the actions or occurrences which form the basis for disqualification under the Code, or under the Certifications hereinafter set forth.

Proposal means a response to an RFP.

Proposer means a person submitting a Proposal.

Response means response to an RFQ.

Respondent means a person responding to an RFQ.

RFP means a Request for Proposals issued pursuant to this Procurement Code.

RFQ means a Request for Qualifications issued to obtain the qualifications of interested parties.

INSTRUCTIONS FOR COMPLETION OF ECONOMIC DISCLOSURE STATEMENT AND EXECUTION DOCUMENT

Section 1: Instructions. Section 1 sets forth the instructions for completing and executing this EDS.

Section 2: Certifications. Section 2 sets forth certifications that are required for contracting parties under the Code and other applicable laws. Execution of this EDS constitutes a warranty that all the statements and certifications contained, and all the facts stated, in the Certifications are true, correct and complete as of the date of execution.

Section 3: Economic and Other Disclosures Statement. Section 3 is the County's required Economic and Other Disclosures Statement form. Execution of this EDS constitutes a warranty that all the information provided in the EDS is true, correct and complete as of the date of execution, and binds the Applicant to the warranties, representations, agreements and acknowledgements contained therein.

Required Updates. The Applicant is required to keep all information provided in this EDS current and accurate. In the event of any change in the information provided, including but not limited to any change which would render inaccurate or incomplete any certification or statement made in this EDS, the Applicant shall supplement this EDS up to the time the County takes action, by filing an amended EDS or such other documentation as is required.

Additional Information. The County's Governmental Ethics and Campaign Financing Ordinances impose certain duties and obligations on persons or entities seeking County contracts, work, business, or transactions, and the Applicant is expected to comply fully with these ordinances. For further information please contact the Director of Ethics at (312) 603-4304 (69 W. Washington St. Suite 3040, Chicago, IL 60602) or visit the web-site at cookcountyil.gov/ethics-board-of.

Authorized Signers of Contract and EDS Execution Page. If the Applicant is a corporation, the President and Secretary must execute the EDS. In the event that this EDS is executed by someone other than the President, attach hereto a certified copy of that section of the Corporate By-Laws or other authorization by the Corporation, satisfactory to the County that permits the person to execute EDS for said corporation. If the corporation is not registered in the State of Illinois, a copy of the Certificate of Good Standing from the state of incorporation must be submitted with this Signature Page.

If the Applicant is a partnership or joint venture, all partners or joint venturers must execute the EDS, unless one partner or joint venture has been authorized to sign for the partnership or joint venture, in which case, the partnership agreement, resolution or evidence of such authority satisfactory to the Office of the Chief Procurement Officer must be submitted with this Signature Page.

If the Applicant is a member-managed LLC all members must execute the EDS, unless otherwise provided in the operating agreement, resolution or other corporate documents. If the Applicant is a manager-managed LLC, the manager(s) must execute the EDS. The Applicant must attach either a certified copy of the operating agreement, resolution or other authorization, satisfactory to the County, demonstrating such person has the authority to execute the EDS on behalf of the LLC. If the LLC is not registered in the State of Illinois, a copy of a current Certificate of Good Standing from the state of incorporation must be submitted with this Signature Page.

If the Applicant is a Sole Proprietorship, the sole proprietor must execute the EDS.

A "Partnership" "Joint Venture" or "Sole Proprietorship" operating under an Assumed Name must be registered with the Illinois county in which it is located, as provided in 805 ILCS 405 (2012), and documentation evidencing registration must be submitted with the EDS.

Effective October 1, 2016 all foreign corporations and LLCs must be registered with the Illinois Secretary of State's Office unless a statutory exemption applies to the applicant. Applicants who are exempt from registering must provide a written statement explaining why they are exempt from registering as a foreign entity with the Illinois Secretary of State's Office.

SECTION 2

CERTIFICATIONS

THE FOLLOWING CERTIFICATIONS ARE MADE PURSUANT TO STATE LAW AND THE CODE. THE APPLICANT IS CAUTIONED TO CAREFULLY READ THESE CERTIFICATIONS PRIOR TO SIGNING THE SIGNATURE PAGE. SIGNING THE SIGNATURE PAGE SHALL CONSTITUTE A WARRANTY BY THE APPLICANT THAT ALL THE STATEMENTS, CERTIFICATIONS AND INFORMATION SET FORTH WITHIN THESE CERTIFICATIONS ARE TRUE, COMPLETE AND CORRECT AS OF THE DATE THE SIGNATURE PAGE IS SIGNED. THE APPLICANT IS NOTIFIED THAT IF THE COUNTY LEARNS THAT ANY OF THE FOLLOWING CERTIFICATIONS WERE FALSELY MADE, THAT ANY CONTRACT ENTERED INTO WITH THE APPLICANT SHALL BE SUBJECT TO TERMINATION.

A. PERSONS AND ENTITIES SUBJECT TO DISQUALIFICATION

No person or business entity shall be awarded a contract or sub-contract, for a period of five (5) years from the date of conviction or entry of a plea or admission of guilt, civil or criminal, if that person or business entity:

1) Has been convicted of an act committed, within the State of Illinois, of bribery or attempting to bribe an officer or employee of a unit of state, federal or local government or school district in the State of Illinois in that officer's or employee's official capacity;

2) Has been convicted by federal, state or local government of an act of bid-rigging or attempting to rig bids as defined in the Sherman Anti-Trust Act and Clayton Act. Act. 15 U.S.C. Section 1 *et seq.;*

3) Has been convicted of bid-rigging or attempting to rig bids under the laws of federal, state or local government;

4) Has been convicted of an act committed, within the State, of price-fixing or attempting to fix prices as defined by the Sherman Anti-Trust Act and the Clayton Act. 15 U.S.C. Section 1, *et seq.;*

5) Has been convicted of price-fixing or attempting to fix prices under the laws the State;

6) Has been convicted of defrauding or attempting to defraud any unit of state or local government or school district within the State of Illinois;

7) Has made an admission of guilt of such conduct as set forth in subsections (1) through (6) above which admission is a matter of record, whether or not such person or business entity was subject to prosecution for the offense or offenses admitted to; or

8) Has entered a plea of *nolo contendere* to charge of bribery, price-fixing, bid-rigging, or fraud, as set forth in sub-paragraphs (1) through (6) above.

In the case of bribery or attempting to bribe, a business entity may not be awarded a contract if an official, agent or employee of such business entity committed the Prohibited Act on behalf of the business entity and pursuant to the direction or authorization of an officer, director or other responsible official of the business entity, and such Prohibited Act occurred within three years prior to the award of the contract. In addition, a business entity shall be disqualified if an owner, partner or shareholder controlling, directly or indirectly, 20% or more of the business entity, or an officer of the business entity has performed any Prohibited Act within five years prior to the award of the Contract.

THE APPLICANT HEREBY CERTIFIES THAT: The Applicant has read the provisions of Section A, Persons and Entities Subject to Disqualification, that the Applicant has not committed any Prohibited Act set forth in Section A, and that award of the Contract to the Applicant would not violate the provisions of such Section or of the Code.

B. BID-RIGGING OR BID ROTATING

THE APPLICANT HEREBY CERTIFIES THAT: *In accordance with 720 ILCS 5/33 E-11, neither the Applicant nor any Affiliated Entity is barred from award of this Contract as a result of a conviction for the violation of State laws prohibiting bid-rigging or bid rotating.*

C. DRUG FREE WORKPLACE ACT

THE APPLICANT HEREBY CERTIFIES THAT: The Applicant will provide a drug free workplace, as required by (30 ILCS 580/3).

D. DELINQUENCY IN PAYMENT OF TAXES

THE APPLICANT HEREBY CERTIFIES THAT: *The Applicant is not an owner or a party responsible for the payment of any tax or fee administered by Cook County, such as bar award of a contract or subcontract pursuant to the Code, Chapter 34, Section 34-171.*

E. HUMAN RIGHTS ORDINANCE

No person who is a party to a contract with Cook County ("County") shall engage in unlawful discrimination or sexual harassment against any individual in the terms or conditions of employment, credit, public accommodations, housing, or provision of County facilities, services or programs (Code Chapter 42, Section 42-30 *et seq.*).

F. ILLINOIS HUMAN RIGHTS ACT

THE APPLICANT HEREBY CERTIFIES THAT: *It is in compliance with the Illinois Human Rights Act (775 ILCS 5/2-105), and agrees to abide by the requirements of the Act as part of its contractual obligations.*

G. INSPECTOR GENERAL (COOK COUNTY CODE, CHAPTER 34, SECTION 34-174 and Section 34-250)

The Applicant has not willfully failed to cooperate in an investigation by the Cook County Independent Inspector General or to report to the Independent Inspector General any and all information concerning conduct which they know to involve corruption, or other criminal activity, by another county employee or official, which concerns his or her office of employment or County related transaction.

The Applicant has reported directly and without any undue delay any suspected or known fraudulent activity in the County's Procurement process to the Office of the Cook County Inspector General.

H. CAMPAIGN CONTRIBUTIONS (COOK COUNTY CODE, CHAPTER 2, SECTION 2-585)

THE APPLICANT CERTIFIES THAT: It has read and shall comply with the Cook County's Ordinance concerning campaign contributions, which is codified at Chapter 2, Division 2, Subdivision II, Section 585, and can be read in its entirety at www.municode.com.

I. GIFT BAN, (COOK COUNTY CODE, CHAPTER 2, SECTION 2-574)

THE APPLICANT CERTIFIES THAT: It has read and shall comply with the Cook County's Ordinance concerning receiving and soliciting gifts and favors, which is codified at Chapter 2, Division 2, Subdivision II, Section 574, and can be read in its entirety at www.municode.com.

J. LIVING WAGE ORDINANCE PREFERENCE (COOK COUNTY CODE, CHAPTER 34, SECTION 34-160;

Unless expressly waived by the Cook County Board of Commissioners, the Code requires that a living wage must be paid to individuals employed by a Contractor which has a County Contract and by all subcontractors of such Contractor under a County Contract, throughout the duration of such County Contract. The amount of such living wage is annually by the Chief Financial Officer of the County, and shall be posted on the Chief Procurement Officer's website.

The term "Contract" as used in Section 4, I, of this EDS, specifically excludes contracts with the following:

1) Not-For Profit Organizations (defined as a corporation having tax exempt status under Section 501(C)(3) of the United State Internal Revenue Code and recognized under the Illinois State not-for-profit law);

2) Community Development Block Grants;

3) Cook County Works Department;

4) Sheriff's Work Alternative Program; and

5) Department of Correction inmates.

SECTION 3

REQUIRED DISCLOSURES

1. DISCLOSURE OF LOBBYIST CONTACTS

List all persons that have made lobbying contacts on your behalf with respect to this contract:

Name Address

_____

_____

_____

2. LOCAL BUSINESS PREFERENCE STATEMENT (CODE, CHAPTER 34, SECTION 34-230)

Local business means a Person, including a foreign corporation authorized to transact business in Illinois, having a bona fide establishment located within the County at which it is transacting business on the date when a Bid is submitted to the County, and which employs the majority of its regular, full-time work force within the County. A Joint Venture shall constitute a Local Business if one or more Persons that qualify as a "Local Business" hold interests totaling over 50 percent in the Joint Venture, even if the Joint Venture does not, at the time of the Bid submittal, have such a bona fide establishment within the County.

a) Is Applicant a "Local Business" as defined above?

Yes: ☐ No: ☐

b) If yes, list business addresses within Cook County:

_____

_____

_____

c) Does Applicant employ the majority of its regular full-time workforce within Cook County?

Yes: ☐ No: ☐

3. THE CHILD SUPPORT ENFORCEMENT ORDINANCE (CODE, CHAPTER 34, SECTION 34-172)

Every Applicant for a County Privilege shall be in full compliance with any child support order before such Applicant is entitled to receive or renew a County Privilege. When delinquent child support exists, the County shall not issue or renew any County Privilege, and may revoke any County Privilege.

All Applicants are required to review the Cook County Affidavit of Child Support Obligations attached to this EDS (EDS-5) and complete the Affidavit, based on the instructions in the Affidavit.

4. REAL ESTATE OWNERSHIP DISCLOSURES.

The Applicant must indicate by checking the appropriate provision below and providing all required information that either:

a) The following is a complete list of all real estate owned by the Applicant in Cook County:

PERMANENT INDEX NUMBER(S): _____

_____

_____

(ATTACH SHEET IF NECESSARY TO LIST ADDITIONAL INDEX NUMBERS)

OR:

b) ☐ The Applicant owns no real estate in Cook County.

5. EXCEPTIONS TO CERTIFICATIONS OR DISCLOSURES.

If the Applicant is unable to certify to any of the Certifications or any other statements contained in this EDS and not explained elsewhere in this EDS, the Applicant must explain below:

If the letters, "NA", the word "None" or "No Response" appears above, or if the space is left blank, it will be conclusively presumed that the Applicant certified to all Certifications and other statements contained in this EDS.

CONTRACT #:

COOK COUNTY AFFIDAVIT OF CHILD SUPPORT OBLIGATIONS

Effective July 1, 1998, every applicant for a County Privilege shall be in full compliance with any Child Support Order before such applicant is entitled to receive a County Privilege. When Delinquent Child Support Exists, the County shall not issue or renew any County Privilege, and may revoke any County Privilege.

"*Applicant*" means any person or business entity, **including all Substantial Owners**, seeking issuance of a County Privilege or renewal of an existing County Privilege from the County. This term shall not include any political subdivision of the federal or state government, including units of local government, and not-for-profit organizations.

"*County Privilege*" means any business license, including but not limited to liquor dealers' licenses, packaged goods licenses, tavern licenses, restaurant licenses, and gun licenses; real property license or lease; permit, including but not limited to building permits, zoning permits or approvals; environmental certificate; County HOME Loan, and contracts exceeding the value of $10,000.00.

"*Substantial Owner*" means any person or persons who own or hold a twenty-five\ percent (25%) or more percentage of interest in any business entity seeking a County Privilege, including those shareholders, general or limited partners, beneficiaries and principals; except where a business entity is an individual or sole proprietorship, Substantial Owner means that individual or sole proprietor.

All Applicants/Substantial Owners are required to complete this affidavit and comply with the Child Support Enforcement Ordinance before any privilege is granted. Signature of this form constitutes a certification the information provided below is correct and complete, and that the individual(s) signing this form has/have personal knowledge of such information.

Privilege Information:

Contract #: County Department:

Business Entity Information (INCLUDES CORPORATE APPLICANT AND CORPORATE SUBSTANTIAL OWNERS):

Business Entity Name:

Street Address: City:

State: Zip: Phone #:

Individual Applicant and Individual Substantial Owner Information (If Applicable):

Last name: _____ First Name: _____ MI: _____

SS# (Last Four Digits): ____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Driver's License No: _____

Child Support Obligation Information:

The Applicant, being duly sworn on oath or affirmation hereby states that to the best of my knowledge (place an "X" next to "A", "B", or "C").

_____ ☐ A. The Applicant has no judicially or administratively ordered child support obligations.

_____ ☐ B. The Applicant has an outstanding judicially or administratively ordered obligation, but is paying in accordance with the terms of the order.

_____ ☐ C. The Applicant is delinquent in paying judicially or administratively ordered child support obligations

The Applicant understands that failure to disclose any judicially or administratively ordered child support debt owed will be grounds for revoking the privilege.

Name: _____

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, 20_____

X_____ _____

Notary Public Signature **Notary Seal**

Note: The above information is subject to verification prior to the award of the contract.

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CONTRACT #:

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT

The Cook County Code of Ordinances (§2-610 *et seq.*) requires that any Applicant for any County Action must disclose information concerning ownership interests in the Applicant. This Disclosure of Ownership Interest Statement must be completed with all information current as of the date this Statement is signed. Furthermore, this Statement must be kept current, by filing an amended Statement, until such time as the County Board or County Agency shall take action on the application. The information contained in this Statement will be maintained in a database and made available for public viewing. **County reserves the right to request additional information to verify veracity of information contained in this statement.**

If you are asked to list names, but there are no applicable names to list, you must state NONE. An incomplete Statement will be returned and any action regarding this contract will be delayed. A failure to fully comply with the ordinance may result in the action taken by the County Board or County Agency being voided.

"*Applicant*" means any Entity or person making an application to the County for any County Action.

"County Action" means any action by a County Agency, a County Department, or the County Board regarding an ordinance or ordinance amendment, a County Board approval, or other County agency approval, with respect to contracts, leases, or sale or purchase of real estate.

"Person" "Entity" or *"Legal Entity"* means a sole proprietorship, corporation, partnership, association, business trust, estate, two or more persons having a joint or common interest, trustee of a land trust, other commercial or legal entity or any beneficiary or beneficiaries thereof.

This Disclosure of Ownership Interest Statement must be submitted by :

1. An Applicant for County Action and

2. A Person that holds stock or a beneficial interest in the Applicant and is listed on the Applicant's Statement (a "Holder") must file a Statement and complete #1 only under **Ownership Interest Declaration**.

Please print or type responses clearly and legibly. Add additional pages if needed, being careful to identify each portion of the form to which each additional page refers.

This Statement is being made by the [ ] Applicant or [ ] Stock/Beneficial Interest Holder

This Statement is an: [ ] Original Statement or [ ] Amended Statement

Identifying Information:

Name _____

D/B/A: _____ FEIN # Only: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____ Fax Number: _____ Email: _____

Cook County Business Registration Number: _____
(Sole Proprietor, Joint Venture Partnership)

Corporate File Number (if applicable): _____

Form of Legal Entity:

☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Trustee of Land Trust

☐ Business Trust ☐ Estate ☐ Association ☐ Joint Venture

☐ Other (describe) _____

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CONTRACT #:

Ownership Interest Declaration:

1. List the name(s), address, and percent ownership of each Person having a legal or beneficial interest (including ownership) of more than five percent (5%) in the Applicant/Holder.

Name	Address	Percentage Interest in Applicant/Holder

2. If the interest of any Person listed in (1) above is held as an agent or agents, or a nominee or nominees, list the name and address of the principal on whose behalf the interest is held.

Name of Agent/Nominee	Name of Principal	Principal's Address

3. Is the Applicant constructively controlled by another person or Legal Entity? [☐] Yes [☐] No

If yes, state the name, address and percentage of beneficial interest of such person, and the relationship under which such control is being or may be exercised.

Name	Address	Percentage of Beneficial Interest	Relationship

Corporate Officers, Members and Partners Information:

For all corporations, list the names, addresses, and terms for all corporate officers. For all limited liability companies, list the names, addresses for all members. For all partnerships and joint ventures, list the names, addresses, for each partner or joint venture.

Name	Address	Title (specify title of Office, or whether manager or partner/joint venture)	Term of Office

Declaration (check the applicable box):

☐ I state under oath that the Applicant has withheld no disclosure as to ownership interest in the Applicant nor reserved any information, data or plan as to the intended use or purpose for which the Applicant seeks County Board or other County Agency action.

☐ I state under oath that the Holder has withheld no disclosure as to ownership interest nor reserved any information required to be disclosed.

CONTRACT #:

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT SIGNATURE PAGE

Name of Authorized Applicant/Holder Representative (please print or type)

Title

Signature

Date

E-mail address

Phone Number

Subscribed to and sworn before me
this _____ day of _____, 20__.

My commission expires:

X_____
Notary Public Signature

Notary Seal

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CONTRACT #:

COOK COUNTY BOARD OF ETHICS
69 W. WASHINGTON STREET, SUITE 3040
CHICAGO, ILLINOIS 60602
312/603-4304 Office 312/603-9988 Fax

FAMILIAL RELATIONSHIP DISCLOSURE PROVISION

Nepotism Disclosure Requirement:

Doing a significant amount of business with the County requires that you disclose to the Board of Ethics the existence of any familial relationships with any County employee or any person holding elective office in the State of Illinois, the County, or in any municipality within the County. The Ethics Ordinance defines a significant amount of business for the purpose of this disclosure requirement as more than $25,000 in aggregate County leases, contracts, purchases or sales in any calendar year.

If you are unsure of whether the business you do with the County or a County agency will cross this threshold, err on the side of caution by completing the attached familial disclosure form because, among other potential penalties, any person found guilty of failing to make a required disclosure or knowingly filing a false, misleading, or incomplete disclosure will be prohibited from doing any business with the County for a period of three years. The required disclosure should be filed with the Board of Ethics by January 1 of each calendar year in which you are doing business with the County and again with each bid/proposal/quotation to do business with Cook County. The Board of Ethics may assess a late filing fee of $100 per day after an initial 30-day grace period.

The person that is doing business with the County must disclose his or her familial relationships. If the person on the County lease or contract or purchasing from or selling to the County is a business entity, then the business entity must disclose the familial relationships of the individuals who are and, during the year prior to doing business with the County, were:

- its board of directors,
- its officers,
- its employees or independent contractors responsible for the general administration of the entity,
- its agents authorized to execute documents on behalf of the entity, and
- its employees who directly engage or engaged in doing work with the County on behalf of the entity.

Do not hesitate to contact the Board of Ethics at (312) 603-4304 for assistance in determining the scope of any required familial relationship disclosure.

Additional Definitions:

"*Familial relationship*" means a person who is a spouse, domestic partner or civil union partner of a County employee or State, County or municipal official, or any person who is related to such an employee or official, whether by blood, marriage or adoption, as a:

☐ Parent	☐ Grandparent	☐ Stepfather
☐ Child	☐ Grandchild	☐ Stepmother
☐ Brother	☐ Father-in-law	☐ Stepson
☐ Sister	☐ Mother-in-law	☐ Stepdaughter
☐ Aunt	☐ Son-in-law	☐ Stepbrother
☐ Uncle	☐ Daughter-in-law	☐ Stepsister
☐ Niece	☐ Brother-in-law	☐ Half-brother
☐ Nephew	☐ Sister-in-law	☐ Half-sister

CONTRACT #:

COOK COUNTY BOARD OF ETHICS
FAMILIAL RELATIONSHIP DISCLOSURE FORM

A. PERSON DOING OR SEEKING TO DO BUSINESS WITH THE COUNTY

Name of Person Doing Business with the County: _____

Address of Person Doing Business with the County: _____

Phone number of Person Doing Business with the County: _____

Email address of Person Doing Business with the County: _____

If Person Doing Business with the County is a Business Entity, provide the name, title and contact information for the individual completing this disclosure on behalf of the Person Doing Business with the County:

_____

_____

B. DESCRIPTION OF BUSINESS WITH THE COUNTY

Append additional pages as needed and for each County lease, contract, purchase or sale sought and/or obtained during the calendar year of this disclosure (or the proceeding calendar year if disclosure is made on January 1), identify:

The lease number, contract number, purchase order number, request for proposal number and/or request for qualification number associated with the business you are doing or seeking to do with the County: _____

_____

The aggregate dollar value of the business you are doing or seeking to do with the County: $_____

The name, title and contact information for the County official(s) or employee(s) involved in negotiating the business you are doing or seeking to do with the County: _____

_____

The name, title and contact information for the County official(s) or employee(s) involved in managing the business you are doing or seeking to do with the County: _____

_____

C. DISCLOSURE OF FAMILIAL RELATIONSHIPS WITH COUNTY EMPLOYEES OR STATE, COUNTY OR MUNICIPAL ELECTED OFFICIALS

Check the box that applies and provide related information where needed

☐ The Person Doing Business with the County **is an individual** and there is **no familial relationship** between this individual and any Cook County employee or any person holding elective office in the State of Illinois, Cook County, or any municipality within Cook County.

☐ The Person Doing Business with the County **is a business entity** and there is **no familial relationship** between any member of this business entity's board of directors, officers, persons responsible for general administration of the business entity, agents authorized to execute documents on behalf of the business entity or employees directly engaged in contractual work with the County on behalf of the business entity, and any Cook County employee or any person holding elective office in the State of Illinois, Cook County, or any municipality within Cook County.

CONTRACT #:

COOK COUNTY BOARD OF ETHICS
FAMILIAL RELATIONSHIP DISCLOSURE FORM

☐ The Person Doing Business with the County **is an individual** and **there is a familial relationship** between this individual and at least one Cook County employee and/or a person or persons holding elective office in the State of Illinois, Cook County, and/or any municipality within Cook County. **The familial relationships are as follows:**

Name of Individual Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

If more space is needed, attach an additional sheet following the above format.

☐ The Person Doing Business with the County **is a business entity** and **there is a familial relationship** between at least one member of this business entity's board of directors, officers, persons responsible for general administration of the business entity, agents authorized to execute documents on behalf of the business entity and/or employees directly engaged in contractual work with the County on behalf of the business entity, on the one hand, and at least one Cook County employee and/or a person holding elective office in the State of Illinois, Cook County, and/or any municipality within Cook County, on the other. **The familial relationships are as follows:**

Name of Member of Board of Director for Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*
Name of Officer for Business Entity Doing Business with the County	**Name of Related County Employee or State, County or Municipal Elected Official**	**Title and Position of Related County Employee or State, County or Municipal Elected Official**	**Nature of Familial Relationship***

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Name of Person Responsible for the General Administration of the Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

Name of Agent Authorized to Execute Documents for Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

Name of Employee of Business Entity Directly Engaged in Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

If more space is needed, attach an additional sheet following the above format.

VERIFICATION: To the best of my knowledge, the information I have provided on this disclosure form is accurate and complete. I acknowledge that an inaccurate or incomplete disclosure is punishable by law, including but not limited to fines and debarment.

Signature of Recipient _____ Date _____

SUBMIT COMPLETED FORM TO: Cook County Board of Ethics
69 West Washington Street, Suite 3040, Chicago, Illinois 60602
Office (312) 603-4304 – Fax (312) 603-9988
CookCounty.Ethics@cookcountyil.gov

* Spouse, domestic partner, civil union partner or parent, child, sibling, aunt, uncle, niece, nephew, grandparent or grandchild by blood, marriage (*i.e.* in laws and step relations) or adoption.

SECTION 4

COOK COUNTY AFFIDAVIT FOR WAGE THEFT ORDINANCE

Effective May 1, 2015, every Person, ***including Substantial Owners***, seeking a Contract with Cook County must comply with the Cook County Wage Theft Ordinance set forth in Chapter 34, Article IV, Section 179. Any Person/Substantial Owner, who fails to comply with Cook County Wage Theft Ordinance, may request that the Chief Procurement Officer grant a reduction or waiver in accordance with Section 34-179(d).

"*Contract*" means any written document to make Procurements by or on behalf of Cook County.

"*Person*" means any individual, corporation, partnership, Joint Venture, trust, association, limited liability company, sole proprietorship or other legal entity.

"*Procurement*" means obtaining supplies, equipment, goods, or services of any kind.

"*Substantial Owner*" means any person or persons who own or hold a twenty-five percent (25%) or more percentage of interest in any business entity seeking a County Privilege, including those shareholders, general or limited partners, beneficiaries and principals; except where a business entity is an individual or sole proprietorship, Substantial Owner means that individual or sole proprietor.

All Persons/Substantial Owners are required to complete this affidavit and comply with the Cook County Wage Theft Ordinance before any Contract is awarded. Signature of this form constitutes a certification the information provided below is correct and complete, and that the individual(s) signing this form has/have personal knowledge of such information. **County reserves the right to request additional information to verify veracity of information contained in this Affidavit.**

I. Contract Information:

Contract Number: _____

County Using Agency (requesting Procurement): _____

II. Person/Substantial Owner Information:

Person (Corporate Entity Name): _____

Substantial Owner Complete Name: _____

FEIN# _____

Date of Birth: _____ E-mail address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____

III. Compliance with Wage Laws:

Within the past five years has the Person/Substantial Owner, in any judicial or administrative proceeding, been convicted of, entered a plea, made an admission of guilt or liability, or had an administrative finding made for committing a repeated or willful violation of any of the following laws:

Illinois Wage Payment and Collection Act, 820 ILCS 115/1 et seq., ***YES or NO***

Illinois Minimum Wage Act, 820 ILCS 105/1 et seq., ***YES or NO***

Illinois Worker Adjustment and Retraining Notification Act, 820 ILCS 65/1 et seq., ***YES or NO***

Employee Classification Act, 820 ILCS 185/1 et seq., **YES or NO**

Fair Labor Standards Act of 1938, 29 U.S.C. 201, et seq., ***YES or NO***

Any comparable state statute or regulation of any state, which governs the payment of wages ***YES or NO***

If the Person/Substantial Owner answered **"Yes"** to any of the questions above, it is ineligible to enter into a Contract with Cook County, but can request a reduction or waiver under **Section IV.**

IV. Request for Waiver or Reduction

If Person/Substantial Owner answered **"Yes"** to any of the questions above, it may request a reduction or waiver in accordance with Section 34-179(d), provided that the request for reduction of waiver is made on the basis of one or more of the following actions that have taken place:

There has been a bona fide change in ownership or Control of the ineligible Person or Substantial Owner ***YES or NO***

Disciplinary action has been taken against the individual(s) responsible for the acts giving rise to the violation ***YES or NO***

Remedial action has been taken to prevent a recurrence of the acts giving rise to the disqualification or default ***YES or NO***

Other factors that the Person or Substantial Owner believe are relevant.
YES or NO

The Person/Substantial Owner must submit documentation to support the basis of its request for a reduction or waiver. The Chief Procurement Officer reserves the right to make additional inquiries and request additional documentation.

V. Affirmation

The Person/Substantial Owner affirms that all statements contained in the Affidavit are true, accurate and complete.

Signature: _____ Date: _____

Name of Person signing (Print): _____ Title: _____

Subscribed and sworn to before me this _____ day of _____, 20_____

X_____ _____

Notary Public Signature **Notary Seal**

Note: The above Information is subject to verification prior to the award of the Contract.

CONTRACT #:

SECTION 5

CONTRACT AND EDS EXECUTION PAGE

The Applicant hereby certifies and warrants that all of the statements, certifications and representations set forth in this EDS are true, complete and correct; that the Applicant is in full compliance and will continue to be in compliance throughout the term of the Contract or County Privilege issued to the Applicant with all the policies and requirements set forth in this EDS; and that all facts and information provided by the Applicant in this EDS are true, complete and correct. The Applicant agrees to inform the Chief Procurement Officer in writing if any of such statements, certifications, representations, facts or information becomes or is found to be untrue, incomplete or incorrect during the term of the Contract or County Privilege.

Execution by Corporation

Corporation's Name

President's Printed Name and Signature

Telephone

Email

Secretary Signature

Date

Execution by LLC

LLC Name

*Member/Manager Printed Name and Signature

Date

Telephone and Email

Execution by Partnership/Joint Venture

Partnership/Joint Venture Name

*Partner/Joint Venturer Printed Name and Signature

Date

Telephone and Email

Execution by Sole Proprietorship

Printed Name Signature

Assumed Name (if applicable)

Date

Telephone and Email

Subscribed and sworn to before me this
_____day of _____, 20___.

My commission expires:

Notary Public Signature

Notary Seal

*If the operating agreement, partnership agreement or governing documents requiring execution by multiple members, managers, partners, or joint venturers, please complete and execute additional Contract and EDS Execution Pages.

CONTRACT #:

SECTION 6
COOK COUNTY SIGNATURE PAGE

ON BEHALF OF THE COUNTY OF COOK, A BODY POLITIC AND CORPORATE OF THE STATE OF ILLINOIS, THIS CONTRACT IS HEREBY EXECUTED BY:

Cook County Chief Procurement Officer

Date

APPROVED AS TO FORM:

Assistant State's Attorney
(Required on contracts over $1,000,000

Date

CONTRACT TERM & AMOUNT

Contract #

Original Contract Term

Renewal Options (If Applicable)

Contract Amount

Cook County Board Approval Date (If Applicable)

MBE/WBE UTILIZATION PLAN - FORM 1

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions – Section 19.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

____ Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of current Letter of Certification)

____ Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs. (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available online at www.cookcountyil.gov/contractcompliance)

____ Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either directly or indirectly in the performance of the Contract. (If so, complete Sections II below and the Letter(s) of Intent – Form 2).

II. ☐ **Direct Participation of MBE/WBE Firms** ☐ **Indirect Participation of MBE/WBE Firms**

NOTE: Where goals have not been achieved through direct participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission. Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs that will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: _____

Address: _____

E-mail: _____

Contact Person: _____ Phone: _____

Dollar Amount Participation: $_____

Percent Amount of Participation: _____%

*Letter of Intent attached? Yes _____ No _____
*Current Letter of Certification attached? Yes _____ No _____

MBE/WBE Firm: _____

Address: _____

E-mail: _____

Contact Person: _____ Phone: _____

Dollar Amount Participation: $_____

Percent Amount of Participation: _____%

*Letter of Intent attached? Yes _____ No _____
*Current Letter of Certification attached? Yes _____ No _____

Attach additional sheets as needed.

*** Letter(s) of Intent and current Letters of Certification must be submitted at the time of bid.**

MBE/WBE LETTER OF INTENT - FORM 2

M/WBE Firm: _____ Certifying Agency: _____

Contact Person: _____ Certification Expiration Date: _____

Address: _____ Ethnicity: _____

City/State: _____ Zip: _____ Bid/Proposal/Contract #: _____

Phone: _____ Fax: _____ FEIN #: _____

Email: _____

Participation: [ ] Direct [ ] Indirect

Will the M/WBE firm be subcontracting any of the goods or services of this contract to another firm?

[ ] No [ ] Yes – Please attach explanation. Proposed Subcontractor(s): _____

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract: *(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)*

_____

_____

_____

_____

Indicate the **Dollar Amount**, **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

_____

_____

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement for the above work, conditioned upon (1) the Bidder/Proposer's receipt of a signed contract from the County of Cook; (2) Undersigned Subcontractor remaining compliant with all relevant credentials, codes, ordinances and statutes required by Contractor, Cook County, and the State to participate as a MBE/WBE firm for the above work. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

_____ _____

Signature (*M/WBE*) Signature (*Prime Bidder/Proposer*)

_____ _____

Print Name Print Name

_____ _____

Firm Name Firm Name

_____ _____

Date Date

Subscribed and sworn before me Subscribed and sworn before me

this ____ day of_____, 20____. this ____ day of_____, 20____.

Notary Public _____ Notary Public _____

SEAL SEAL

PETITION FOR WAIVER OF MBE/WBE PARTICIPATION – FORM 3

A. BIDDER/PROPOSER HEREBY REQUESTS:

☐ **FULL MBE WAIVER** ☐ **FULL WBE WAIVER**

☐ **REDUCTION (PARTIAL MBE and/or WBE PARTICIPATION)**

_____% of Reduction for MBE Participation
_____% of Reduction for WBE Participation

B. REASON FOR FULL/REDUCTION WAIVER REQUEST

Bidder/Proposer shall check each item applicable to its reason for a waiver request. Additionally, supporting documentation shall be submitted with this request.

☐ (1) Lack of sufficient qualified MBEs and/or WBEs capable of providing the goods or services required by the contract. **(Please explain)**

☐ (2) The specifications and necessary requirements for performing the contract make it impossible or economically infeasible to divide the contract to enable the contractor to utilize MBEs and/or WBEs in accordance with the applicable participation. **(Please explain)**

☐ (3) Price(s) quoted by potential MBEs and/or WBEs are above competitive levels and increase cost of doing business and would make acceptance of such MBE and/or WBE bid economically impracticable, taking into consideration the percentage of total contract price represented by such MBE and/or WBE bid. **(Please explain)**

☐ (4) There are other relevant factors making it impossible or economically infeasible to utilize MBE and/or WBE firms. **(Please explain)**

C. GOOD FAITH EFFORTS TO OBTAIN MBE/WBE PARTICIPATION

☐ (1) Made timely written solicitation to identified MBEs and WBEs for utilization of goods and/or services; and provided MBEs and WBEs with a timely opportunity to review and obtain relevant specifications, terms and conditions of the proposal to enable MBEs and WBEs to prepare an informed response to solicitation. **(Attach of copy written solicitations made)**

☐ (2) Used the services and assistance of the Office of Contract Compliance staff. **(Please explain)**

☐ (3) Timely notified and used the services and assistance of community, minority and women business organizations. **(Attach of copy written solicitations made)**

☐ (4) Followed up on initial solicitation of MBEs and WBEs to determine if firms are interested in doing business. **(Attach supporting documentation)**

☐ (5) Engaged MBEs & WBEs for direct/indirect participation. **(Please explain)**

D. OTHER RELEVANT INFORMATION

Attach any other documentation relative to Good Faith Efforts in complying with MBE/WBE participation.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract**. In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.:	Date:
Total Bid or Proposal Amount:	Contract Title:
Contractor:	Subcontractor/Supplier/ Subconsultant to be added or substitute:
Authorized Contact for Contractor:	Authorized Contact for Subcontractor/Supplier/ Subconsultant:
Email Address (Contractor):	Email Address (Subcontractor):
Company Address (Contractor):	Company Address (Subcontractor):
City, State and Zip (Contractor):	City, State and Zip (Subcontractor):
Telephone and Fax (Contractor)	Telephone and Fax (Subcontractor)
Estimated Start and Completion Dates (Contractor)	Estimated Start and Completion Dates (Subcontractor)

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor

_____

Name

_____

Title

_____

Prime Contractor Signature Date

ISF-1 8/2015

OFFICE OF THE COOK COUNTY COMPTROLLER
ELECTRONIC PAYABLES PROGRAM ("E-PAYABLES")

FOR INFORMATION PURPOSES ONLY

This document describes the Office of the Cook County Comptroller's Electronic Payables Program ("E-Payables"). If you wish to participate in E-Payables, please contact the Cook County Comptroller's Office, Accounts Payable, 118 N. Clark Street, Room 500, Chicago, IL 60602.

DESCRIPTION
To increase payment efficiency and timeliness, we have introduced E-Payables program, a new payment initiative to our accounts payable model. This new initiative utilizes a Visa purchasing card and operates through the Visa payment network. This is County's preferred method of payment and your participation in our Visa purchasing card program will provide mutual benefits both to your organization and ours.

As a vendor, you may experience the following benefits by accepting this new payment type:
- Improved cash flow and accelerated payment
- Reduced paperwork and a more streamlined accounts receivable process
- Elimination of stop payment issues
- Reduced payment delays
- Reduced costs for handling paper checks
- Payments settled directly to your merchant account

There are two options within this initiative:

3. Dedicated Credit Card – "PULL" Settlement
For this option, you will have an assigned dedicated credit card to be used for each payment. You will provide a point of contact within your organization who will keep credit card information on file. Each time a payment is made, you will receive a remittance advice via email detailing the invoices being paid. Each time you receive a remittance advice, you will process payments in the same manner you process credit card transactions today.

4. One-Time Use Credit Card – "SUGA" Settlement
For this option, you will provide a point of contact within your organization who will receive an email notification authorizing you to process payments in the same manner you process credit card transactions today. Each time payment is made, you will receive a remittance advice, via email, detailing the invoices being paid. Also, each time you receive a remittance advice, you will receive a new, unique credit card number. This option is ideal for suppliers who are unable to keep credit card account information on file.

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PROFESSIONAL SERVICES AGREEMENT

TABLE OF CONTENTS

List of Exhibits

AGREEMENT

This Agreement is made and entered into by and between the County of Cook, a public body corporate of the State of Illinois, on behalf of Office of the Chief Procurement Officer hereinafter referred to as "County" and _____doing business as a Corporation of the State of Illinois, hereinafter referred to as "Consultant", pursuant to authorization by the Cook County Board of Commissioners on_____ _____, as evidenced by Board Authorization letter attached hereto as Exhibit "5".

BACKGROUND

The County of Cook issued a Request for Proposals "RFP" for_____ _____. Proposals were evaluated in accordance with the evaluation criteria published in the RFP. The Consultant was selected based on the proposal submitted and evaluated by the County representatives.

Consultant represents that it has the professional experience and expertise to provide the necessary services and further warrants that it is ready, willing and able to perform in accordance with the terms and conditions as set forth in this Agreement.

NOW, THEREFORE, the County and Consultant agree as follows:

TERMS AND CONDITIONS

ARTICLE 1) INCORPORATION OF BACKGROUND

The Background information set forth above is incorporated by reference as if fully set forth here.

ARTICLE 2) DEFINITIONS

a) Definitions

The following words and phrases have the following meanings for purposes of this Agreement:

"**Additional Services**" means those services which are within the general scope of Services of this Agreement, but beyond the description of services required under Article 3, and all services reasonably necessary to complete the Additional Services to the standards of performance required by this Agreement. Any Additional Services requested by the Using Agency require the approval of the Chief Procurement Officer in a written amendment to this Agreement before Consultant is obligated to perform those Additional Services and before the County becomes obligated to pay for those Additional Services.

"**Agreement**" means this Professional Services Agreement, including all exhibits attached to it and incorporated in it by reference, and all amendments, modifications or revisions made in accordance with its terms.

"**Chief Procurement Officer**" means the Chief Procurement Officer for the County of Cook and any representative duly authorized in writing to act on his behalf.

"**Services**" means, collectively, the services, duties and responsibilities described in Article 3 of this Agreement and any and all work necessary to complete them or carry them out fully and to the standard of performance required in this Agreement.

"**Subcontractor**" or "**Subconsultant**" means any person or entity with whom Consultant contracts to provide any part of the Services, of any tier, suppliers and materials providers, whether or not in privity with Consultant.

"**Using Agency**" shall mean the department of agency within Cook County including elected officials.

b) Interpretation

i) The term "**include**" (in all its forms) means "include, without limitation" unless the context clearly states otherwise.

ii) All references in this Agreement to Articles, Sections or Exhibits, unless otherwise expressed or indicated are to the Articles, Sections or Exhibits of this Agreement.

iii) Words importing persons include firms, associations, partnerships, trusts, corporations and other legal entities, including public bodies, as well as natural persons.

iv) Any headings preceding the text of the Articles and Sections of this Agreement, and any tables of contents or marginal notes appended to it are solely for convenience or reference and do not constitute a part of this Agreement, nor do they affect the meaning, construction or effect of this Agreement.

v) Words importing the singular include the plural and vice versa. Words of the masculine gender include the correlative words of the feminine and neuter genders.

vi) All references to a number of days mean calendar days, unless expressly indicated otherwise.

c) Incorporation of Exhibits

The following attached Exhibits are made a part of this Agreement:

Exhibit 1:	Scope of Services
Exhibit 2:	Schedule of Compensation
Exhibit 3:	Evidence of Insurance
Exhibit 4:	Identification of Subcontractor/Supplier/Subconsultant Form
Exhibit 5:	Board Authorization
Exhibit 6:	MBE/WBE Utilization Plan
Exhibit 7:	Economic Disclosure Statement

ARTICLE 3) DUTIES AND RESPONSIBILITIES OF CONSULTANT

a) Scope of Services

This description of Services is intended to be general in nature and is neither a complete description of Consultant's Services nor a limitation on the Services that Consultant is to provide under this Agreement. Consultant must provide the Services in accordance with the standards of performance set forth in Section 3c. The Services that Consultant must provide include, but are not limited to, those described in Exhibit 1, Scope of Services and Time Limits for Performance, which is attached to this Agreement and incorporated by reference as if fully set forth here.

b) Deliverables

In carrying out its Services, Consultant must prepare or provide to the County various Deliverables. "**Deliverables**" include work product, such as written reviews, recommendations, reports and analyses, produced by Consultant for the County.

The County may reject Deliverables that do not include relevant information or data, or do not include all documents or other materials specified in this Agreement or reasonably necessary for the purpose for which the County made this Agreement or for which the County intends to use the Deliverables. If the County determines that Consultant has failed to comply with the foregoing standards, it has 30 days from the discovery to notify Consultant of its failure. If Consultant does not correct the failure, if it is possible to do so, within 30 days after receipt of notice from the County specifying the failure, then the County, by written notice, may treat the failure as a default of this Agreement under Article 9.

Partial or incomplete Deliverables may be accepted for review only when required for a specific and well-defined purpose and when consented to in advance by the County. Such Deliverables will not be considered as satisfying the requirements of this Agreement and partial or incomplete Deliverables in no way relieve Consultant of its commitments under this Agreement.

c) Standard of Performance

Consultant must perform all Services required of it under this Agreement with that degree of skill, care and diligence normally shown by a consultant performing services of a scope and purpose and magnitude comparable with the nature of the Services to be provided under this Agreement. Consultant acknowledges that it is entrusted with or has access to valuable and confidential information and records of the County and with respect to that information, Consultant agrees to be held to the standard of care of a fiduciary.

Consultant must assure that all Services that require the exercise of professional skills or judgment are accomplished by professionals qualified and competent in the applicable discipline and appropriately licensed, if required by law. Consultant must provide copies of any such licenses. Consultant remains responsible for the professional and technical accuracy of all Services or Deliverables furnished, whether by Consultant or its Subconsultants or others on its behalf. All Deliverables must be prepared in a form and content satisfactory to the Using Agency and delivered in a timely manner consistent with the requirements of this Agreement.

If Consultant fails to comply with the foregoing standards, Consultant must perform again, at its own expense, all Services required to be re-performed as a direct or indirect result of that failure. Any review, approval, acceptance or payment for any of the Services by the County does not relieve Consultant of its responsibility for the professional skill and care and technical accuracy of its Services and Deliverables. This provision in no way limits the County's rights against Consultant either under this Agreement, at law or in equity.

d) Personnel

i) **Adequate Staffing**

Consultant must, upon receiving a fully executed copy of this Agreement, assign and maintain during the term of this Agreement and any extension of it an adequate staff of competent personnel that is fully equipped, licensed as appropriate, available as needed, qualified and assigned exclusively to perform the Services. Consultant must include among its staff the Key Personnel and positions as identified below. The level of staffing may be revised from time to time by notice in writing from Consultant to the County and with written consent of the County, which consent the County will not withhold unreasonably. If the County fails to object to the revision within 14 days after receiving the notice, then the revision will be considered accepted by the County.

ii) **Key Personnel**

Consultant must not reassign or replace Key Personnel without the written consent of the County, which consent the County will not unreasonably withhold. **"Key Personnel"** means those job titles and the persons assigned to those positions in accordance with the provisions of this Section 3.d(ii). The Using Agency may at any time in writing notify Consultant that the County will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice Consultant must immediately suspend the services of the key person or persons and must replace him or them in accordance with the terms of this Agreement. A list of Key Personnel is found in Exhibit 1, Scope of Services.

iii) **Salaries and Wages**

Consultant and Subconsultants must pay all salaries and wages due all employees performing Services under this Agreement unconditionally and at least once a month without deduction or rebate on any account, except only for those payroll deductions that are mandatory by law or are permitted under applicable law and regulations. If in the performance of this Agreement Consultant underpays any such salaries or wages, the Comptroller for the County may withhold, out of payments due to Consultant, an amount sufficient to pay to employees underpaid the difference between the salaries or wages required to be paid under this Agreement and the salaries or wages actually paid these employees for the total number of hours worked. The amounts withheld may be disbursed by the Comptroller for and on account of Consultant to the respective employees to whom they are due. The parties acknowledge that this Section 3.d(iii) is solely for the benefit of the County and that it does not grant any third party beneficiary rights.

e) Minority and Women Owned Business Enterprises Commitment

In the performance of this Agreement, including the procurement and lease of materials or equipment, Consultant must abide by the minority and women's business enterprise commitment requirements of the Cook County Ordinance, (Article IV, Section 34-267 through 272) except to the extent waived by the Compliance Director, which are set forth in Exhibit 3. Consultant's completed MBE/WBE Utilization Plan evidencing its compliance with this requirement are a part of this Agreement, in Form 1 of the MBE/WBE Utilization Plan, upon acceptance by the Compliance Director. Consultant must utilize minority and women's business enterprises at the greater of the amounts committed to by the Consultant for this Agreement in accordance with Form 1 of the MBE/WBE Utilization Plan.

f) Insurance

Consultant must provide and maintain at Consultant's own expense, during the term of this Agreement and any time period following expiration if Consultant is required to return and perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified below, insuring all operations related to this Agreement.

i) **Insurance To Be Provided**

(1) Workers Compensation and Employers Liability

Workers Compensation Insurance, as prescribed by applicable law, covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $500,000 each accident or illness.

(2) Commercial General Liability (Primary and Umbrella)

Commercial General Liability Insurance or equivalent with limits of not less than $2,000,000 per occurrence for bodily injury, personal injury and property damage liability. Coverages must include the following: All premises and operations, products/completed operations, separation of insureds, defense and contractual liability (with no limitation endorsement). Cook County is to be named as an additional insured on a primary, non-contributory basis for any liability arising directly or indirectly from the Services.

Subconsultants performing Services for Consultant must maintain limits of not less than $1,000,000 with the same terms in this Section 3.i(2).

(3) Automobile Liability (Primary and Umbrella)

When any motor vehicles (owned, non-owned and hired) are used in connection with Services to be performed, Consultant must provide Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence limit, for bodily injury and property damage. The County is to be named as an additional insured on a primary, non-contributory basis.

(4) Professional Liability

When any professional consultants perform Services in connection with this Agreement, Professional Liability Insurance covering acts, errors or omissions must be maintained with limits of not less than $2,000,000. Coverage must include contractual liability. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, start of Services on this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of 2 years.

Subconsultants performing Services for Consultant must maintain limits of not less than $1,000,000 with the same terms in this Section 3.i(4).

(5) Valuable Papers

When any designs, drawings, specifications and documents are produced or used under this Agreement, Valuable Papers Insurance must be maintained in an amount to insure against any loss whatsoever, and must have limits sufficient to pay for the re-creation and reconstruction of such records.

ii) **Additional Requirements**

(1) Consultant must furnish the County of Cook, Cook County, Office of the Chief Procurement Officer, 118 N, Clark St., Room 1018, Chicago, IL 60602, original Certificates of Insurance, or such similar evidence, to be in force on the date of this Agreement, and Renewal Certificates of Insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Consultant must submit evidence of insurance on the County Insurance Certificate Form (copy attached as Exhibit 3) or equivalent prior to the effective date of the Agreement. The receipt of any certificate does not constitute agreement by the County that the insurance requirements in this Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all Agreement requirements. The failure of the County to obtain certificates or other insurance evidence from Consultant is not a waiver by the County of any requirements for Consultant to obtain and maintain the specified coverages. Consultant must advise all insurers of the provisions in this Agreement regarding insurance. Non-conforming insurance does not relieve Consultant of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of this Agreement, and the County retains the right to terminate this Agreement or to suspend this Agreement until proper evidence of insurance is provided.

(2) The insurance must provide for 60 days prior written notice to be given to the County in the event coverage is substantially changed, canceled or non-renewed. All deductibles or self-insured retentions on referenced insurance coverages must be borne by Consultant. Consultant agrees that insurers waive their rights of subrogation against the County of Cook, its employees, elected officials, agents or representatives.

(3) The coverages and limits furnished by Consultant in no way limit Consultant's liabilities and responsibilities specified within this Agreement or by law. Any insurance or self-insurance programs maintained by the County of Cook apply in excess of and do not contribute with insurance provided by Consultant under this Agreement.

(4) The required insurance is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

(5) Consultant must require all Subconsultants to provide the insurance required in this Agreement, or Consultant may provide the coverages for Subconsultants. All Subconsultants are subject to the same insurance requirements as Consultant unless otherwise specified in this Agreement. If Consultant or Subconsultant desires additional coverages, the party desiring the additional coverages is responsible for its acquisition and cost.

(6) The County's Risk Management Office maintains the rights to modify, delete, alter or change these requirements. "**Risk Management Office**" means the Risk Management Office, which is under the direction of the Director of Risk Management and is charged with reviewing and analyzing insurance and related liability matters for the County.

g) Indemnification

The Consultant covenants and agrees to indemnify and save harmless the County and its commissioners, officials, employees, agents and representatives, and their respective heirs, successors and assigns, from and against any and all costs, expenses, attorney's fees, losses, damages and liabilities incurred or suffered directly or indirectly from or attributable to any claims arising out of or incident to the performance or nonperformance of the Contract by the Consultant, or the acts or omissions of the officers, agents, employees, Consultants, subconsultants, licensees or invitees of the Consultant. The Consultant expressly understands and agrees that any Performance Bond or insurance protection required of the Consultant, or otherwise provided by the Consultant, shall in no way limit the responsibility to indemnify the County as hereinabove provided.

h) Confidentiality and Ownership of Documents

Consultant acknowledges and agrees that information regarding this Contract is confidential and shall not be disclosed, directly, indirectly or by implication, or be used by Consultant in any way, whether during the term of this Contract or at any time thereafter, except solely as required in the course of Consultant's performance hereunder. Consultant shall comply with the applicable privacy laws and regulations affecting County and will not disclose any of County's records, materials, or other data to any third party. Consultant shall not have the right to compile and distribute statistical analyses and reports utilizing data derived from information or data obtained from County without the prior written approval of County. In the event such approval is given, any such reports published and distributed by Consultant shall be furnished to County without charge.

All documents, data, studies, reports, work product or product created as a result of the performance of the Contract (the "Documents") shall be included in the Deliverables and shall be the property of the County of Cook. It shall be a breach of this Contract for the Consultant to reproduce or use any documents, data, studies, reports, work product or product obtained from the County of Cook or any Documents created hereby, whether such reproduction or use is for Consultant's own purposes or for those of any third party. During the performance of the Contract Consultant shall be responsible of any loss or damage to the Documents while they are in Consultant's possession, and any such loss or damage shall be restored at the expense of the Consultant. The County and its designees shall be afforded full access to the Documents and the work at all times.

i) Patents, Copyrights and Licenses

If applicable, Consultant shall furnish the Chief Procurement Officer with all licenses required for the County to utilize any software, including firmware or middleware, provided by Consultant as part of the Deliverables. Such licenses shall be clearly marked with a reference to the number of this County Contract. Consultant shall also furnish a copy of such licenses to the Chief Procurement Officer. Unless otherwise stated in these Contract documents, such licenses shall be perpetual and shall not limit the number of persons who may utilize the software on behalf of the County.

Consultant agrees to hold harmless and indemnify the County, its officers, agents, employees and affiliates from and defend, as permitted by Illinois law, at its own expense (including reasonable attorneys', accountants' and consultants' fees), any suit or proceeding brought against County based upon a claim that the ownership and/or use of equipment, hardware and software or any part thereof provided to the County or utilized in performing Consultant's services constitutes an infringement of any patent, copyright or license or any other property right.

In the event the use of any equipment, hardware or software or any part thereof is enjoined, Consultant with all reasonable speed and due diligence shall provide or otherwise secure for County, at the Consultant's election, one of the following: the right to continue use of the equipment, hardware or software; an equivalent system having the Specifications as provided in this Contract; or Consultant shall modify the system or its component parts so that they become non-infringing while performing in a substantially similar manner to the original system, meeting the requirements of this Contract.

j) Examination of Records and Audits

The Consultant agrees that the Cook County Auditor or any of its duly authorized representatives shall, until expiration of three (3) years after the final payment under the Contract, have access and the right to examine any books, documents, papers, canceled checks, bank statements, purveyor's and other invoices, and records of the Consultant related to the Contract, or to Consultant's compliance with any term, condition or provision thereof. The Consultant shall be responsible for establishing and maintaining records sufficient to document the costs associated with performance under the terms of this Contract.

The Consultant further agrees that it shall include in all of its subcontracts hereunder a provision to the effect that the Subcontractor agrees that the Cook County Auditor or any of its duly authorized representatives shall, until expiration of three (3) years after final payment under the subcontract, have access and the right to examine any books, documents, papers, canceled checks, bank statements, purveyor's and other invoices and records of such Subcontractor involving transactions relating to the subcontract, or to such Subcontractor compliance with any term, condition or provision thereunder or under the Contract.

In the event the Consultant receives payment under the Contract, reimbursement for which is later disallowed by the County, the Consultant shall promptly refund the disallowed amount to the County on request, or at the County's option, the County may credit the amount disallowed from the next payment due or to become due to the Consultant under any contract with the County.

To the extent this Contract pertains to Deliverables which may be reimbursable under the Medicaid or Medicare Programs, Consultant shall retain and make available upon request, for a period of four (4) years after furnishing services pursuant to this Agreement, the contract, books, documents and records which are necessary to certify the nature and extent of the costs of such services if requested by the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives.

If Consultant carries out any of its duties under the Agreement through a subcontract with a related organization involving a value of cost of $10,000.00 or more over a 12 month period, Consultant will cause such subcontract to contain a clause to the effect that, until the expiration of four years after the furnishing of any service pursuant to said subcontract, the related organization will make available upon request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of said subcontract and any books, documents, records and other data of said related organization that are necessary to certify the nature and extent of such costs. This paragraph relating to the retention and production of documents is included because of possible application of Section 1861(v)(1)(I) of the Social Security Act to this Agreement; if this Section should be found to be inapplicable, then this paragraph shall be deemed inoperative and without force and effect.

k) Subcontracting or Assignment of Contract or Contract Funds

Once awarded, this Contract shall not be subcontracted or assigned, in whole or in part, without the advance written approval of the Chief Procurement Officer, which approval shall be granted or withheld at the sole discretion of the Chief Procurement Officer. In no case, however, shall such approval relieve the Consultant from its obligations or change the terms of the Contract. The Consultant shall not transfer or assign any Contract funds or any interest therein due or to become due without the advance written approval of the Chief Procurement Officer. The unauthorized subcontracting or assignment of the Contract, in whole or in part, or the unauthorized transfer or assignment of any Contract funds, either in whole or in part, or any interest therein, which shall be due or are to become due the Consultant shall have no effect on the County and are null and void.

Prior to the commencement of the Contract, the Consultant shall identify in writing to the Chief Procurement Officer the names of any and all Subcontractors it intends to use in the performance of the Contract by completing the Identification of Subcontractor/Supplier/ Subconsultant Form ("ISF"). The Chief Procurement Officer shall have the right to disapprove any Subcontractor. All Subcontractors shall be subject to the terms of this Contract. Consultant shall incorporate into all subcontracts all of the provisions of the Contract which affect such subcontract. Copies of subcontracts shall be provided to the Chief Procurement Officer upon request.

The Consultant must disclose the name and business address of each Subcontractor, attorney, lobbyist, accountant, consultant and any other person or entity whom the Consultant has retained or expects to retain in connection with the Matter, as well as the nature of the relationship, and the total amount of the fees paid or estimated to be paid. The Consultant is not required to disclose employees who are paid or estimated to be paid. The Consultant is not required to disclose employees who are paid solely through the Consultant's regular payroll. "Lobbyist" means any person or entity who undertakes to influence any legislation or administrative action on behalf of any person or entity other than: (1) a not-for-profit entity, on an unpaid basis, or (2), himself.

"Lobbyist" also means any person or entity any part of whose duties as an employee of another includes undertaking to influence any legislative or administrative action. If the Consultant is uncertain whether a disclosure is required under this Section, the Consultant must either ask the County, whether disclosure is required or make the disclosure.

The County reserves the right to prohibit any person from entering any County facility for any reason. All Consultants and Subcontractor of the Consultant shall be accountable to the Chief Procurement Officer or his designee while on any County property and shall abide by all rules and regulations imposed by the County.

l) Professional Social Services

In accordance with 34-146, of the Cook County Procurement Code, all Consultants or providers providing services under a Professional Social Service Contracts or Professional Social Services Agreements, shall submit an annual performance report to the Using Agency, i.e., the agency for whom the Consultant or provider is providing the professional social services, that includes but is not limited to relevant statistics, an empirical analysis where applicable, and a written narrative describing the goals and objectives of the contract or agreement and programmatic outcomes. The annual performance report shall be provided and reported to the Cook County Board of Commissioners by the applicable Using Agency within forty-five days of receipt. Failure of the Consultant or provider to provide an annual performance report will be considered a breach of contract or agreement by the Consultant or provider, and may result in termination of the Contract or agreement.

For purposes of this Section, a Professional Social Service Contract or Professional Social Service Agreement shall mean any contract or agreement with a social service provider, including other governmental agencies, nonprofit organizations, or for profit business enterprises engaged in the field of and providing social services, juvenile justice, mental health treatment, alternative sentencing, offender rehabilitation, recidivism reduction, foster care, substance abuse treatment, domestic violence services, community transitioning services, intervention, or such other similar services which provide mental, social or physical treatment and services to individuals. Said Professional Social Service Contracts or Professional Social Service Agreements do not include CCHHS managed care contracts that CCHHS may enter into with health care providers.

ARTICLE 4) TERM OF PERFORMANCE

a) Term of Performance

This Agreement takes effect when approved by the Cook County Board and its term shall begin on _____("**Effective Date**") and continue until _____ _____or until this Agreement is terminated in accordance with its terms, whichever occurs first.

b) Timeliness of Performance

i) Consultant must provide the Services and Deliverables within the term and within the time limits required under this Agreement, pursuant to the provisions of Section 4.a and Exhibit 1. Further, Consultant acknowledges that TIME IS OF THE ESSENCE and that the failure of Consultant to comply with the time limits described in this Section 4.b may result in economic or other losses to the County.

ii) Neither Consultant nor Consultant's agents, employees nor Subcontractors are entitled to any damages from the County, nor is any party entitled to be reimbursed by the County, for damages, charges or other losses or expenses incurred by Consultant by reason of delays or hindrances in the performance of the Services, whether or not caused by the County.

c) Agreement Extension Option

The Chief Procurement Officer may at any time before this Agreement expires elect to renew this Agreement for _____additional one-year periods under the same terms and conditions as this original Agreement, except as provided otherwise in this Agreement, by notice in writing to Consultant. After notification by the Chief Procurement Officer, this Agreement must be modified to reflect the time extension in accordance with the provisions of Section 10.c.

ARTICLE 5) COMPENSATION

a) Basis of Payment

The County will pay Consultant according to the Schedule of Compensation in the attached Exhibit 2 for the successful completion of services.

b) Method of Payment

All invoices submitted by the Consultant shall be in accordance with the cost provisions contained in the Agreement and shall contain a detailed description of the Deliverables, including the quantity of the Deliverables, for which payment is requested. All invoices for services shall include itemized entries indicating the date or time period in which the services were provided, the amount of time spent performing the services, and a detailed description of the services provided during the period of the invoice. All Contracts for services that are procured as Sole Source must also contain a provision requiring the Contractor to submit itemized records indicating the dates that services were provided, a detailed description of the work performed on each such date, and the amount of time spent performing work on each such date. All invoices shall reflect the amounts invoiced by and the amounts paid to the Consultant as of the date of the invoice. Invoices for new charges shall not include "past due" amounts, if any, which amounts must be set forth on a separate invoice. Consultant shall not be entitled to invoice the County for any late fees or other penalties.

In accordance with Section 34-177 of the Cook County Procurement Code, the County shall have a right to set off and subtract from any invoice(s) or Contract price, a sum equal to any fines and penalties, including interest, for any tax or fee delinquency and any debt or obligation owed by the Consultant to the County.

The Consultant acknowledges its duty to ensure the accuracy of all invoices submitted to the County for payment. By submitting the invoices, the Consultant certifies that all itemized entries set forth in the invoices are true and correct. The Consultant acknowledges that by submitting the invoices, it certifies that it has delivered the Deliverables, i.e., the goods, supplies, services or equipment set forth in the Agreement to the Using Agency, or that it has properly performed the services set forth in the Agreement. The invoice must also reflect the dates and amount of time expended in the provision of services under the Agreement. The Consultant acknowledges that any inaccurate statements or negligent or intentional misrepresentations in the invoices shall result in the County exercising all remedies available to it in law and equity including, but not limited to, a delay in payment or non-payment to the Consultant, and reporting the matter to the Cook County Office of the Independent Inspector General.

When a Consultant receives any payment from the County for any supplies, equipment, goods, or services, it has provided to the County pursuant to its Agreement, the Consultant must make payment to its Subcontractors within 15 days after receipt of payment from the County, provided that such Subcontractor has satisfactorily provided the supplies, equipment, goods or services in accordance with the Contract and provided the Consultant with all of the documents and information required of the Consultant. The Consultant may delay or postpone payment to a Subcontractor when the Subcontractor's supplies, equipment, goods, or services do not comply with the requirements of the Contract, the Consultant is acting in good faith, and not in retaliation for a Subcontractor exercising legal or contractual rights.

c) Funding

The source of funds for payments under this Agreement is identified in Exhibit 2, Schedule of Compensation. Payments under this Agreement must not exceed the dollar amount shown in Exhibit 2 without a written amendment in accordance with Section 10.c.

d) Non-Appropriation

If no funds or insufficient funds are appropriated and budgeted in any fiscal period of the County for payments to be made under this Agreement, then the County will notify Consultant in writing of that occurrence, and this Agreement will terminate on the earlier of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for payment under this Agreement are exhausted. Payments for Services completed to the date of notification will be made to Consultant. No payments will be made or due to Consultant and under this Agreement beyond those amounts appropriated and budgeted by the County to fund payments under this Agreement.

e) Taxes

Federal Excise Tax does not apply to materials purchased by the County by virtue of Exemption Certificate No. 36-75-0038K. Illinois Retailers' Occupation Tax, Use Tax and Municipal Retailers' Occupation Tax do not apply to deliverables, materials or services purchased by the County by virtue of statute. The price or prices quoted herein shall include any and all other federal and/or state, direct and/or indirect taxes which apply to this Contract. The County's State of Illinois Sales Tax Exemption Identification No. is E-9998-2013-07.

f) Price Reduction

If at any time after the contract award, Consultant makes a general price reduction in the price of any of the Deliverables, the equivalent price reduction based on similar quantities and/or considerations shall apply to this Contract for the duration of the Contract period. For purposes of this Section 5.f., Price Reduction, a general price reduction shall include reductions in the effective price charged by Consultant by reason of rebates, financial incentives, discounts, value points or other benefits with respect to the purchase of the Deliverables. Such price reductions shall be effective at the same time and in the same manner as the reduction Consultant makes in the price of the Deliverables to its prospective customers generally.

g) Consultant Credits

To the extent the Consultant gives credits toward future purchases of goods or services, financial incentives, discounts, value points or other benefits based on the purchase of the materials or services provided for under this Contract, such credits belong to the County and not any specific Using Agency. Consultant shall reflect any such credits on its invoices and in the amounts it invoices the County.

ARTICLE 6) DISPUTES

Any dispute arising under the Contract between the County and Consultant shall be decided by the Chief Procurement Officer. The complaining party shall submit a written statement detailing the dispute and specifying the specific relevant Contract provision(s) to the Chief Procurement Officer. Upon request of the Chief Procurement Officer, the party complained against shall respond to the complaint in writing within five days of such request. The Chief Procurement Officer will reduce her decision to writing and mail or otherwise furnish a copy thereof to the Consultant. The decision of the Chief Procurement Officer will be final and binding. Dispute resolution as provided herein shall be a condition precedent to any other action at law or in equity. However, unless a notice is issued by the Chief Procurement Officer indicating that additional time is required to review a dispute, the parties may exercise their contractual remedies, if any, if no decision is made within sixty (60) days following notification to the Chief Procurement Officer of a dispute. No inference shall be drawn from the absence of a decision by the Chief Procurement Officer.

Notwithstanding a dispute, Consultant shall continue to discharge all its obligations, duties and responsibilities set forth in the Contract during any dispute resolution proceeding unless otherwise agreed to by the County in writing.

ARTICLE 7) COOPERATION WITH INSPECTOR GENERAL AND COMPLIANCE WITH ALL LAWS

The Consultant, Subcontractor, licensees, grantees or persons or businesses who have a County contract, grant, license, or certification of eligibility for County contracts shall abide by all of the applicable provisions of the Office of the Independent Inspector General Ordinance (Section 2-281 et. seq. of the Cook County Code of Ordinances). Failure to cooperate as required may result in monetary and/or other penalties.

The Consultant shall observe and comply with the laws, ordinances, regulations and codes of the Federal, State, County and other local government agencies which may in any manner affect the performance of the Contract including, but not limited to, those County Ordinances set forth in the Certifications attached hereto and incorporated herein. Assurance of compliance with this requirement by the Consultant's employees, agents or Subcontractor shall be the responsibility of the Consultant.

The Consultant shall secure and pay for all federal, state and local licenses, permits and fees required hereunder.

ARTICLE 8) SPECIAL CONDITIONS

a) Warranties and Representations

In connection with signing and carrying out this Agreement, Consultant:

i) warrants that Consultant is appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which Consultant is not appropriately licensed;

ii) warrants it is financially solvent; it and each of its employees, agents and Subcontractors of any tier are competent to perform the Services required under this Agreement; and Consultant is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

iii) warrants that it will not knowingly use the services of any ineligible consultant or Subcontractor for any purpose in the performance of its Services under this Agreement;

iv) warrants that Consultant and its Subcontractors are not in default at the time this Agreement is signed, and has not been considered by the Chief Procurement Officer to have, within 5 years immediately preceding the date of this Agreement, been found to be in default on any contract awarded by the County;

v) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this Agreement; this Agreement is feasible of performance in accordance with all of its provisions and requirements, and Consultant warrants it can and will perform, or cause to be performed, the Services in strict accordance with the provisions and requirements of this Agreement;

vi) represents that Consultant and, to the best of its knowledge, its Subcontractors are not in violation of the provisions of the Illinois Criminal Code, 720 ILCS 5/33E as amended; and

vii) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 9.a and 9.c.

b) Ethics

i) In addition to the foregoing warranties and representations, Consultant warrants:

(1) no officer, agent or employee of the County is employed by Consultant or has a financial interest directly or indirectly in this Agreement or the compensation to be paid under this Agreement except as may be permitted in writing by the Board of Ethics.

(2) no payment, gratuity or offer of employment will be made in connection with this Agreement by or on behalf of any Subcontractors to the prime Consultant or higher tier Subcontractors or anyone associated with them, as an inducement for the award of a subcontract or order.

c) Joint and Several Liability

If Consultant, or its successors or assigns, if any, is comprised of more than one individual or other legal entity (or a combination of them), then under this Agreement, each and without limitation every obligation or undertaking in this Agreement to be fulfilled or performed by Consultant is the joint and several obligation or undertaking of each such individual or other legal entity.

d) Business Documents

At the request of the County, Consultant must provide copies of its latest articles of incorporation, by-laws and resolutions, or partnership or joint venture agreement, as applicable.

e) Conflicts of Interest

i) No member of the governing body of the County or other unit of government and no other officer, employee or agent of the County or other unit of government who exercises any functions or responsibilities in connection with the Services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. No member of or delegate to the Congress of the United States or the Illinois General Assembly and no Commissioner of the Cook County Board or County employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.

ii) Consultant covenants that it, and to the best of its knowledge, its Subcontractors if any (collectively, "**Consulting Parties**"), presently have no direct or indirect interest and will not acquire any interest, direct or indirect, in any project or contract that would conflict in any manner or degree with the performance of its Services under this Agreement.

iii) Upon the request of the County, Consultant must disclose to the County its past client list and the names of any clients with whom it has an ongoing relationship. Consultant is not permitted to perform any Services for the County on applications or other documents submitted to the County by any of Consultant's past or present clients. If Consultant becomes aware of a conflict, it must immediately stop work on the assignment causing the conflict and notify the County.

iv) Without limiting the foregoing, if the Consulting Parties assist the County in determining the advisability or feasibility of a project or in recommending, researching, preparing, drafting or issuing a request for proposals or bid specifications for a project, the Consulting Parties must not participate, directly or indirectly, as a prime, Subcontractor or joint venturer in that project or in the preparation of a proposal or bid for that project during the term of this Agreement or afterwards. The Consulting Parties may, however, assist the County in reviewing the proposals or bids for the project if none of the Consulting Parties have a relationship with the persons or entities that submitted the proposals or bids for that project.

v) The Consultant further covenants that, in the performance of this Agreement, no person having any conflicting interest will be assigned to perform any Services or have access to any confidential information, as defined in Section 3.h of this Agreement. If the County, by the Chief Procurement Officer in his reasonable judgment, determines that any of Consultant's Services for others conflict with the Services Consultant is to render for the County under this Agreement, Consultant must terminate such other services immediately upon request of the County.

vi) Furthermore, if any federal funds are to be used to compensate or reimburse Consultant under this Agreement, Consultant represents that it is and will remain in compliance with federal restrictions on lobbying set forth in Section 319 of the Department of the Interior and Related Agencies Appropriations Act for Fiscal year 1990, 31 U.S.C. § 1352, and related rules and regulations set forth at 54 Fed. Reg. 52,309 ff. (1989), as amended. If federal funds are to be used, Consultant must execute a Certification Regarding Lobbying, which will be attached as an exhibit and incorporated by reference as if fully set forth here.

f) Non-Liability of Public Officials

Consultant and any assignee or Subcontractor of Consultant must not charge any official, employee or agent of the County personally with any liability or expenses of defense or hold any official, employee or agent of the County personally liable to them under any term or provision of this Agreement or because of the County's execution, attempted execution or any breach of this Agreement.

ARTICLE 9) EVENTS OF DEFAULT, REMEDIES, TERMINATION, SUSPENSION AND RIGHT TO OFFSET

a) Events of Default Defined

The following constitute events of default:

i) Any material misrepresentation, whether negligent or willful and whether in the inducement or in the performance, made by Consultant to the County.

ii) Consultant's material failure to perform any of its obligations under this Agreement including the following:

(a) Failure due to a reason or circumstances within Consultant's reasonable control to perform the Services with sufficient personnel and equipment or with sufficient material to ensure the performance of the Services;

(b) Failure to perform the Services in a manner reasonably satisfactory to the Chief Procurement Officer or inability to perform the Services satisfactorily as a result of insolvency, filing for bankruptcy or assignment for the benefit of creditors;

(c) Failure to promptly re-perform within a reasonable time Services that were rejected as erroneous or unsatisfactory;

(d) Discontinuance of the Services for reasons within Consultant's reasonable control; and

(e) Failure to comply with any other material term of this Agreement, including the provisions concerning insurance and nondiscrimination.

iii) Any change in ownership or control of Consultant without the prior written approval of the Chief Procurement Officer, which approval the Chief Procurement Officer will not unreasonably withhold.

iv) Consultant's default under any other agreement it may presently have or may enter into with the County during the life of this Agreement. Consultant acknowledges and agrees that in the event of a default under this Agreement the County may also declare a default under any such other Agreements.

v) Failure to comply with Article 7 in the performance of the Agreement.

vi) Consultant's repeated or continued violations of County ordinances unrelated to performance under the Agreement that in the opinion of the Chief Procurement Officer indicate a willful or reckless disregard for County laws and regulations.

b) Remedies

The occurrence of any event of default permits the County, at the County's sole option, to declare Consultant in default. The Chief Procurement Officer may in his sole discretion give Consultant an opportunity to cure the default within a certain period of time, which period of time must not exceed 30 days, unless extended by the Chief Procurement Officer. Whether to declare Consultant in default is within the sole discretion of the Chief Procurement Officer and neither that decision nor the factual basis for it is subject to review or challenge under the Disputes provision of this Agreement.

The Chief Procurement Officer will give Consultant written notice of the default, either in the form of a cure notice ("**Cure Notice**"), or, if no opportunity to cure will be granted, a default notice ("**Default Notice**"). If the Chief Procurement Officer gives a Default Notice, he will also indicate any present intent he may have to terminate this Agreement, and the decision to terminate (but not the decision not to terminate) is final and effective upon giving the notice. The Chief Procurement Officer may give a Default Notice if Consultant fails to affect a cure within the cure period given in a Cure Notice. When a Default Notice with intent to terminate is given as provided in this Section 9.b and Article 11, Consultant must discontinue any Services, unless otherwise directed in the notice, and deliver all materials accumulated in the performance of this Agreement, whether completed or in the process, to the County. After giving a Default Notice, the County may invoke any or all of the following remedies:

i) The right to take over and complete the Services, or any part of them, at Consultant's expense and as agent for Consultant, either directly or through others, and bill Consultant for the cost of the Services, and Consultant must pay the difference between the total amount of this bill and the amount the County would have paid Consultant under the terms and conditions of this Agreement for the Services that were assumed by the County as agent for the Consultant under this Section 9.b;

ii) The right to terminate this Agreement as to any or all of the Services yet to be performed effective at a time specified by the County;

iii) The right of specific performance, an injunction or any other appropriate equitable remedy;

iv) The right to money damages;

v) The right to withhold all or any part of Consultant's compensation under this Agreement;

vi) The right to consider Consultant non-responsible in future contracts to be awarded by the County.

If the Chief Procurement Officer considers it to be in the County's best interests, he may elect not to declare default or to terminate this Agreement. The parties acknowledge that this provision is solely for the benefit of the County and that if the County permits Consultant to continue to provide the Services despite one or more events of default, Consultant is in no way relieved of any of its responsibilities, duties or obligations under this Agreement, nor does the County waive or relinquish any of its rights.

The remedies under the terms of this Agreement are not intended to be exclusive of any other remedies provided, but each and every such remedy is cumulative and is in addition to any other remedies, existing now or later, at law, in equity or by statute. No delay or omission to exercise any right or power accruing upon any event of default impairs any such right or power, nor is it a waiver of any event of default nor acquiescence in it, and every such right and power may be exercised from time to time and as often as the County considers expedient.

c) Early Termination

In addition to termination under Sections 9.a and 9.b of this Agreement, the County may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by a notice in writing from the County to Consultant. The County will give notice to Consultant in accordance with the provisions of Article 11. The effective date of termination will be the date the notice is received by Consultant or the date stated in the notice, whichever is later. If the County elects to terminate this Agreement in full, all Services to be provided under it must cease and all materials that may have been accumulated in performing this Agreement, whether completed or in the process, must be delivered to the County effective 10 days after the date the notice is considered received as provided under Article 11 of this Agreement (if no date is given) or upon the effective date stated in the notice.

After the notice is received, Consultant must restrict its activities, and those of its Subcontractors, to winding down any reports, analyses, or other activities previously begun. No costs incurred after the effective date of the termination are allowed. Payment for any Services actually and satisfactorily performed before the effective date of the termination is on the same basis as set forth in Article 5, but if any compensation is described or provided for on the basis of a period longer than 10 days, then the compensation must be prorated accordingly. No amount of compensation, however, is permitted for anticipated profits on unperformed Services. The County and Consultant must attempt to agree on the amount of compensation to be paid to Consultant, but if not agreed on, the dispute must be settled in accordance with Article 6 of this Agreement. The payment so made to Consultant is in full settlement for all Services satisfactorily performed under this Agreement.

Consultant must include in its contracts with Subcontractors an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the County arising from termination of subcontracts after the early termination. Consultant will not be entitled to make any early termination claims against the County resulting from any Subcontractor's claims against Consultant or the County to the extent inconsistent with this provision.

If the County's election to terminate this Agreement for default under Sections 9.a and 9.b is determined in a court of competent jurisdiction to have been wrongful, then in that case the termination is to be considered to be an early termination under this Section 9.c.

d) Suspension

The County may at any time request that Consultant suspend its Services, or any part of them, by giving 15 days prior written notice to Consultant or upon informal oral, or even no notice, in the event of emergency. No costs incurred after the effective date of such suspension are allowed. Consultant must promptly resume its performance of the Services under the same terms and conditions as stated in this Agreement upon written notice by the Chief Procurement Officer and such equitable extension of time as may be mutually agreed upon by the Chief Procurement Officer and Consultant when necessary for continuation or completion of Services. Any additional costs or expenses actually incurred by Consultant as a result of recommencing the Services must be treated in accordance with the compensation provisions under Article 5 of this Agreement.

No suspension of this Agreement is permitted in the aggregate to exceed a period of 45 days within any one year of this Agreement. If the total number of days of suspension exceeds 45 days, Consultant by written notice may treat the suspension as an early termination of this Agreement under Section 9.c.

e) Right to Offset

In connection with performance under this Agreement, the County may offset any excess costs incurred:

i) if the County terminates this Agreement for default or any other reason resulting from Consultant's performance or non-performance;

ii) if the County exercises any of its remedies under Section 9.b of this Agreement; or

iii) if the County has any credits due or has made any overpayments under this Agreement.

The County may offset these excess costs by use of any payment due for Services completed before the County terminated this Agreement or before the County exercised any remedies. If the amount offset is insufficient to cover those excess costs, Consultant is liable for and must promptly remit to the County the balance upon written demand for it. This right to offset is in addition to and not a limitation of any other remedies available to the County.

f) Delays

Consultant agrees that no charges or claims for damages shall be made by Consultant for any delays or hindrances from any cause whatsoever during the progress of any portion of this Contract.

g) Prepaid Fees

In the event this Contract is terminated by either party, for cause or otherwise, and the County has prepaid for any Deliverables, Consultant shall refund to the County, on a prorated basis to the effective date of termination, all amounts prepaid for Deliverables not actually provided as of the effective date of the termination. The refund shall be made within fourteen (14) days of the effective date of termination.

ARTICLE 10) GENERAL CONDITIONS

a) Entire Agreement

i) General

This Agreement, and the exhibits attached to it and incorporated in it, constitute the entire agreement between the parties and no other warranties, inducements, considerations, promises or interpretations are implied or impressed upon this Agreement that are not expressly addressed in this Agreement.

ii) No Collateral Agreements

Consultant acknowledges that, except only for those representations, statements or promises expressly contained in this Agreement and any exhibits attached to it and incorporated by reference in it, no representation, statement or promise, oral or in writing, of any kind whatsoever, by the County, its officials, agents or employees, has induced Consultant to enter into this Agreement or has been relied upon by Consultant, including any with reference to:

(a) the meaning, correctness, suitability or completeness of any provisions or requirements of this Agreement;

(b) the nature of the Services to be performed;

(c) the nature, quantity, quality or volume of any materials, equipment, labor and other facilities needed for the performance of this Agreement;

(d) the general conditions which may in any way affect this Agreement or its performance;

(e) the compensation provisions of this Agreement; or

(f) any other matters, whether similar to or different from those referred to in (a) through (e) immediately above, affecting or having any connection with this Agreement, its negotiation, any discussions of its performance or those employed or connected or concerned with it.

iii) **No Omissions**

Consultant acknowledges that Consultant was given an opportunity to review all documents forming this Agreement before signing this Agreement in order that it might request inclusion in this Agreement of any statement, representation, promise or provision that it desired or on that it wished to place reliance. Consultant did so review those documents, and either every such statement, representation, promise or provision has been included in this Agreement or else, if omitted, Consultant relinquishes the benefit of any such omitted statement, representation, promise or provision and is willing to perform this Agreement in its entirety without claiming reliance on it or making any other claim on account of its omission.

b) Counterparts

This Agreement is comprised of several identical counterparts, each to be fully signed by the parties and each to be considered an original having identical legal effect.

c) Contract Amendments

The parties may during the term of the Contract make amendments to the Contract but only as provided in this section. Such amendments shall only be made by mutual agreement in writing.

In the case of Contracts not approved by the Board, the Chief Procurement Officer may amend a contract provided that any such amendment does not extend the Contract by more than one (1) year, and further provided that the total cost of all such amendments does not increase the total amount of the Contract beyond $150,000. Such action may only be made with the advance written approval of the Chief Procurement Officer. If the amendment extends the Contract beyond one (1) year or increases the total award amount beyond $150,000, then Board approval will be required.

No Using Agency or employee thereof has authority to make any amendments to this Contract. Any amendments to this Contract made without the express written approval of the Chief Procurement Officer is void and unenforceable.

Consultant is hereby notified that, except for amendments which are made in accordance with this Section10.c. Contract Amendments, no Using Agency or employee thereof has authority to make any amendment to this Contract.

d) Governing Law and Jurisdiction

This Contract shall be governed by and construed under the laws of the State of Illinois. The Consultant irrevocably agrees that, subject to the County's sole and absolute election to the contrary, any action or proceeding in any way, manner or respect arising out of the Contract, or arising from any dispute or controversy arising in connection with or related to the Contract, shall be litigated only in courts within the Circuit Court of Cook County, State of Illinois, and the Consultant consents and submits to the jurisdiction thereof. In accordance with these provisions, Consultant waives any right it may have to transfer or change the venue of any litigation brought against it by the County pursuant to this Contract.

e) Severability

If any provision of this Agreement is held or considered to be or is in fact invalid, illegal, inoperative or unenforceable as applied in any particular case in any jurisdiction or in all cases because it conflicts with any other provision or provisions of this Agreement or of any constitution, statute, ordinance, rule of law or public policy, or for any other reason, those circumstances do not have the effect of rendering the provision in question invalid, illegal, inoperative or unenforceable in any other case or circumstances, or of rendering any other provision or provisions in this Agreement invalid, illegal, inoperative or unenforceable to any extent whatsoever. The invalidity, illegality, inoperativeness or unenforceability of any one or more phrases, sentences, clauses or sections in this Agreement does not affect the remaining portions of this Agreement or any part of it.

f) Assigns

All of the terms and conditions of this Agreement are binding upon and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

g) Cooperation

Consultant must at all times cooperate fully with the County and act in the County's best interests. If this Agreement is terminated for any reason, or if it is to expire on its own terms, Consultant must make every effort to assure an orderly transition to another provider of the Services, if any, orderly demobilization of its own operations in connection with the Services, uninterrupted provision of Services during any transition period and must otherwise comply with the reasonable requests and requirements of the Using Agency in connection with the termination or expiration.

h) Waiver

Nothing in this Agreement authorizes the waiver of a requirement or condition contrary to law or ordinance or that would result in or promote the violation of any federal, state or local law or ordinance.

Whenever under this Agreement the County by a proper authority waives Consultant's performance in any respect or waives a requirement or condition to either the County's or Consultant's performance, the waiver so granted, whether express or implied, only applies to the particular instance and is not a waiver forever or for subsequent instances of the performance, requirement or condition. No such waiver is a modification of this Agreement regardless of the number of times the County may have waived the performance, requirement or condition. Such waivers must be provided to Consultant in writing.

i) Independent Consultant

This Agreement is not intended to and will not constitute, create, give rise to, or otherwise recognize a joint venture, partnership, corporation or other formal business association or organization of any kind between Consultant and the County. The rights and the obligations of the parties are only those expressly set forth in this Agreement. Consultant must perform under this Agreement as an independent Consultant and not as a representative, employee, agent, or partner of the County.

This Agreement is between the County and an independent Consultant and, if Consultant is an individual, nothing provided for under this Agreement constitutes or implies an employer-employee relationship such that:

i) The County will not be liable under or by reason of this Agreement for the payment of any compensation award or damages in connection with the Consultant performing the Services required under this Agreement.

ii) Consultant is not entitled to membership in the County Pension Fund, Group Medical Insurance Program, Group Dental Program, Group Vision Care, Group Life Insurance Program, Deferred Income Program, vacation, sick leave, extended sick leave, or any other benefits ordinarily provided to individuals employed and paid through the regular payrolls of the County.

iv) The County is not required to deduct or withhold any taxes, FICA or other deductions from any compensation provided to the Consultant.

j) Governmental Joint Purchasing Agreement

Pursuant to Section 4 of the Illinois Governmental Joint Purchasing Act (30 ILCS 525) and the Joint Purchase Agreement approved by the Cook County Board of Commissioners (April 9, 1965), other units of government may purchase goods or services under this contract.

In the event that other agencies participate in a joint procurement, the County reserves the right to renegotiate the price to accommodate the larger volume.

k) Comparable Government Procurement

As permitted by the County of Cook, other government entities, if authorized by law, may wish to purchase the goods, supplies, services or equipment under the same terms and conditions contained in this Contract (i.e., comparable government procurement). Each entity wishing to reference this Contract must have prior authorization from the County of Cook and the Consultant. If such participation is authorized, all purchase orders will be issued directly from and shipped directly to the entity requiring the goods, supplies, equipment or services supplies/services. The County shall not be held responsible for any orders placed, deliveries made or payment for the goods, supplies, equipment or services supplies/services ordered by these entities. Each entity reserves the right to determine the amount of goods, supplies, equipment or services it wishes to purchase under this Contract.

l) Force Majeure

Neither Consultant nor County shall be liable for failing to fulfill any obligation under this Contract if such failure is caused by an event beyond such party's reasonable control and which is not caused by such party's fault or negligence. Such events shall be limited to acts of God, acts of war, fires, lightning, floods, epidemics, or riots.

ARTICLE 11) NOTICES

All notices required pursuant to this Contract shall be in writing and addressed to the parties at their respective addresses set forth below. All such notices shall be deemed duly given if hand delivered or if deposited in the United States mail, postage prepaid, registered or certified, return receipt requested. Notice as provided herein does not waive service of summons or process.

If to the County: Cook County Department of Risk Management
118 N. Clark Street, Room 1072
Chicago, IL 60602
Attention: Deanna L. Zalas, Director

and

Cook County Chief Procurement Officer
118 North Clark Street. Room 1018
Chicago, Illinois 60602
(Include County Contract Number on all notices)

If to Consultant: _____
_____
_____
Attention: _____

Changes in these addresses must be in writing and delivered in accordance with the provisions of this Article 11. Notices delivered by mail are considered received three days after mailing in accordance with this Article 11. Notices delivered personally are considered effective upon receipt. Refusal to accept delivery has the same effect as receipt.

ARTICLE 12) AUTHORITY

Execution of this Agreement by Consultant is authorized by a resolution of its Board of Directors, if a corporation, or similar governing document, and the signature(s) of each person signing on behalf of Consultant have been made with complete and full authority to commit Consultant to all terms and conditions of this Agreement, including each and every representation, certification and warranty contained in it, including the representations, certifications and warranties collectively incorporated by reference in it.

EXHIBIT 1

Scope of Services

EXHIBIT 2

Schedule of Compensation

EXHIBIT 3

Evidence of Insurance

EXHIBIT 4

Identification of Subcontractor/Supplier/Subconsultant Form

EXHIBIT 5

Board Authorization

EXHIBIT 6

Minority and Women Owned Business Enterprise Commitment

EXHIBIT 7

Economic Disclosure Statement

Insurance Requirements of the Contractor

Prior to the effective date of this Contract, the Contractor, at its cost, shall secure and maintain at all times until completion of the term of this Contract the insurance specified below, unless specified otherwise.

Nothing contained in these insurance requirements is to be construed as limiting the extent of the Contractor's responsibility for payment of damages resulting from its operations under this Contract.

Contractor shall require all Subcontractors to provide the insurance required in this Agreement, or Contractor may provide the coverages for Subcontractors. All Subcontractors are subject to the same insurance requirements as Contractor unless specified otherwise.

The Cook County Department of Risk Management maintains the right to modify, delete, alter or change these requirements.

Coverages

(a) **Workers Compensation Insurance**

Workers' Compensation shall be in accordance with the laws of the State of Illinois or any other applicable jurisdiction.

The Workers Compensation policy shall also include the following provisions:

(1) Employers' Liability coverage with a limit of
$500,000 each Accident
$500,000 each Employee
$500,000 Policy Limit for Disease

(b) **Commercial General Liability Insurance**

The Commercial General Liability shall be on an occurrence form basis (ISO Form CG 0001 or equivalent) to cover bodily injury, personal injury and property damage.

Each Occurrence	$ 1,000,000
General Aggregate	$ 2,000,000
Completed Operations Aggregate	$ 2,000,000

The General Liability policy shall include the following coverages:

(a) All premises and operations;
(b) Contractual Liability;
(c) Products/Completed Operations;
(d) Severability of interest/separation of insureds clause

(c) **Commercial Automobile Liability Insurance**

When any vehicles are used in the performance of this contract, Contractor shall secure Automobile Liability Insurance for bodily injury and property damage arising from the ownership, maintenance or use of owned, hired and non-owned vehicles with a limit no less than $1,000,000 per accident.

(d) **Umbrella/Excess Liability**

Such policy shall be excess over Commercial General Liability, Automobile Liability, and Employer's Liability with limits not less than the following amounts:

Each Occurrence:	$2,000,000

Contractor shall determine if Subcontractors shall maintain Umbrella/Excess Liability insurance and the limits of coverage.

(e) Professional Errors and Omissions Liability

When any professional services are provided, Contractor shall secure Professional Liability insurance covering claims arising out of the performance or nonperformance of professional services for the County under this Agreement. This professional liability insurance shall remain in force for the life of the Contractor's obligations under this Agreement, and shall have a limit of liability of not less than $5,000,000 per claim. Contractor shall determine if Subcontractors shall maintain Professional Errors & Omissions Liability insurance and the limits of coverage.

(a) The retroactive coverage date shall be no later than the effective date of this contract.
(b) Coverage shall be maintained for a minimum of two (2) years after final completion of the services or work provided by the vendor.

(f) Network Security Liability

Contractor shall secure coverage for third party claims and losses to the County arising from network security risks related to services or products provided under this agreement such as data breaches, breaches of confidential information, transmission of virus or malicious code, unauthorized access or criminal use of third party information, ID/data theft, and, invasion of privacy regardless of the type of media involved in the loss, breach, transmission, or access.

This insurance shall remain in force for the life of the Contractor's obligations under this Agreement, including any period that results from a renewal or extension of the agreement, and shall have a limit of liability of not less than $5,000,000 per claim. Contractor shall determine if Subcontractors shall maintain Network Security Liability insurance and the limits of coverage.

(a) Coverage must be maintained for a minimum of two (2) years after the completion of services or work provided by the vendor.

Additional requirements

(a) **Additional Insured**

The required insurance policies, with the exception of Workers Compensation and Professional Liability, shall name Cook County, its officials, employees and agents as additional insureds with respect to operations performed on a primary and non-contributory basis. Any insurance or self-insurance maintained by Cook County shall be excess of the Contractor's insurance and shall not contribute with it. The full policy limits and scope of protection shall apply to Cook County as an additional insured even if it exceeds the minimum insurance requirements specified herein.

All insurance companies providing coverage shall be licensed/approved/authorized by the Department of Insurance, State of Illinois, and shall have a financial rating no lower than (A-) VII as listed in A.M. Best's Key Rating Guide, current edition or interim report. Companies with ratings lower than (A-) VII will be acceptable only upon consent of the Cook County Department of Risk Management. The insurance limits required herein may be satisfied by a combination of primary, umbrella and/or excess liability insurance policies.

(c) **Insurance Notices**

Contractor shall provide the Office of the Chief Procurement Officer with thirty (30) days advance written notice in the event any required insurance will be cancelled or non-renewed. Contractor shall secure replacement coverage to comply with the stated

insurance requirements and provide new certificates of insurance to the Office of the Chief Procurement Officer.

Prior to the date on which Contractor commences performance of its part of the work, Contractor shall furnish to the Office of the Chief Procurement Officer certificates of insurance maintained by Contractor. The receipt of any certificate of insurance does not constitute agreement by the County that the insurance requirements have been fully met or that the insurance policies indicated on the certificate of insurance are in compliance with insurance required above.

In no event shall any failure of the County to receive certificates of insurance required hereof or to demand receipt of such Certificates of Insurance be construed as a waiver of Contractor's obligations to obtain insurance pursuant to these insurance requirements.

(d) **Waiver of Subrogation Endorsements**

All insurance policies, except professional liability, shall contain a Waiver of Subrogation Endorsement in favor of Cook County.

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the <<insert date>> by and between County of Cook ("County"), a public body corporate of the State of Illinois, hereinafter referred to as "Covered Entity", and <<entity>> hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

Business Associate may have access to Protected Health Information ("PHI") from or on behalf of Covered Entity. To the extent applicable, the Parties desire to meet their respective obligations under the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"). The HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules codified in the Code of Federal Regulations ("C.F.R.") at 45 C.F.R. parts 160 and 164, Pub. Law No. 104-191 (collectively, "HIPAA") and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations (collectively, "HITECH").

Business Associate agrees that as of the effective date this Agreement it shall abide by the provisions of this Agreement with respect to any Protected Health Information or Electronic Protected Health Information (as defined below).

1. **DEFINITIONS**

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule.

(a). Breach. "Breach" shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information subject to the exceptions set forth in 45 C.F.R. 164.402.

(b). Business Associate. "Business Associate" shall generally have the same meaning as the term "Business Associate" at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean the entity named above.

(c). Covered Entity. "Covered Entity" shall generally have the same meaning as the term "Covered Entity" at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean Cook County.

(d). Electronic Protected Health Information. "Electronic Protected Health Information" or "EPHI" shall have the same meaning as the term "Electronic Protected Health Information" in 45 C.F.R. 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

(e). Individual. "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. 164.502(g).

(f). Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164.

(g). Protected Health Information. "Protected Health Information" or PHI shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. 106.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

(h). Required By Law. "Required By Law" shall have the same meaning as the term "Required By Law" in 45

C.F.R. 164.103.

(i). Secretary. "Secretary" shall mean the Secretary of the U.S Department of Health and Human Services or his designee.

(j). Security Rule. "Security Rule" shall mean the Security Standards at 45 C.F.R. parts 160, and 164.

(k). Unsecured Protected Health Information. "Unsecured Protected Health Information" shall mean Protected Health Information is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary.

2. **OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

(a). For purposes of this Part 2, Business Associate shall ensure that any obligations, restrictions, or conditions set forth herein shall apply to any of its employees, agents, consultants, contractors or subcontractors or assigns who creates, receives, maintains or transmits Covered Entity's Protected Health Information. Business Associate shall not use any Subcontractor to assist Business Associate with the provision of services under the Master Agreement without the prior written consent of Covered Entity.

(b). Business Associate shall not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

(c). Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Privacy Rule, Security Rule, and the HITECH Act.

(d). Business Associate shall report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

(e). Business Associate must, following the discovery of any appearance of a Breach, non-permitted use or disclosure, security incident, or other incident affecting unsecured Protected Health Information, notify the _____without unreasonable delay, and no later than 5 days from the date that the Business Associate discovers such Breach, non-permitted use or disclosure, security incident, or other incident. Business Associate shall provide any reports or notices required by HIPAA as a result of Business Associate's discovery. On behalf of Covered Entity, Business Associate will provide such reports or notices to any party or entity (including but not limited to media, Secretary, and individuals affected by the Breach) entitled by law to receive the reports or notices as directed by the_____ for Cook County. Business Associate agrees to pay the costs associated with notifying individuals affected by the Breach, which may include, but are not limited to, paper, printing, and mailing costs. In the event of a disagreement, the final determination of whether a Breach occurred will be made by the _____ .

(f). If applicable, Business Associate shall provide access, at the request of Covered Entity, and in a reasonable time and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual or an individual's designee in order to meet the requirements under 45 C.F.R. 164.524.

(g). Business Associate shall, when directed by Covered Entity, make amendment(s) to Protected Health

Information in a Designated Record Set in a reasonable time and manner, or take other measures as necessary, as required by 45 C.F.R. 164.526.

(h). Business Associate shall make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with HIPAA and the HITECH Act.

(i). Business Associate shall restrict disclosure of an Individual's Protected Health Information as directed by Covered Entity.

(j). Business Associate shall provide to Covered Entity when requested for a specific individual, in a reasonable time and manner, an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

(k). In order to monitor the privacy and security of its PHI, the Covered Entity may request, and Business Associate shall make available to Covered Entity, information regarding the Business Associate's HIPAA Privacy and/or Security program, including the most recent electronic Protected Health Information risk analysis, policies, procedures, Security Incident log and responses, and evidence of training, including training materials and training logs.

(l). To the extent Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.

3. **PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

3.1 For purposes of this Part 3, Business Associate shall ensure that any of its employees, agents, consultants, contractors or subcontractors or assigns who creates, receives, maintains or transmits Covered Entity's Protected Health Information shall comply with the provisions set for herein.

(a). Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as set forth in this Agreement.

(b). Business Associate may use or disclose Protected Health Information as Required by Law.

(c). Business Associate agrees to make uses and disclosures and requests for Protected Health Information consistent with Covered Entity's minimum necessary policies and procedures.

(d). Business Associate may not use or disclose Protected Health Information in a manner that would violate the Privacy Rule if done by Covered Entity, except for the specific uses and disclosures set forth below in Section 3.1 (f), (g), and 3.2.

(e). Business Associate shall not, directly or indirectly, receive remuneration in exchange for any Protected Health Information unless the exchange qualifies as an exception to the HIPAA general rule, as outlined in the HIPAA regulations and is permitted by this Agreement and the Master Agreement.

(f). Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

(g). Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(h). Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(i). Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

3.2 **Data Ownership**

Business Associate acknowledges and agrees that Covered Entity owns all right, title, and interest in and to all Protected Health Information of Covered Entity that Business Associate creates, receives, maintains or transmits and that such all such right, title, and interest is vested in Covered Entity; nor shall Business Associate nor any of its employees, agents, consultants or assigns have any right, title or interest to any of the Protected Health Information. Business Associate shall not use the Protected Health Information in any form including, but not limited to, stripped, de-identified, or aggregated information, or statistical information derived from or in connection with the Protected Health Information, except as expressly set forth in this Agreement. Business Associate represents, warrants, and covenants that it will not compile and/or distribute analyses to third parties using any Protected Health Information without Covered Entity's express written consent.

4. **OBLIGATIONS OF COVERED ENTITY**

4.1 **Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions**

(a). Covered Entity shall notify Business Associate itself of any limitation(s) in the Notice of Privacy Practices of Covered Entity, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b). Covered Entity shall notify Business Associate itself of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c). Covered Entity shall notify Business Associate itself of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to as provided in 45 C.F.R. 164.522,

to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

(d). Covered Entity shall obtain any consent, authorization or permission that may be required by the Privacy Rule or applicable state law and/or regulations prior to furnishing Business Associate with Protected Health Information .

4.2 **Permissible Requests by Covered Entity**

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except for uses and disclosures under Section 3.2.

5. **TERMINATION**

(a). Term. This Agreement shall be effective as of the Effective Date, and shall either terminate when Covered Entity provides written notice to Business Associate or as provided in 5(b), Termination for Cause, below.

(b). Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement;
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

(c). Effect of Termination.

1. Except as provided in paragraph (2) of this Section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, received, or maintained by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of consultants, contractors, subcontractors, employees or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

   a. Business Associate shall render all paper PHI unusable through an appropriate method, which may include shredding, pulverization or burning.

   b. Business Associate shall render all ePHI unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of HHS.

   c. To the extent it is necessary for Business Associate to destroy any PHI, Business Associate shall provide a specific, detailed account of the destruction process if so account is requested by Covered Entity.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make returning or destroying it infeasible. If Covered Entity

agrees that such return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

3. The provisions of this Section 5(c), Effect of Termination, shall survive the termination of this Agreement.

6. **MITIGATION**

(a). Mitigation. To the extent known or reasonably foreseeable, Business Associate agrees to use commercially reasonable efforts to mitigate, to the extent practicable, any harmful effect resulting from a use or disclosure of Protected Health Information by Business Associate or its agents in violation of the terms of this Agreement. Business Associate agrees to establish procedures to investigate the PHI Incident, mitigate losses and protect against any future PHI Incidents, and to provide a description of these procedures and the specific findings of the investigation to Covered Entity in the time and manner reasonably requested by Covered Entity.

7. **MISCELLANEOUS**

(a). Regulatory References. A reference in this Agreement to a Section in HIPAA or the HITECH Act means the Section as in effect or as amended.

(b). Amendment. The Parties agree to meet and confer regarding amendment of this Agreement from time to time as is necessary for either Party or both Parties to comply with the requirements of HIPAA and the HITECH Act. Any amendment, however, must be mutually agreed upon by the Parties in writing. In the event the Parties are, for any reason, unable to agree on an acceptable amendment, either Party may terminate this Agreement on written notice to the other Party.

(c). Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Parties to comply with the HIPAA and the HITECH Act as may be amended from time to time.

(d). Construction of Terms. The terms of this Agreement shall be construed in light of any applicable interpretation or guidance on HIPAA and/or the HITECH Act issued by HHS or the Office for Civil Rights ("OCR") from time to time.

(e). No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

BUSINESS ASSOCIATE		COVERED ENTITY	
TYPE OR PRINT YOUR NAME		TYPE OR PRINT YOUR NAME	
TITLE		TITLE	
SIGNATURE	DATE	SIGNATURE	DATE

Requirements for Cook County Pension Fund (The Fund)

Table of Contents

Description of Benefits

Summary Plan Description

Cook County Pension Fund
Choice Plan

Effective: January 1, 2018
Group Number: 902956

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (888) 651-7313.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

Cook County & Forest Preserve District Annuity & Benefit Fund (referred to in this SPD as Cook County Pension Fund) is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Cook County Pension Fund is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact Cook County Health Benefits at (312) 603-1200 or call the number on the back of your ID card.

How to Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of your SPD and any future amendments by contacting Cook County Health Benefits at (312) 603-1200.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Cook County Pension Fund is also referred to as Company.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are an "Annuitant" as defined in Section 9-239 of the Illinois Pension Code (40 ILCS 5/9-239) and provided that you were been last employed with Cook County or the Forest Preserve District.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child up age 30 if he or she:
  - lives within the State of Illinois; and
  - has served as an active or reserve member of any branch of the Armed Forces of the United States; and
  - has received a release or discharge other than a dishonorable discharge; or
- an unmarried child age 26 who is disabled and dependent upon you and enrolled in the plan before age 26.

Note: Cook County Pension Fund will review all requests for coverage for a disabled dependent. Please redirect any inquiries, including requests for forms to Cook County Health Benefits to 312-603-1200.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Cook County Pension Fund share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Note: The Internal Revenue Service generally does not consider Civil Unions and their children eligible Dependents. Therefore, the value of Cook County Pension Fund's cost in covering a Civil Union may be imputed to the Participant as income. Your contributions are subject to review and Cook County Pension Fund reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Cook County Pension Fund Health Benefits at (312) 603-1200.

How to Enroll

To enroll, call Cook County Pension Fund Health Benefits at (312) 603-1200 within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Cook County Pension Fund Health Benefits within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Cook County Pension Fund Health Benefits receives your properly completed enrollment, coverage will begin on the first day of the month following your date of retirement. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Cook County Pension Fund Health Benefits within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Cook County Pension Fund Health Benefits within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Cook County Health Benefits within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Cook County Health Benefits within 60 days of determination of subsidy eligibility); or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Cook County Pension Fund Health Benefits within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 18 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Cook County Pension Fund's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Cook County Pension Fund's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. You must see a Network Physician in order to obtain Benefits. Except as specifically described within the SPD, Benefits are not available for services provided by a non-Network provider. This Plan does not provide a non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com.**

Network providers are independent practitioners and are not employees of Cook County Pension Fund or UnitedHealthcare. It is your responsibility to select your provider.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Benefits will not be paid.

Designated Provider

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Benefits will not be paid.

Eligible Expenses

Cook County Pension Fund has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network provider for any amount billed that is greater than the

amount UnitedHealthcare determines to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in this SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is calculated as a flat dollar amount and is paid at the time of service or when billed by the provider. When Copayments apply, the amount is listed in Section 5, *Plan Highlights*, next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Copays count toward the Out-of-Pocket Maximum.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays	Yes
Coinsurance payments	Yes
Charges for non-Covered Health Services	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies.

Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Requirements for Notifying Personal Health Support

Notification is required within two business days after admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, see Section 6, *Additional Coverage Details*.

Contacting the Claims Administrator or Personal Health Support is easy.
Simply call the number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Out-of-Pocket Maximum.

Plan Features	Network Amounts
Copays[1]	
■ Acupuncture	$25
■ Emergency Health Services	$100
■ Hospital - Inpatient Stay	$100
■ Physician's Office Services – Primary Physician	$15
■ Physician's Office Services – Specialist Physician	$25
■ Rehabilitation Services	$25
■ Urgent Care Center Services	$40
Annual Out-of-Pocket Maximum	
■ Individual	$1,500
■ Family (not to exceed the applicable Individual amount per Covered Person)	$3,000
Lifetime Maximum Benefit	Unlimited

[1]Copays apply toward the Out-of-Pocket Maximum.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits	100% after you pay a Copayment of $25 per visit
Ambulance Services ■ Emergency Ambulance. ■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.	*Ground or Air Ambulance* 100% 100%
Cancer Resource Services *To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. See Section 6, *Additional Coverage Details*, for coverage information.	Designated Provider Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. *Network facility* Not Applicable*
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Congenital Heart Disease (CHD) Surgeries	100% after you pay a Copayment of $100 per Inpatient Stay
Dental Services	100%
Diabetes Services ■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care ■ Diabetes Self-Management Items - diabetes equipment	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. 100%
Durable Medical Equipment (DME)	100%
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a Copayment of $100 per visit
Enteral and Parenteral Nutritional Therapy	*Primary Physician* 100% after you pay a Copayment of $15 per visit *Specialist Physician* 100% after you pay a Copayment of $25 per visit
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	100%
Home Health Care See Section 6, *Additional Coverage Details*, for limits	100%

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Hospice Care	100%
Hospital - Inpatient Stay	100% after you pay a Copayment of $100 per Inpatient Stay
Kidney Resource Services *To receive Benefits for a kidney disease treatment, you are not required to visit a Designated Provider. See Section 6, *Additional Coverage Details*, for coverage information.	Designated Provider Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. *Network facility* Not Applicable*
Lab, X-Ray and Diagnostics - Outpatient ■ Lab Testing - Outpatient. ■ X-Ray and Other Diagnostic Testing - Outpatient.	 100% 100%
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100%
Mental Health Services ■ Inpatient. ■ Outpatient	 100% after you pay a Copayment of $100 per Inpatient Stay 100% after you pay a Copayment of $15 per visit
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient	 100% after you pay a Copayment of $100 per Inpatient Stay 100% after you pay a Copayment of $15 per visit

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Nutritional Counseling	*Primary Physician* 100% after you pay a Copayment of $15 per visit *Specialist Physician* 100% after you pay a Copayment of $25 per visit
Ostomy Supplies	100%
Pharmaceutical Products - Outpatient	100%
Physician Fees for Surgical and Medical Services	100%
Physician's Office Services - Sickness and Injury ■ Primary Physician ■ Specialist Physician	 100% after you pay a Copayment of $15 per visit 100% after you pay a Copayment of $25 per visit
Pregnancy - Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.
Preventive Care Services ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests	 100% 100%
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	100%
Prosthetic Devices	100%

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for limits	100% after you pay a Copayment of $15 per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	100% after you pay a Copayment of $100 per Inpatient Stay
Substance Use Disorder Services ■ Inpatient. ■ Outpatient.	100% after you pay a Copayment of $100 per Inpatient Stay 100% after you pay a Copayment of $15 per visit
Surgery - Outpatient	100%
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section
Therapeutic Treatments - Outpatient	100%
Transplantation Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Network
Travel and Lodging Covered Health Services must be received at a Designated Facility. See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing cancer treatment, Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services	100% after you pay a Copayment of $40 per visit
Wigs See Section 6, *Additional Coverage Details*, for limits	100%

[1]In general, your Network provider should notify the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support* before you receive certain Covered Health Services. There are some Network Benefits, however, for which you should notify the Claims Administrator or Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that for which you should notify the Claims Administrator or Personal Health Support before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment and Coinsurance information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Benefits are limited to 10 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist,

UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you should notify the Claims Administrator or Personal Health Support as soon as possible prior to the transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit **www.myoptumhealthcomplexmedical.com**.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.

  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Department of Veterans Affairs.*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before

participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you should notify the Claims Administrator or Personal Health Support as soon as the possibility of participation in a Clinical Trial arises.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services

Dental Anesthesia

Benefits are provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or outpatient surgical facility if the Covered Person:

- Is a child is age six or under.
- Has a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency.
- Has a medical condition requiring hospitalization or general anesthesia for dental care.

Oral Surgery

Benefits are also provided for oral surgery, limited to the following services:

- Surgical removal of completely bony impacted teeth.
- Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
- Treatment of fractures of facial bones.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Reduction of dislocation of, or excision of, the temporomandibular joints.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Accident-Related

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth.
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.
- Completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.
- Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Accident-Related Dental Services: Please remember that you should notify the Claims Administrator or Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, the Claims Administrator can determine whether the service is a Covered Health Service.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).
- Continuous glucose monitors and supplies including continuous interstitial glucose monitors and supplies that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

Benefits for insulin and diabetes supplies, including blood glucose monitors, test strips, lancets, needles, and syringes are provided under your separate prescription drug coverage.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.

- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time.

Shoes and Foot Orthotics

Benefits are provided for the initial purchase, fitting and repair of a custom-made rigid or semi-rigid orthotic or other supportive devices of the feet when prescribed for treatment of an injury or other medical condition of the foot, including braces, splints, insoles, and foot supports constructed of acrylic, plastic, or metal, as well as impression cast required for the fitting of those devices, when prescribed by a Physician. The device must be intended for wear at all times that shoes are worn and not just for specific activities.

When the above coverage criteria are met, coverage is provided for:

- One pair of custom-molded shoes (which includes inserts provided with the shoes) and two additional pairs of inserts, per calendar year; or
- One pair of depth shoes and three pairs of inserts (not including the non-customized removal inserts provided with such shoes), per calendar year.

Separate inserts independent of the therapeutic shoes are covered when the Covered Person meets the coverage criteria above and the prescribing provider verifies in writing that the Covered Person has the appropriate footwear into which the insert can be placed.

Modifications of custom-molded or depth shoes (e.g., wedges, offset heels or shoe lifts, Velcro closures, inserts for missing toes, etc.) are covered instead a pair of inserts in any combination when the Covered Person meets the above coverage criteria.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days after admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Benefits will not be provided. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *Plan Highlights*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

> Please remember that you should notify the Claims Administrator within two business days after admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

Enteral and Parenteral Nutritional Therapy

Benefits are provided for enteral and parenteral nutritional therapy, including formula, accessories and supplies, when the Covered Person exhibits one of the following conditions:

- Permanent disease or non-function of the structures that would normally permit food to reach the digestive tract.
- Disease of the small bowel that prevents digestion and absorption of an oral diet, either of which requires tube feedings in order to maintain weight and strength.

Benefits are also provided for enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, then they are the only source of nutrition or

when they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to $2,500 per hearing impaired ear per lifetime.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder that are the following:

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for

which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health Services/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).

- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to 3 individual sessions during a Covered Person's lifetime for each medical condition.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Deodorants, filters and lubricants.
- Tape, appliance cleaners, adhesive and adhesive remover.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient*.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

In general, the Plan pays preventive care Benefits based on the recommendations of the *U.S. Preventive Services Task Force (USPSTF)* although other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

Examples of Covered Health Services for preventive care include:

Covered Preventive Care Services	
Physician Office Services	■ Routine physical including vision and hearing screenings. ■ Metabolic screening tests (including phenylketonuria (PKU)). ■ Immunizations[1]. ■ Well baby and well child care. ■ Routine gynecological exam including breast and pelvic examination, treatment of minor infections, and PAP test.
Lab, X-Ray or Other Preventive Tests	■ Mammogram. ■ Colorectal cancer screening. ■ Cervical cancer screening. ■ PSA blood test and digital rectal exam. ■ Bone mineral density tests.

[1]Covered childhood and adult immunizations include those that are recommended by the *Center for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP)* and whose recommendations have been published in the *Center for Disease Control and Prevention's Mortality and Morbidity Weekly Report (MMWR).*

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 10 days per month, but not to exceed 120 visits per calendar year.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same

manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that you should notify the Claims Administrator or Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Post-cochlear implant aural therapy.
- Manipulative Treatment.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative

services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type,

frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Benefits are limited to:

- 60 treatments per calendar year for physical, occupational, speech and cognitive rehabilitation therapy combined.
- 30 visits per calendar year for Manipulative Treatment (limited to chiropractor/DC provider type only).
- 36 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.

Benefits for post-cochlear implant aural therapy do not have a limit.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Benefits are limited to 90 days per calendar year.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital or an

Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Temporomandibular Joint (TMJ) Services

The Plan covers Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis includes examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider or a Network facility that is not a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

> Please remember that you should notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the

qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offers a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.

- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for temporary loss of hair resulting from treatment of a malignancy and alopecia.

Benefits are limited to $300 per calendar year.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

Cook County Pension Fund believes in giving you the tools you need to be an educated health care consumer. To that end, Cook County Pension Fund has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Cook County Pension Fund are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Survey*. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders - Cook County Pension Fund's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Cook County Pension Fund has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;

- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk survey to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition;
  - medication management and compliance;
  - reinforcement of on-line behavior modification program goals;
  - preparation and support for upcoming Physician visits;
  - review of psychosocial services and community resources;
  - caregiver status and in-home safety;
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care. HealtheNotes℠ provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. The one-on-one coaching integrates phone- and mail-based communications with online interactive health programs on **www.myuhc.com**.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. These certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes lifestyle;
- exercise management;
- heart health lifestyle;
- nutrition management;
- stress management;
- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call the number on the back of your ID card.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressives drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to, some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting).

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain specialty medications ordered by a Physician through Caremark.

7. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

8. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

10. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoes (standard or custom), lifts and wedges, shoe inserts, arch supports or shoe orthotics, except as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. This exclusion does not apply to:

   - Surgical or compression stockings.
   - Urinary catheters.
   - Surgical dressings.
   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

3. The replacement of lost or stolen Durable Medical Equipment.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details* and *Section 1 – What's Covered – Benefits*.

1 Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.

8. Transitional Living Services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods, low carbohydrate foods and food products naturally low in protein).

2. Food of any kind. Foods that are not covered include:

   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals, herbs and dietary or electrolyte supplements.
   - Baby foods, groceries or blenderized foods.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.

3. Parenteral or enteral feedings and other nutritional and electrolyte formulas, except as described under *Enteral and Parenteral Nutritional Therapy* in Section 6, *Additional Coverage Details*. Non-prescription oral formula and infant formula available over the counter is always excluded.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.

- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. ***Note:*** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss except for loss of hair resulting from temporary loss of hair resulting from treatment of a malignancy and alopecia, in which case the Plan pays up to a maximum of $300 per Covered Person per calendar year.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. Sex transformation operations and related services.

12. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

15. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

16. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details.*

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. Contraceptive supplies and services.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing received on an inpatient basis.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice

care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

3. Eye exercise or vision therapy.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.

- Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com** or calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to a provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a provider with UnitedHealthcare's consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to a provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will

include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Cook County Pension Fund. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Cook County Pension Fund within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Cook County Pension Fund, or if Cook County Pension Fund fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Cook County Pension Fund's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Cook County Pension Fund's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making Cook County Pension Fund's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by Cook County Pension Fund.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cook County Pension Fund. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Cook County Pension Fund's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the

life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cook County Pension Fund. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Cook County Pension Fund must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Cook County Pension Fund must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Limitation of Action

You cannot bring any legal action against Cook County Pension Fund or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Cook County Pension Fund or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Cook County Pension Fund or the Claims Administrator.

You cannot bring any legal action against Cook County Pension Fund or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Cook County Pension Fund or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Cook County Pension Fund or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

When This Plan is Secondary

If this Plan is secondary, to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay or Coinsurance payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the

primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Civil Unions are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare in its sole discretion may treat the provider's billed charges as the

allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible, Coinsurance and Copay requirements of the Plan.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare

the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the [participant][employee], deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Cook County Pension Fund will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The date of your death.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from Cook County Pension Fund to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends, except that coverage will continue for your Dependents in the event of your death, subject to the remaining provisions on this list.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from Cook County Pension Fund to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Cook County Pension Fund find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional

misrepresentation of material fact, Cook County Pension Fund has the right to demand that you pay back all Benefits Cook County Pension Fund paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to Cook County Pension Fund proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon Cook County Pension Fund's request, that the child continues to meet these conditions.

The proof might include medical examinations at Cook County Pension Fund's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's absence from work.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Cook County Pension Fund.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Cook County Pension Fund

In order to make choices about your health care coverage and treatment, Cook County Pension Fund believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Cook County Pension Fund and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD).

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Cook County Pension Fund and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Cook County Pension Fund and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Cook County Pension Fund and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Cook County Pension Fund, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Cook County Pension Fund's agents or employees, nor are they agents or employees of UnitedHealthcare. Cook County Pension Fund and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Cook County Pension Fund and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Cook County Pension Fund and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Cook County Pension Fund's employees nor are they employees of UnitedHealthcare. Cook County Pension Fund and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Cook County Pension Fund and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Cook County Pension Fund is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.

- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Interpretation of Benefits

Cook County Pension Fund and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Cook County Pension Fund and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Cook County Pension Fund may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Cook County Pension Fund does so in any particular case shall not in any way be deemed to require Cook County Pension Fund to do so in other similar cases.

Information and Records

Cook County Pension Fund and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Cook County Pension Fund and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Cook County Pension Fund and UnitedHealthcare will keep this information confidential. Cook County Pension Fund and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Cook County Pension Fund and UnitedHealthcare with all information or copies of records relating to the services provided to you. Cook County Pension Fund and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Cook County Pension Fund and UnitedHealthcare agree that such information and records will be considered confidential.

Cook County Pension Fund and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Cook County Pension Fund is required to do by law or regulation. During and after the term of the Plan, Cook County Pension Fund and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Cook County Pension Fund recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Cook County Pension Fund and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Cook County Pension Fund recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Cook County Pension Fund and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. Cook County Pension Fund and UnitedHealthcare do not pass these rebates on to you, nor are they taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Fund's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Fund does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

  Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annuitant – a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, a minimum annuity, or a child's annuity on or after January 1, 1990, under Article 9 or 10 by reason of previous employment by Cook County or the Forest Preserve District of Cook County.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Cook County Pension Fund. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Civil Union - a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company - Cook County Pension Fund.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Employer - Cook County Pension Fund.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at

the time the Claims Administrator and Cook County Pension Fund make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Cook County Pension Fund may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and Cook County Pension Fund must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Cook County Pension Fund. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by Cook County Pension Fund who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions and Limitations*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

Open Enrollment - the period of time, determined by Cook County Pension Fund, during which eligible Participants may enroll themselves and their Dependents under the Plan. Cook County Pension Fund determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the

Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Cook County Pension Fund Health Plan.

Plan Administrator - Cook County & Forest Preserve District Annuity & Benefit Fund or its designee.

Plan Sponsor - Cook County & Forest Preserve District Annuity & Benefit Fund.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse or Civil Union - an individual to whom you are legally married or, your partner in a Civil Union, as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and*

Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Cook County Pension Fund may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and Cook County Pension Fund must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's and Cook County Pension Fund's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company . The named fiduciary of Plan is Cook County Pension Fund, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	□□ □□□ □□□ □□□□□ □□□□□ □□□ □□□□□ □□□ □□□□□ □□□□□□ □□□□□□□□ □□□□ □□□ □□□ □□□□□□□ □□ □□□ □□□ □□□□ □□□ □□□ □□□□□ 0□ □□□□ TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরো·ধ থাকলে, আপনার স্বাস্থ্য পরকিল্পনার আই ডি কার্ড এ তালকিাভূক্ত ও কর দতিে হবে না এমন টলেফিো·ন নম্বরে ফো·ন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᏥᏁ ᏗᏣᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎥᎨ ᏣᏤᏁ ᏙᎯ ᏥᎡ ᏗᏗᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏲᏐᎤᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधकिार है। दुभाषएि के लएि अनुरोध करने के लएि, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိၣ်ဟ့ၣ်အ ပှ့ၤဘၣ်နူၣ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကီးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိၣ်ဟ့ၣ်အပှ့ၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျဲၤ အကးအလိၤဒီးဆိၣ်လီၤနီၣ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दुभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबद्ध केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan

Language	Translated Taglines
	me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईले आफ्नो भाषामा नःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधकिार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परचिय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थच्निुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤਿੇ ਗਏ ਟੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Language	Translated Taglines
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܟ ܙܟܘܬܐ ܕܡܬܚܙܐ ܠܡܕܥ ܒܠܫܢܟ ܕܠܐ ܡܫܘܡ ܐܢ ܐܝܬ ܠܟ ܫܐܠܬܐ ܐܘ ܒܥܝܬ ܕܬܪܓܡܢܐ ܬܬܨܠ ܒܡܣܦܪ ܕܛܠܦܘܢ ܕܟܬܘܒ ܥܠ ܟܪܛܝܣ ܗܘܐ ܕܐܝܕܟ ܕܒܝܛܘܚ ܕܫܪܝܢ ܠܟ. ܠܚܘ 0 ܘܬܫܘܒ ܠܟܘܢ ܒܛܠܦܘܢ ܕ TTY 711.
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమా

Language	Translated Taglines
	చూర పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేసేక్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פריי מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711

Language	Translated Taglines
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> *Important*:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps® program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> ParentSteps® is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps® will collect the provider payment from you online via the ParentSteps® website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description Section 5, *Plan Highlights* when a benefit is available.

What is ParentSteps®?

ParentSteps® is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- Guidance to help you make informed decisions on where to receive care.
- Education and support resources through experienced infertility nurses.
- Access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services.
- Discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps®

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at **www.myoptumhealthparentsteps.com** or by calling ParentSteps® toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps® facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see

the specific rates negotiated by ParentSteps® with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps® member. ParentSteps® will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps® discounts apply, the provider will enter in your proposed course of treatment. ParentSteps® will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps® website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps® will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps® program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps® nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps® nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps® Information

Additional information on the ParentSteps® program can be obtained online at **www.myoptumhealthparentsteps.com** or by calling 1-877-801-3507 (toll-free).

Summary Plan Description

Cook County Pension Fund
Choice Plus Plan

Effective: January 1, 2018
Group Number: 902956

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (888) 651-7313.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

Cook County & Forest Preserve District Annuity & Benefit Fund (referred to in this SPD as Cook County Pension Fund) is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Cook County Pension Fund is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact Cook County Health Benefits at (312) 603-1200 or call the number on the back of your ID card.

How to Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of your SPD and any future amendments by contacting Cook County Health Benefits at (312) 603-1200.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Cook County Pension Fund is also referred to as Company.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are an "Annuitant" as defined in Section 9-239 of the Illinois Pension Code (40 ILCS 5/9-239) and provided that you were been last employed with Cook County or the Forest Preserve District.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child up age 30 if he or she:
  - lives within the State of Illinois; and
  - has served as an active or reserve member of any branch of the Armed Forces of the United States; and
  - has received a release or discharge other than a dishonorable discharge; or
- an unmarried child age 26 or over who is disabled and dependent upon you and enrolled in the plan before age 26.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Cook County Pension Fund share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Note: The Internal Revenue Service generally does not consider Civil Unions and their children eligible Dependents. Therefore, the value of Cook County Pension Fund's cost in covering a Civil Union may be imputed to the Participant as income.

Your contributions are subject to review and Cook County Pension Fund reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Cook County Pension Fund Health Benefits at (312) 603-1200.

How to Enroll

To enroll, call Cook County Pension Fund Health Benefits at (312) 603-1200 within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Cook County Pension Fund Health Benefits within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Cook County Pension Fund Health Benefits receives your properly completed enrollment, coverage will begin on the first day of the month following your date of retirement. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Cook County Pension Fund Health Benefits within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Cook County Pension Fund Health Benefits within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Cook County Health Benefits within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Cook County Health Benefits within 60 days of determination of subsidy eligibility); or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Cook County Pension Fund Health Benefits within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 18 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Cook County Pension Fund's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Cook County Pension Fund's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way

of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Cook County Pension Fund or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular

Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare at the number on your ID card for assistance.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Designated Provider

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within

31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

Cook County Pension Fund has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in this SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a

psychologist and by 35% for Covered Health Services provided by a masters level counselor.

- ♦ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

  When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- ■ When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 85% after you meet the Annual Deductible, you are responsible for paying the other 15%. This 15% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	No	No
Coinsurance payments	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses	No	No

Annual Maximum Benefit

The Annual Maximum Benefit is the maximum amount the Plan will pay each calendar year for Covered Health Services. There is a combined Annual Maximum Benefit for Network Benefits and Non-Network Benefits.

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Requirements for Notifying Personal Health Support

Notification is required within two business days after admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, see Section 6, *Additional Coverage Details*.

Contacting the Claims Administrator or Personal Health Support is easy.
Simply call the number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Annual Maximum Benefit.

Plan Features	Network Amounts	Non-Network Amounts
Copays[1,2]		
■ Emergency Health Services	$100	$100
Annual Deductible[3]		
■ Individual	$300	$600
■ Family (not to exceed the applicable Individual amount per Covered Person)	$600	$1,200
Annual Out-of-Pocket Maximum[3]		
■ Individual	$1,500	$5,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$3,000	$10,000
Annual Maximum Benefit	$1,250,000	
Lifetime Maximum Benefit	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

[2]Copays do not apply toward the Annual Deductible but do apply toward the Out-of-Pocket Maximum.

[3]The Annual Deductible does not apply toward the Out-of-Pocket Maximum for any Covered Health Services.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services	*Ground or Air Ambulance*	*Ground or Air Ambulance*
■ Emergency Ambulance	85% after you meet the Annual Deductible	Same as Network
■ Non-Emergency Ambulance Ground or air ambulance, as the Claims Administrator determines appropriate.	85% after you meet the Annual Deductible	Same as Network
Cancer Resource Services *To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. See Section 6, *Additional Coverage Details*, for coverage information.	*Designated Provider* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. *Network facility* Not Applicable*	Not Applicable*

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
■ Diabetes Self-Management Items - diabetes equipment	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Durable Medical Equipment (DME)	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	85% after you pay a Copayment of $100 per visit and after you meet the Annual Deductible	Same as Network
Enteral and Parenteral Nutritional Therapy	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Kidney Resource Services *To receive Benefits for a kidney disease treatment, you are not required to visit a Designated Provider. See Section 6, *Additional Coverage Details*, for coverage information.	*Designated Provider* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. *Network facility* Not Applicable*	Not Applicable*
Lab, X-Ray and Diagnostics - Outpatient		
■ Lab Testing - Outpatient.	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing - Outpatient.	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services	100% Annual Deductible does not apply	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Test	100% Annual Deductible does not apply	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Disorder Services		
■ Inpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Therapeutic Treatments - Outpatient	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Travel and Lodging Covered Health Services must be received at a Designated Provider. See Section 6, *Additional Coverage Details*, for limits	For patient and companion(s) of patient undergoing cancer treatment, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	85% after you meet the Annual Deductible	85% after you meet the Annual Deductible
Wigs See Section 6, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]In general, your Network provider should notify the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support* before you receive certain Covered Health Services. There are some Network Benefits, however, for which you should notify the Claims Administrator or Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that for which you should notify the Claims Administrator or Personal Health Support before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Any combination of Network Benefits and Non-Network Benefits is limited to 10 treatments per calendar year.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you should notify the Claims Administrator or Personal Health Support as soon as possible prior to the transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit **www.myoptumhealthcomplexmedical.com**.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*

- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Department of Veterans Affairs*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.

- ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you should notify the Claims Administrator or Personal Health Support as soon as the possibility of participation in a Clinical Trial arises.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Please remember for Non-Network Benefits you should notify the Claims Administrator or Personal Health Support as soon as the possibility of a CHD surgery arises.

Dental Services

Dental Anesthesia

Benefits are provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or outpatient surgical facility if the Covered Person:

- Is a child is age six or under.
- Has a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency.
- Has a medical condition requiring hospitalization or general anesthesia for dental care.

Oral Surgery

Benefits are also provided for oral surgery, limited to the following services:

- Surgical removal of completely bony impacted teeth.
- Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.

- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
- Treatment of fractures of facial bones.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Reduction of dislocation of, or excision of, the temporomandibular joints.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Accident-Related

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth.
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan.
- Completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

- Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Accident-Related Dental Services: Please remember that you should notify the Claims Administrator or Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, the Claims Administrator can determine whether the service is a Covered Health Service.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).
- Continuous glucose monitors and supplies including continuous interstitial glucose monitors and supplies that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

Benefits for insulin and diabetes supplies, including blood glucose monitors, test strips, lancets, needles, and syringes are provided under your separate prescription drug coverage.

Please remember for Non-Network Benefits, you should notify the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.

- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time.

Shoes and Foot Orthotics

Benefits are provided for the initial purchase, fitting and repair of a custom-made rigid or semi-rigid orthotic or other supportive devices of the feet when prescribed for treatment of an injury or other medical condition of the foot, including braces, splints, insoles, and foot supports constructed of acrylic, plastic, or metal, as well as impression cast required for the fitting of those devices, when prescribed by a Physician. The device must be intended for wear at all times that shoes are worn and not just for specific activities.

When the above coverage criteria are met, coverage is provided for:

- One pair of custom-molded shoes (which includes inserts provided with the shoes) and two additional pairs of inserts, per calendar year; or
- One pair of depth shoes and three pairs of inserts (not including the non-customized removal inserts provided with such shoes), per calendar year.

Separate inserts independent of the therapeutic shoes are covered when the Covered Person meets the coverage criteria above and the prescribing provider verifies in writing that the Covered Person has the appropriate footwear into which the insert can be placed.

Modifications of custom-molded or depth shoes (e.g., wedges, offset heels or shoe lifts, Velcro closures, inserts for missing toes, etc.) are covered instead a pair of inserts in any combination when the Covered Person meets the above coverage criteria.

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days after admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided .Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible

Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Please remember that you should notify the Claims Administrator within two business days after admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

Enteral and Parenteral Nutritional Therapy

Benefits are provided for enteral and parenteral nutritional therapy, including formula, accessories and supplies, when the Covered Person exhibits one of the following conditions:

- Permanent disease or non-function of the structures that would normally permit food to reach the digestive tract.
- Disease of the small bowel that prevents digestion and absorption of an oral diet, either of which requires tube feedings in order to maintain weight and strength.

Benefits are also provided for enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, then they are the only source of nutrition or when they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $2,500 per hearing impaired ear per lifetime.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support five business days before an inpatient admission.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-

based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you should notify the Claims Administrator as follows:

- For scheduled admissions: five business days before admission.
- For non-scheduled admissions (including Emergency admissions): within two business days after admission or on the same day of admission if reasonably possible.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury*.
- *Physician Fees for Surgical and Medical Services*.
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.
- *Therapeutic Treatments - Outpatient*.
- *Hospital - Inpatient Stay*.
- *Surgery - Outpatient*.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for sleep studies, you must notify the Claims Administrator five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits. A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, you must provide notification before the following services are received Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Please call the number that appears on your ID card.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder that are the following:

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health Services/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you should notify the Claims Administrator to receive these Benefits. For a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Any combination of Network and non-Network Benefits is limited to 3 individual sessions during a Covered Person's lifetime for each medical condition.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Please remember for Non-Network Benefits, that you must notify the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as reasonably possible.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Deodorants, filters and lubricants.
- Tape, appliance cleaners, adhesive and adhesive remover.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient*.

Please remember for Non-Network Benefits you should notify the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA is performed.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you should notify the Claims Administrator as soon as is reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

In general, the Plan pays preventive care Benefits based on the recommendations of the *U.S. Preventive Services Task Force (USPSTF)* although other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

Examples of Covered Health Services for preventive care include:

Covered Preventive Care Services	
Physician Office Services	■ Routine physical including vision and hearing screenings. ■ Metabolic screening tests (including phenylketonuria (PKU)). ■ Immunizations[1]. ■ Well baby and well child care. ■ Routine gynecological exam including breast and pelvic examination, treatment of minor infections, and PAP test.
Lab, X-Ray or Other Preventive Tests	■ Mammogram. ■ Colorectal cancer screening. ■ Cervical cancer screening. ■ PSA blood test and digital rectal exam. ■ Bone mineral density tests.

[1]Covered childhood and adult immunizations include those that are recommended by the *Center for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP)* and whose recommendations have been published in the *Center for Disease Control and Prevention's Mortality and Morbidity Weekly Report (MMWR).*

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Network Benefits and Non-Network Benefits is limited to 10 days per month, but not to exceed 120 visits per calendar year.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

For Non-Network Benefits you must notify the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. When you provide notification, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Post-cochlear implant aural therapy.
- Manipulative Treatment.
- Pulmonary rehabilitation.

- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Benefits are limited to:

- 60 treatments per calendar year for physical, occupational, speech and cognitive rehabilitation therapy combined.
- 30 visits per calendar year for Manipulative Treatment (limited to chiropractor/DC provider type only).
- 36 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.

These limits apply to Network Benefits and Non-Network Benefits combined. Benefits for post-cochlear implant aural therapy do not have a limit.

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as reasonably possible.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 90 days per calendar year.

Please remember for Non-Network Benefits, you should notify the Claims Administrator as follows:

- For a scheduled admission: five business days before admission.
- For non-scheduled admissions: within two business days after admission or on the same day of admission if reasonably possible.

Substance Use Disorder Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Benefits Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.

- Provider-based case management services.
- Crisis intervention.
- Transitional Living services.
- Intensive Outpatient Treatment.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you should notify the Claims Administrator to receive these Benefits. For a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received. Services requiring advance notification: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

Please call the phone number that appears on your ID card.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries, cochlear implant you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

Temporomandibular Joint (TMJ) Services

The Plan covers Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis includes examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support five business days before temporomandibular joint services are performed during an Inpatient Hospital Stay in a Hospital.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you should notify the Claims Administrator for the following outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Please remember that you should notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offers a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for temporary loss of hair resulting from treatment of a malignancy and alopecia.

Any combination of Network Benefits and Non-Network Benefits is limited to $300 per calendar year.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

Cook County Pension Fund believes in giving you the tools you need to be an educated health care consumer. To that end, Cook County Pension Fund has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Cook County Pension Fund are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Survey* link. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders - Cook County Pension Fund's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Cook County Pension Fund has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;

- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk survey to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition;
  - medication management and compliance;
  - reinforcement of on-line behavior modification program goals;
  - preparation and support for upcoming Physician visits;
  - review of psychosocial services and community resources;
  - caregiver status and in-home safety;
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care. HealtheNotes℠ provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. The one-on-one coaching integrates phone- and mail-based communications with online interactive health programs on **www.myuhc.com**.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. These certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes lifestyle;
- exercise management;
- heart health lifestyle;
- nutrition management;
- stress management;
- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call the number on the back of your ID card.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to," it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressives drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include but are not limited to, some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting).

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain specialty medications ordered by a Physician through Caremark.

7. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

8. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

10. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoes (standard or custom), lifts and wedges, shoe inserts, arch supports or shoe orthotics, except as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. This exclusion does not apply to:

   - Surgical or compression stockings.
   - Urinary catheters.
   - Surgical dressings.
   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

3. The replacement of lost or stolen Durable Medical Equipment.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details* and *Section 1 – What's Covered – Benefits*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.
8. Transitional Living Services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods, low carbohydrate foods and food products naturally low in protein).

2. Food of any kind. Foods that are not covered include:

   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals, herbs and dietary or electrolyte supplements.
   - Baby foods, groceries or blenderized foods.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.

3. Parenteral or enteral feedings and other nutritional and electrolyte formulas, except as described under *Enteral and Parenteral Nutritional Therapy* in Section 6, *Additional Coverage Details*. Non-prescription oral formula and infant formula available over the counter is always excluded.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - electric scooters;
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.

- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. ***Note:*** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss except for loss of hair resulting from temporary loss of hair resulting from treatment of a malignancy and alopecia, in which case the Plan pays up to a maximum of $300 per Covered Person per calendar year.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. Sex transformation operations and related services.

12. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

15. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

16. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details.*

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. Contraceptive supplies and services.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing received on an inpatient basis.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice

care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

3. Eye exercise or vision therapy.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.

- Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.
   - For which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com** or calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion

of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Cook County Pension Fund. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Cook County Pension Fund within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Cook County Pension Fund, or if Cook County Pension Fund fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Cook County Pension Fund's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Cook County Pension Fund's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making Cook County Pension Fund's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by Cook County Pension Fund.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cook County Pension Fund. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Cook County Pension Fund's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the

life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cook County Pension Fund. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Cook County Pension Fund must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Cook County Pension Fund must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Limitation of Action

You cannot bring any legal action against Cook County Pension Fund or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Cook County Pension Fund or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Cook County Pension Fund or the Claims Administrator.

You cannot bring any legal action against Cook County Pension Fund or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Cook County Pension Fund or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Cook County Pension Fund or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

When This Plan is Secondary

If this Plan is secondary, to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the

primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Civil Unions are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare in its sole discretion may treat the provider's billed charges as the

allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible, Coinsurance and Copay requirements of the Plan.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare

the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or

otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or

characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical

Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to

discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Cook County Pension Fund will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- The date of your death.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from Cook County Pension Fund to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends, except that coverage will continue for your Dependents in the event of your death, subject to the remaining provisions on this list.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from Cook County Pension Fund to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Cook County Pension Fund find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional

misrepresentation of material fact, Cook County Pension Fund has the right to demand that you pay back all Benefits Cook County Pension Fund paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to Cook County Pension Fund proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon Cook County Pension Fund's request, that the child continues to meet these conditions.

The proof might include medical examinations at Cook County Pension Fund's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's absence from work.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Cook County Pension Fund.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Cook County Pension Fund

In order to make choices about your health care coverage and treatment, Cook County Pension Fund believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Cook County Pension Fund and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD).

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Cook County Pension Fund and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Cook County Pension Fund and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Cook County Pension Fund and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Cook County Pension Fund, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Cook County Pension Fund's agents or employees, nor are they agents or employees of UnitedHealthcare. Cook County Pension Fund and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Cook County Pension Fund and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Cook County Pension Fund and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Cook County Pension Fund's employees nor are they employees of UnitedHealthcare. Cook County Pension Fund and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Cook County Pension Fund and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Cook County Pension Fund is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.

- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Interpretation of Benefits

Cook County Pension Fund and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Cook County Pension Fund and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Cook County Pension Fund may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Cook County Pension Fund does so in any particular case shall not in any way be deemed to require Cook County Pension Fund to do so in other similar cases.

Information and Records

Cook County Pension Fund and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Cook County Pension Fund and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Cook County Pension Fund and UnitedHealthcare will keep this information confidential. Cook County Pension Fund and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Cook County Pension Fund and UnitedHealthcare with all information or copies of records relating to the services provided to you. Cook County Pension Fund and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Cook County Pension Fund and UnitedHealthcare agree that such information and records will be considered confidential.

Cook County Pension Fund and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Cook County Pension Fund is required to do by law or regulation. During and after the term of the Plan, Cook County Pension Fund and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Cook County Pension Fund recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Cook County Pension Fund and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Cook County Pension Fund recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Cook County Pension Fund and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Cook County Pension Fund and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Fund's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Fund does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

  Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Annuitant – a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, a minimum annuity, or a child's annuity on or after January 1, 1990, under Article 9 or 10 by reason of previous employment by Cook County or the Forest Preserve District of Cook County.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Cook County Pension Fund. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Civil Union - a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company - Cook County Pension Fund.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Employer - Cook County Pension Fund.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at

the time the Claims Administrator and Cook County Pension Fund make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Cook County Pension Fund may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and Cook County Pension Fund must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Cook County Pension Fund. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by Cook County Pension Fund who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions and Limitations*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by Cook County Pension Fund, during which eligible Participants may enroll themselves and their Dependents under the Plan. Cook County Pension Fund determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Cook County Pension Fund Health Plan.

Plan Administrator - Cook County & Forest Preserve District Annuity & Benefit Fund or its designee.

Plan Sponsor - Cook County & Forest Preserve District Annuity & Benefit Fund.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse or **Civil Union**- an individual to whom you are legally married or your partner in a Civil Union, as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Cook County Pension Fund may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and Cook County Pension Fund must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's and Cook County Pension Fund's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company . The named fiduciary of Plan is Cook County Pension Fund, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	□□ □□□ □□□ □□□□□ □□□□□ □□□ □□□□□ □□□ □□□□□ □□□□□□ □□□□□□□□ □□□□ □□□ □□□ □□□□□□□ □□ □□□ □□□ □□□□ □□□ □□□ □□□□□ 0□ □□□□ TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরো·ধ থাকলে, আপনার স্বাস্থ্য পরকিল্পনার আই ডি কার্ড এ তালকিাভূক্ত ও কর দতিে হবে না এমন টলেফিো·ন নম্বরে ফো·ন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန် သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᏲᎱ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎢᏳ ᏟᏤᎱ ᏙᏘ ᏲᎡ ᏗᏗᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏫᏖᏬᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधकिार है। दुभाषएि के लएि अनुरोध करने के लएि, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိၣ်ဟ့ၣ်အ ပ့ၤဘၣ်န့ၣ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိၣ်ဟ့ၣ်အပှၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျဲၤ အကးအလိၤဒီးဆီၣ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສຳລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दुभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōņāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan

Language	Translated Taglines
	me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bąąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईले आफ्नो भाषामा नःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधकिार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परचिय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थच्निुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤਿ ਗਏ ਟੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Language	Translated Taglines
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma faʻamatalaga i lau gagana e aunoa ma se totogi. Ina ia faʻatalosagaina se tagata faʻaliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܲܚܬܘܿܢ ܐܝܼܬܠܵܘܟ݂ܘܿܢ ܙܸܕܩܘܼܬܵܐ ܕܩܲܒܠܝܼܬܘܿܢ ܗܲܝܵܪܬܵܐ ܘܡܘܿܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܘܟ݂ܘܿܢ ܒܬܒܥܬܐ ܠܡܦܫܩܢܐ ܩܪܘ ܠܗ̇ ܡܢܝܢܐ ܡܓܢܐܝܬ، ܗܘ݂ ܥܠ ܡܢܝܢܐ ܝܠܦܘܢ ܕܐܝܠܗ ܟܪܛܐ ܕܝܠܟ݂ ܦܬܩܐ ܕܚܘܠܡܢܐ ܘܕܘܫ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమా

Language	Translated Taglines
	చూర పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేసుకో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פריי מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711

Language	Translated Taglines
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps® program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> ParentSteps® is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps® will collect the provider payment from you online via the ParentSteps® website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description Section 5, *Plan Highlights* when a benefit is available.

What is ParentSteps®?

ParentSteps® is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- Guidance to help you make informed decisions on where to receive care.
- Education and support resources through experienced infertility nurses.
- Access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services.
- Discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps®

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at **www.myoptumhealthparentsteps.com** or by calling ParentSteps® toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps® facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see

the specific rates negotiated by ParentSteps® with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps® member. ParentSteps® will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps® discounts apply, the provider will enter in your proposed course of treatment. ParentSteps® will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps® website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps® will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps® program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps® nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps® nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps® Information

Additional information on the ParentSteps® program can be obtained online at **www.myoptumhealthparentsteps.com** or by calling 1-877-801-3507 (toll-free).

Cook County Pension Fund

Benefit Plan Year 2018

UnitedHealthcare®

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 15.00
Materials	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$75.00 retail frame allowance
Retail Chain Provider	$75.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com).	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$75.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $75.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $75.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

1. Economic Disclosures

Warranties and Representations

In connection with signing and carrying out this Agreement, Vendor:

i) warrants that Vendor is appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which Vendor is not appropriately licensed;

ii) warrants it is financially solvent; it and each of its employees, agents and subcontractors of any tier are competent to perform the Services required under this Agreement; and Vendor is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

iii) warrants that it will not knowingly use the services of any ineligible vendor or subcontractor for any purpose in the performance of its Services under this Agreement;

iv) warrants that Vendor and its subcontractors are not in default at the time this Agreement is signed, and has not been , within 5 years immediately preceding the date of this Agreement, found to be in default on any Agreement awarded by the Fund;

v) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this agreement; this Agreement is feasible of performance in accordance with all of its provisions and requirements, and Vendor warrants it can and will perform, or cause to be performed, the Services in strict accordance with the provisions and requirements of this Agreement;

vi) represents that Vendor and, to the best of its knowledge, its subcontractors are not in violation of the provisions of the Illinois Criminal Code, 720 ILCS 5/33E as amended; and

vii) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 9.a and 9.c.

vii) agrees to furnish prompt written notice to the Fund, if any of the following events occur:

(1) A material adverse change to Vendor's financial condition which could reasonably be expected to impair its obligations hereunder;

(2) Vendor's insolvency, filing of a petition in bankruptcy, becoming party to an involuntary bankruptcy proceeding, or Vendor making an assignment for the benefit of creditors;
(3) Vendor's inability to comply with this Agreement or the Scope of Services/Statement of Work, as agreed to and set forth in Exhibit 1 (including without limitation any violation or incidence of non-compliance);
(4) Any sale, transfer, conveyance or other disposal resulting in a change of ownership of Vendor;
(5) Any significant legal actions instituted against vendor, against Vendor's partners, executive officers, or any other persons performing similar functions, or any person employed by Vendor performing services under this Agreement;
(6) Any investigations, examinations or other proceedings relating to the Vendor's business commenced by any governmental or regulatory agency; and
(7) Any cancellation of or adverse change to Vendor's insurance coverage.

Financial Rating requirements (Note: Left this in from original document).

The selected vendor must have the following minimum insurance company ratings from the following agencies:

a. Standard and Poor's – a rating of "A" or higher
b. A.M. Best – a rating of "A-" or higher

The ratings must reflect and measure the company's ability to meet its ongoing obligations to policyholder. If not rated by at least one of the above two agencies, an alternative rating can be provided from another insurance company rating organization, such as Fitch or Moody's, and subject to evaluation. Two ratings from reputable organizations that are the equivalent of Standard & Poor's "A" or A.M. Best's "A-" ratings are required.

2. MBE/WBE Requirements

Minority, Women and Persons with a Disability
Owned Business Enterprises

It is the practice of the Fund to prevent discrimination in the award of or participation in Fund agreements and to eliminate arbitrary barriers for participation in such agreements by businesses certified as a Minority Business Enterprise (MBE), a Women-owned Business Enterprise (WBE), or a Business Owned by a Person with a Disability, as such terms are defined in the Illinois Business Enterprise for Minorities, Females, and Persons with Disabilities Act (collectively referred to as "MWDBE"). A vendor seeking to do business with the Fund shall, as part of the procurement process, document its commitment to utilizing specific MWDBEs related to the services provided to the Fund. As part of such documentation, vendors are encouraged to provide any additional information related to the respected vendor's diversity initiatives.
Additionally, such vendors submitting bidding proposals to the Fund shall disclosure the following numerical data:

(a) The number of vendor's staff who are (i) minority person, (ii) female, or (iii) persons with a disability;

(b) The number of contracts, oral or written, that the vendor has in place for consulting services and professional and artistic services that constitute a (i) minority owned business, (ii) female owned business, or (iii) business owned by a person with a disability; and

(c) The number of contracts, oral or written, that the vendor has in place for consulting services and professional and artistic services where more than 50% of services performed pursuant to contract are performed by a (i) minority person, (ii) female, or (iii) persons with a disability but do not constitute a business owned by a minority, female or persons with a disability.

Vendors selected by the Fund for an award must update such information on an annual basis. Failure to provide such information may render the contract voidable by the Fund and may result in the termination of any existing relationship.
A vendor, during its performance of a resulting agreement with the Fund, may not change the original MBE or WBE commitments specified in the vendor's response to the RFP including but not limited to, terminating a MWDBE agreement, reducing the scope of the work to be performed by a MWDBE, or decreasing the price to be paid to a MBE/WBE without prior written notification to the Fund. Where a firm listed under the vendor's response to the RFP was previously considered to be a MWDBE but is later found not to be, the vendor shall seek to discharge the disqualified enterprise, upon proper written notification to the to the Fund and make every effort to identify and engage a qualified MWDBE as its replacement. Failure to obtain an MWDBE replacement may in the Fund's sole discretion, result in the termination of the Agreement.

This policy may be amended or revised by the Fund at any point with written notice to the vendor.

3. Minimum Contractual Requirements

1. **Maintenance and Ownership of Records**: Your organization will be required to maintain all pertinent records for seven years. This is in conjunction with prudent business practices. Your organization would be charged with the safekeeping of plan experience information and, in the event of contract termination, would be required to cooperate with the Fund, or their representative, in the orderly transfer of this plan experience information to the Fund or its designated succeeding health plan/carrier.

2. **Audit Rights**

   a. Once each year, or more frequently as reasonably determined by the Fund, or within two (2) years following termination of this Agreement, Fund's third party Auditor(s) or internal Auditor ("Auditor"), as reasonably approved by Vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, healthcare benefits, clinical programs, subcontracted administrative services directly related to the Fund's Member utilization and services, performance guarantees, and operational processes relating to the services provided to the Fund pursuant to this Agreement to ensure Vendor's compliance with the terms and conditions of this Agreement, as the Fund deems appropriate.

   b. Bidder agrees to grant the right of the Fund or its representative(s) to audit claims at any time during and up to two years following termination of the business relationship with prior written notification. The Fund will have access to 100% of all valid claim records to complete the audit at no cost to the plan sponsor. Bidder agrees to provide all necessary claims details, data definitions and reasonable support to complete an independent claim audit for each completed year under the contract in effect. The Fund will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space.

   c. Such audits may be based on either a 100% review of claims or a statistically representative sample thereof, or combination of methodologies. Auditor's preliminary findings will be shared with Vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; Vendor will produce financial impact reports for confirmed systemic errors. In the instance where Auditor has reviewed 100% of claims and identified suspect claims, Vendor may elect to review a mutually-agreed upon representative sample of the suspect claims.

   d. The audit may include an onsite review of the sample claims by the Auditor at Vendor's office. The Auditor will provide Vendor with the sample claims thirty

(30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days.

e. The scope of such audits may include up to three (3) benefit plan years as determined by the Fund.

f. Any and all costs and expenses of each party associated with Fund's audit shall be borne by the party incurring the cost. The parties agree that the scope of audits by Fund or Auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of and support for such information. Audit materials or documentation provided by Vendor will be confined to Fund-specific information.

g. If the audit discovers any validated overpayment of fees or claim payments by Vendor or other errors that result in economic losses to the Fund for failure to meet all vendor guarantees or performance standards, then Vendor shall pay the amount owed to the Fund following completion of the audit, within 30 days of written confirmation from the Fund as to the agreed upon settlement terms and amounts.

3. **Termination Provisions:** The Fund may terminate the contract at any time with or without cause by giving 60 days written notice. Your organization may only terminate the contract prior to the renewal date and then only by giving notice 120 days in advance, except in the event of non-payment of premium.

4. **General Compliance**: All bidder services must adhere to relevant federal and state laws and regulations.

5. **Eligibility Rules**: The bidder agrees to the specified eligibility rules established by the Fund. Any proposed modifications to the specified eligibility rules must be clearly pointed out in the appropriate section of the proposal.

6. **HIPAA.** Your organization agrees to hold the Fund harmless for any HIPAA Violations made by your organization or its Network Providers.

7. **Indemnification:** The Vendor covenants and agrees to indemnify and save harmless the Fund and its trustees (former and current), officials, employees, agents and representatives, and their respective heirs, successors and assigns, from and against any and all costs, expenses, attorney's fees, losses, damages and liabilities incurred or suffered directly or indirectly from or attributable to any claims arising out of or incident to the performance or nonperformance of the Agreement by the Vendor, or the acts or omissions of the officers, agents, employees, vendors, subcontractors, licensees or invitees of the Vendor. The Vendor expressly understands and agrees that any Performance Bond or insurance protection required of the Vendor, or otherwise provided by the Vendor, shall in no way limit the responsibility to indemnify the Fund as hereinabove provided.

8. **Renewal Notification**: Your organization must provide any fee changes in writing with full justification at least 90 days prior to a contract anniversary. The long lead-time is required due to the annual budget pricing, communications, and administration requirements associated with the Fund's benefit program.

9. **Governing Law and Jurisdiction.** This Agreement shall be governed by and construed under the laws of the State of Illinois. The Vendor irrevocably agrees that, subject to the Fund 's sole and absolute election to the contrary, any action or proceeding in any way, manner or respect arising out of the Agreement, or arising from any dispute or controversy arising in connection with or related to the Agreement, shall be litigated only in courts within the Circuit Court of Cook County State of Illinois or the United States District Court for the Northern District of Illinois and the Vendor consents and submits to the jurisdiction thereof. In accordance with these provisions, Vendor waives any right it may have to transfer or change the venue of any litigation brought against it by the Fund pursuant to this Agreement.

10. **No Personal Liability.** Vendor and any assignee or subcontractor of Vendor must not charge any employee, officers, trustees or agents of the Fund personally with any liability or expenses of defense or hold an official, employee or agent of the Fund personally liable to them under any term or provision of this Agreement or because of the Fund's execution, attempted execution or any breach of this Agreement.

11. This RFP and your response, including all subsequent documents provided during this RFP process will become the contract between the parties until replaced by a final written contract signed by both parties.

4. Insurance Requirements

Insurance

Prior to the effective date of this Agreement, the Vendor, at its cost, shall secure and maintain at all times, unless specified otherwise, until completion of the term of this Agreement the insurance specified below.

Nothing contained in these insurance requirements is to be construed as limiting the extent of the Vendor's responsibility for payment of damages resulting from its operations under this Agreement.

Vendor shall require all subcontractors to provide the insurance required in this Agreement, or Vendor may provide the coverages for Subcontractors. All Subcontractors are subject to the same insurance requirements as the Vendor except paragraph (d) Umbrella/Excess Liability or unless specified otherwise.

The Fund maintains the right to modify, delete, alter or change these requirements.

Coverages

(i) Workers Compensation Insurance

Workers' Compensation shall be in accordance with the laws of the State of Illinois or any other applicable jurisdiction.

The Workers Compensation policy shall also include the following provisions:

(1) Employers' Liability coverage with a limit of
$500,000 each Accident
$500,000 each Employee
$500,000 Policy Limit for Disease

(ii) Commercial General Liability Insurance

The Commercial General Liability shall be on an occurrence form basis (ISO Form CG 0001 or equivalent) to cover bodily injury, personal injury and property damage.

Each Occurrence	$ 1,000,000
General Aggregate	$ 2,000,000
Completed Operations Aggregate	$ 2,000,000

The General Liability policy shall include the following coverages:

(a) All premises and operations;
(b) Contractual Liability;

(c) Products/Completed Operations;
(d) Severability of interest/separation of insureds clause

(iii) Commercial Automobile Liability Insurance

When any vehicles are used in the performance of this Agreement, Vendor shall secure Automobile Liability Insurance for bodily injury and property damage arising from the Ownership, maintenance or use of owned, hired and non-owned vehicles with a limit no less than $1,000,000 per accident.

(iv) Umbrella/Excess Liability

Such policy shall be excess over Commercial General Liability, Automobile Liability, and Employer's Liability with limits not less than the following amounts:

Each Occurrence: $1,000,000

(v) Professional /Errors and Omissions Liability

Vendor shall secure Professional Liability insurance covering any and all claims arising out of the performance or nonperformance of professional services for the Fund under this Agreement. This insurance shall include coverage for third party claims and losses arising from network security risks such as data breaches, transmission of virus/malicious code; unauthorized access or criminal use of third party, ID/data theft and invasion of privacy regardless of the type of media involved in the loss of private information. This insurance shall remain in force for the life of the Vendor's obligations under this Agreement, and shall have a limit of liability of not less than $2,000,000 per claim. Subcontractors performing these services for the Vendor shall maintain limits of not less than $1,000,000 with the same terms in this section.

(a) The retroactive coverage date shall be no later than the effective date of this Agreement.

(b) Coverage shall be maintained for a minimum of two (2) years after final completion of the services or work provided by the Vendor.

Additional requirements

(a) Additional Insured

The required insurance policies, with the exception of the Workers Compensation and Professional Liability, must name the Fund, its trustees, officials, employees and agents as additional insureds with respect to operations performed on a primary and non-contributory basis. Any insurance or self-insurance maintained by the Fund shall be excess of the Vendor's insurance and shall not contribute with it. If Vendor maintains broader coverage and/or higher limits than the minimums shown above, the additional

insured requires and shall be entitled to the broader coverage and/or higher limits maintained by Vendor.

(b) Qualification of Insurers

All insurance companies providing coverage shall be licensed or approved by the Department of Insurance, State of Illinois, and shall have a financial rating no lower than (A-) VII as listed in A.M. Best's Key Rating Guide, current edition or interim report. Companies with ratings lower than (A-) VII will be acceptable only upon consent of the Fund. The insurance limits required herein may be satisfied by a combination of primary, umbrella and/or excess liability insurance policies.

(c) Insurance Notices

Vendor shall provide the Fund with thirty (30) days advance written notice in the event any required insurance will be cancelled, materially reduced or non-renewed. Vendor shall secure replacement coverage to comply with the stated insurance requirements and provide new certificates of insurance to the Fund.

Prior to the date on which Vendor commences performance of its part of the work, Vendor shall furnish to the Fund certificates of insurance maintained by Vendor. The receipt of any certificate of insurance does not constitute agreement by the Fund that the insurance requirements have been fully met or that the insurance policies indicated on the certificate of insurance are in compliance with insurance required above.

In no event shall any failure of the Fund to receive certificates of insurance required hereof or to demand receipt of such Certificates of Insurance be construed as a waiver of Vendor's obligations to obtain insurance pursuant to these insurance requirements.

(d) Waiver of Subrogation Endorsements

All insurance policies must contain a Waiver of Subrogation Endorsement in favor of the Fund.

5. **Business Associate Agreement**

   Negotiated between winning bidder and Cook County Pension Fund

6. Sole Source Requirements

N/A

7. Ethics Document

See attached Cook County Pension Fund Ethics Policy.

ETHICS POLICY

WHEREAS, the Trustees elected or appointed to serve as members of the Retirement Board (the "Board") of the County Employees' and Officers' Annuity and Benefit Fund of Cook County and ex officio of the Forest Preserve District Employees' Annuity and Benefit Fund (collectively, the "Fund") desire to enhance and promote the professional management of the Fund in order to ensure that the Fund provides retirement and other benefits to participants and beneficiaries who have served the County of Cook and its citizens; and

WHEREAS, effective April 3, 2009 the General Assembly of Illinois amended the Illinois Pension Code (the "Code") to make certain provisions within the State Officials and Employees Ethics Act, 5 ILCS 430 et seq. ("State Ethics Act"), which established a code of ethical conduct for all state officers, members of the Illinois General Assembly, and state employees, applicable to pension fund and retirement system board members and employees of public pension funds; and

WHEREAS, it is essential to the proper operation of a public pension fund that pension fund board members and employees be independent and impartial, that public office and employment not be used for personal gain, and that the participants and beneficiaries of a public pension fund have full confidence in the integrity and fair and honest administration of such pension fund; and

WHEREAS, the Board Members and certain Employees of the Fund, serve the Fund in a fiduciary capacity, and must act at all times to avoid conflicts of interest, impropriety, or even the appearance of impropriety; and

WHEREAS, a written Ethics Policy will assist Board Members and Employees of the Fund to conform their conduct to the highest acceptable standards and to properly discharge their fiduciary and other duties owed to the Fund and its participants and beneficiaries.

NOW, THEREFORE, BE IT ORDAINED BY THE TRUSTEES OF THE RETIREMENT BOARD OF THE FUND, THAT THE FOLLOWING STATEMENTS OF POLICY SHALL SERVE AS THE FUND'S CODE OF ETHICAL CONDUCT:

ARTICLE I

DEFINITIONS

The definitions used in this Ethics Policy are limited to this Policy and shall not be binding on the Fund for any other purpose. Whenever used in this Policy, the following terms shall have the following meanings:

(a) "Board" means the Retirement Board of the Fund.

(b) "Board Member" means each of the elected and the appointed members of the Board.

(c) "County" means the County of Cook and all government agencies of the County of Cook.

(d) "Compensation" means money, thing of value or other pecuniary benefit received or to be received in return for, or as reimbursement for, services rendered or to be rendered.

(e) "Economic interest" means any direct or indirect interest valued or capable of valuation in monetary terms; provided, however, "economic interest" shall not include (1) any ownership through purchase at fair market value or inheritance of less than 1% of the shares of a corporation, or any value of or dividends of such shares, if such shares are registered on a securities exchange pursuant to the Securities Exchange Act of 1934, as amended; (2) the authorized compensation paid to a Board Member or Employee for his office or employment; (3) any economic benefit provided equally to all residents of the County; (4) a time or demand deposit in a financial institution; (5) an endowment or insurance policy or annuity contract purchased from an insurance company; (6) any accrued pension rights in the County Fund; or (7) with respect to a mutual fund, the individual securities of other instruments owned by the mutual fund.

(f) "Employee" means an individual employed by the Fund whether part-time or full-time or by a contract of employment, excluding any third party vendors of the Fund or any appointed or elected Board Member of the Fund.

(g) "Ethics Officer" means the legal counsel for the Fund designated as being the Fund's "Ethics Officer".

(h) "Fund" means the County Employees' and Officers' Annuity and Benefit Fund of Cook County and ex officio of the Forest Preserve District Employees' Annuity and Benefit Fund.

(i) "Gift" means any gratuity, discount, entertainment, hospitality, loan, forbearance, or other tangible or intangible item having monetary value including, but not limited to, cash, food and drink, and honoraria for speaking engagements related to or attributable to Fund employment or the official position of a Board Member or Employee of the Fund; provided, however, Gift shall not be deemed to include reimbursement from the Fund of travel or educational expenses relating to Fund business.

(j) "Party in interest" means (1) any person that is a fiduciary, counsel or Employee of the Fund or a relative of such person; (2) any person that provides services to the Fund or a relative of such person; (3) an employer, any of whose employees are covered by the Fund; (4) an employee organization, any members of which are covered by the Fund; and (5) an Employee, officer or director of the Fund or of a person described under items (2), (3) or (4) above.

(k) "Person" means any individual, entity, corporation, partnership, firm, association, union, trust, estate, as well as any parent or subsidiary of any of the foregoing, and whether or not operated for profit.

(l) "Prohibited source" means any person or entity who:

(1) is seeking official action (A) by the Board; (B) by the Board Member; or (C) by the Employee;

(2) does business or seeks to do business (A) with the Board or (B) with a Board Member;

(3) has interests that may be substantially affected by the performance or non performance of the official duties of the Board Member; or

(4) is registered or required to be registered with the Secretary of State under the Lobbyist Registration Act, except that an entity not otherwise a prohibited source does not become a prohibited source merely because a registered lobbyist is one of its members or serves on its board of directors.

(m) "State" means the State of Illinois.

(n) "State Ethics Act" means the State Officials and Employees Ethics Act, 5 ILCS 430/1, as amended from time to time.

(o) "Statement" means the statement of economic interest form required to be filed by the Illinois Governmental Ethics Act, 5 ILCS 420/4A-101 et seq., as amended from time to time.

ARTICLE II

2.1 Fiduciary Duty

Board Members and Employees, who exercise discretionary authority or responsibility with respect to the management of the Fund or the management or operation of its assets, shall at all times in the performance of their public duties owe a fiduciary duty to the Fund and its participants and beneficiaries.

2.2 Offering, Receiving and Soliciting Gifts and Favors

(a) No Board Member or Employee shall intentionally solicit or accept any Gift from any Prohibited Source or in violation of any federal or state statute, rule or

regulation. This prohibition applies to the spouse, domestic partner and immediate family members living with the Board Member or Employee.

(b) No Prohibited Source shall give or offer to give to any Board Member or Employee or to the spouse, domestic partner or immediate family member living with a Board Member or Employee anything of value, including, but not limited to, a Gift, favor or promise of future employment, based upon any mutual understanding, either explicit or implicit, that the votes, Board Member actions, decisions or judgments of any Board Member or Employee, concerning the business of the Fund would be influenced thereby.

(c) Nothing in this Policy shall prohibit any Board Member or Employee, or spouse, domestic partner or immediate family member living with a Board Member or Employee from accepting a Gift on the Fund's behalf; provided, however, the person accepting the Gift shall promptly report receipt of the Gift to the Board and to the Fund's Ethics Officer, who shall add it to the inventory of Fund property.

(d) The restrictions in Subsections (a) and (b) above do not apply to the following:

(1) Opportunities, benefits, and services available on the same conditions as for the general public.

(2) Anything for which the Board Member or Employee or his or her spouse, domestic partner or immediate family member living with him or her pays the market value.

(3) Any (i) contribution that is lawfully made under the Election Code or under the State Ethics Act or (ii) activities associated with a fundraising event in support of a political organization or a candidate for any elective office.

(4) Educational materials.

(5) A Gift from a relative, meaning those people related to the individual as father, mother, son, daughter, brother, sister, uncle, aunt, great uncle, great aunt, first cousin, nephew, niece, husband, wife, grandfather, grandmother, grandson, granddaughter, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, half sister, and including the father, mother, grandfather, or grandmother of the individual's spouse and the individual's fiancé or fiancée.

(6) Anything provided by an individual on the basis of a personal friendship unless the Board Member or Employee has reason to believe that, under the circumstances, the Gift was provided because of the official position or employment of the Board Member or Employee and not because of the personal friendship.

In determining whether a Gift is provided on the basis of personal friendship, the Board Member or Employee shall consider the circumstances under which the Gift was offered, such as:

(i) the history of the relationship between the individual giving the Gift and the recipient of the gift, including any previous exchange of Gifts between those individuals;

(ii) whether to the actual knowledge of the Board Member or Employee the individual who gave the gift personally paid for the Gift or sought a tax deduction or business reimbursement for the Gift; and

(iii) whether to the actual knowledge of the Board Member or Employee the individual who gave the Gift also at the same time gave the same or similar Gifts to other Board Members or employees or their spouses, domestic partners or immediate family members living with them.

(7) Food or refreshments not exceeding $75 per person in value on a single calendar day; provided that the food or refreshments are (i) consumed on the premises from which they were purchased or prepared or (ii) catered. For purposes of this subsection, "catered" means food or refreshments that are purchased ready to eat and delivered by any means.

(8) Food, refreshments, lodging, transportation, and other benefits resulting from the outside business or employment activities (or outside activities that are not connected to the duties of the Board Member or Employee as an office holder or employee) of the Board Member or Employee, or the spouse of the Board Member or Employee, if the benefits have not been offered or enhanced because of the position or employment of the Board Member or Employee, and are customarily provided to others in similar circumstances.

(9) Intra-governmental and inter-governmental gifts. For the purpose of this Policy, "intra-governmental gift" means any Gift given to a Board Member or Employee of the Fund from another Board Member or Employee of the Fund; and "inter-governmental gift" means any gift given to a Board Member or Employee of the Fund by a Board Member or employee of another County agency or department, of a State of Illinois agency, of a federal agency, or of any governmental entity.

(10) Bequests, inheritances, and other transfers at death.

(11) Any item or items from any one Prohibited Source during any calendar year having a cumulative total value of less than $100.

Each of the exceptions listed in this subsection (d) is mutually exclusive and independent of one another.

(e) A Board Member or Employee does not violate this Policy if the Board Member or Employee promptly takes reasonable action to return the prohibited Gift to its source or gives the Gift or an amount equal to its value to an appropriate charity that is exempt from income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as now or hereafter amended, renumbered, or succeeded.

2.3 Fund Owned Property

No Board Member or Employee shall engage in or permit the unauthorized use of Fund-owned or Fund-leased property. Fund-owned and Fund-leased property shall only be used for official Fund business.

2.4 Use or Disclosure of Confidential Information

No Board Member or Employee shall use or disclose, other than (i) in the performance of his or her official duties as a Board Member or Employee; (ii) as may be required by law; or (iii) as permitted by this Policy or by resolution of the Board, confidential information gained in the course of or by reason of his or her position or employment with the Fund. For purposes of this Section, "confidential information" means any information that may not be obtained pursuant to the Illinois Freedom of Information Act, as amended from time to time.

2.5 Conflicts of Interest

(a) No Board Member or Employee shall make, or participate in making, any Fund decision with respect to any matter in which the Board Member or Employee, or the spouse or domestic partner of the Board Member or Employee, has any economic interest distinguishable from that of the general public.

(b) Any Employee who has a conflict of interest as described by subsection (a) above shall advise his or her supervisor of the conflict or potential conflict. The immediate supervisor shall either:

(1) assign the matter to another Employee; or

(2) require the Employee to eliminate the economic interest giving rise to the conflict and only thereafter shall the Employee continue to participate in the matter.

(c) Any Board Member who has a conflict of interest as described by subsection (a) above shall disclose the existence of the conflict of interest on the record and should consider the possibility of abstaining from official action in relation to the matter. In making the decision as to abstention, the following factors should be considered:

(1) whether a substantial threat to the Board Member's independence of judgment has been created by the conflict situation;

(2) the effect of participation on public confidence in the integrity of the Board's decision;

(3) whether participation is likely to have any significant effect on the disposition of the matter;

(4) the need for the Board Member's contribution, such as special knowledge of the subject matter, to the effective functioning of the Fund.

2.6 Representation of Other Persons

No Board Member or Employee may represent, or have an economic interest in the representation of, any person in a formal or informal proceeding or transaction before the Fund in which the Board's or Employee's action or non-action is of a non-ministerial nature.

2.7 Post Employment Restrictions

For a period of one year from and after the expiration or other termination of a his or her term of office as a member of the Board or as an Employee, no former Board Member or Employee shall assist or represent any person in any business or adversarial transaction involving the Fund, if the Board Member or Employee participated personally and substantially in the consideration of or implementation of that transaction during his or her term of office or employment.

2.8 Ethics Training

Pursuant to the Illinois Pension Code, 40 ILCS 5 et seq. (the "Code"), all Board Members must attend ethics training of at least eight (8) hours per year. The training required includes training on ethics, fiduciary duty, and investment issues and any other curriculum that the Board establishes as being important for the administration of the Fund. The Board must annually certify its Board Members' compliance with the Code's ethics training requirements.

2.9 No Monetary Gain on Investments

No Board Member or Employee of the Fund, nor any spouse of such Board Member or Employee, shall knowingly have any direct interest in the income, gains, or profits of any investments made on behalf of the Fund, nor receive any pay or emolument for services in connection with any investment. No Board Member or Employee shall become an endorser or surety, or in any manner an obligor for money loaned or

borrowed from the any retirement system or pension fund or the Illinois State Board of Investment. For the purposes of this Section 2.9, an annuity otherwise provided in accordance with the Code or any income, gains, or profits related to any non-controlling interest in any public securities, mutual fund, or other passive investment is not considered monetary gain on investments.

Pursuant to the Code, a violation of this Section 2.9 shall be a Class 3 felony.

2.10 Prohibited Transactions

(a) A fiduciary of the Fund shall not cause the Fund to engage in a transaction if he or she knows or should know that such transaction constitutes a direct or indirect:

(1) Sale or exchange, or leasing of any property from the Fund to a party in interest for less than adequate consideration, or from a party in interest to the Fund for more than adequate consideration.

(2) Lending of money or other extension of credit from the Fund to a party in interest without the receipt of adequate security and a reasonable rate of interest, or from a party in interest to the Fund with the provision of excessive security or an unreasonably high rate of interest.

(3) Furnishing of goods, services or facilities from the Fund to a party in interest for less than adequate consideration, or from a party in interest to the Fund for more than adequate consideration.

(4) Transfer to, or use by or for the benefit of, a party in interest of any assets of the Fund for less than adequate consideration.

(b) A fiduciary of the Fund shall not:

(1) Deal with the assets of the Fund in his own interest or for his own account;

(2) In his individual capacity or any other capacity act in any transaction involving the Fund on behalf of a party whose interests are adverse to the interests of the Fund or the interests of its participants or beneficiaries; or

(3) Receive any consideration for his own personal account from any party dealing with the Fund in connection with a transaction involving the assets of the Fund.

(c) Nothing in this Section 2.10 shall be construed to prohibit any Board Member from:

(1) Receiving any benefit to which he may be entitled as a participant or beneficiary in the Fund.

(2) Receiving any reimbursement of expenses properly and actually incurred in the performance of his duties with the Fund.

(3) Serving as a Board Member in addition to being an officer, employee, agent or other representative of a party in interest.

(d) A fiduciary of the Fund shall not knowingly cause or advise the Fund to engage in an investment transaction when the fiduciary (1) has any direct interest in the income, gains, or profits of the investment adviser through which the investment transaction is made or (2) has a business relationship with the investment adviser that would result in a pecuniary benefit to the fiduciary as a result of the investment transaction. Violation of this subsection (d) is a Class 4 felony.

(e) A Board Member, Employee or consultant with respect to the Fund shall not knowingly cause or advise the Fund to engage in an investment transaction with an investment adviser when the Board Member, Employee or consultant, or their spouse (i) has any direct interest in the income, gains, or profits of the investment adviser through which the investment transaction is made or (ii) has a relationship with that investment advisor that would result in a pecuniary benefit to the Board Member, Employee or consultant or spouse of such Board Member, Employee or consultant as a result of the investment transaction. For purposes of this subsection (e), a consultant include an employee or agent of a consulting firm who has greater than 7.5% ownership of that consulting firm. Violation of this subsection (e) is a Class 4 Felony.

2.11 Compliance with SEC Rule 206 (4)-5

Any party providing investment advisory services to the Fund shall be required to comply with the requirements of Rule 206(4)-5 of the Securities and Exchange Commission ("Rule") and shall adopt such policies and procedures designed to prevent violations of the Rule. If a violation of the Rule is established, the Board will take such action as required by the Rule to ensure that the investment adviser not receive compensation from the Fund for a two year period after a triggering contribution under the Rule has been made.

ARTICLE III
FINANCIAL DISCLOSURE

On or before May 1 of each year, Board Members shall file verified written statements of economic interests as required by the Illinois Governmental Ethics Act, 5 ILCS 420/4A-101 et seq., as amended. All statements shall be available in electronic form for examination and duplication by the Board upon request.

ARTICLE IV

ETHICS OFFICER

Legal counsel for the Fund shall be designated as the Fund's Ethics Officer for the purposes of this Policy. The duties of the Ethics Officer include (i) reviewing statements of economic interest and disclosure forms of Board Members upon request and (ii) providing requested guidance to Board Members and Employees in the interpretation and implementation of this Policy; *provided, however*, that compliance with this Policy remains the individual responsibility of each Board Member and Employee. If uncertainty exists as to the proper procedure(s) to be followed in connection with this Policy, Board Members and Employees are encouraged to consult with the Fund's Ethics Officer.

Further, Board Members and Employees are hereby advised that the Ethics Officer represents the Fund and not the individual Board Members and Employees. As such, any guidance or advice provided to an individual by the Ethics Officer pursuant to this Policy is not given to him or her personally, but instead is given because of the position or employment of the particular Board Member or Employee with the Fund.

ARTICLE V

PENALTIES FOR VIOLATION

5.1 Sanctions

Any Employee found to have violated any provision of this Policy, or to have knowingly furnished false or misleading information in any investigation, hearing or inquiry held pursuant to this Policy, shall be subject to employment sanctions, including discharge. The provisions of this Policy shall not limit the power of officials to otherwise discipline Employees. Any Board Member who intentionally files a false or misleading Statement of Economic Interests, or knowingly fails to disclose a conflict of interest as described in this Policy, or otherwise knowingly violates any fiduciary duty, may be subject to equitable or remedial relief in accordance with the applicable provisions of the Code.

5.2 Validity of Contracts

All Fund contracts entered into after the effective date of this Policy shall include a provision requiring compliance with this Policy. Any contract negotiated, entered into, or performed in violation of any of the provisions of this Policy shall be voidable as to the Fund.

5.3 Other Remedies

Nothing in this Policy shall preclude the Fund from maintaining an action for an accounting for any pecuniary benefit received by any person in violation of this Policy or other law, or to recover damages for violation of this Policy.

Approved and adopted October 6, 2010.

Agency Exhibit

City Colleges of Chicago

Table of Contents

Medical Benefits

Medical Benefit Highlights	HMO BlueAdvantage Plan	PPO Plan In-Network	PPO Plan Out-of-Network
Annual Deductible			
Individual	None	$500	$1,000
Family	None	$900	$3,000
Annual Out-of-Pocket Maximum			
Individual	$1,500	$2,500 (including deductible)	$3,000 (including deductible)
Family	$3,000	$4,000 (including deductible)	$9,000 (including deductible)
Lifetime Maximum Benefit (per person)	Unlimited	Unlimited	
Preventive Care Services (No co-payment, deductible or co-insurance)	100%	100%	
Physician Services			
Office Visit – Primary Care Physician	100% (after $25 copay)	80% (after $10 copay)	70%
Office Visit – Specialist Physician	100% (after $35 copay)	80% (after $20 copay)	
Hospital Services*			
Inpatient or Outpatient	100% (after $300 copay)**	80% (after $100 copay)	70% (after $100 copay)
Emergency Room Visit	100% (after $200 copay)	80% (after $175 copay)	80% (after $175 copay)
Mental Health Services			
Inpatient	100% (after $300 copay)	80%	70%
Outpatient	100% (after $25 copay)	80% (after $10 copay)	70%
Chemical Dependency Services			
Inpatient	100% (after $300 copay)	80%	70%
Outpatient	100% (after $25 copay)	80%	70%
Other Covered Services (e.g., physical therapy, home health care)	100% (after $25 copay/visit)	80%	70%
Prescription Drugs Retail (30 day supply)			
Generic Copay	$20	$10	Reimbursed at 75% of network rate minus $10 copay
Brand Formulary Copay	$30	$20	Reimbursed at 75% of network rate minus $20 copay
Brand Non-Formulary Copay	$45*	$40*	Reimbursed at 75% of network rate minus $40 copay
Mail-Order (90 day supply)			
Generic Copay	$40	$20	Reimbursed at 75% of network rate minus $20 copay
Brand Formulary Copay	$60	$40	Reimbursed at 75% of network rate minus $40 copay
Brand Non-Formulary Copay	$90*	$80*	Reimbursed at 75% of network rate minus $80 copay

*PPO members must contact the Medical Services Advisory (MSA) at least 1 business day prior to a non-emergency hospital admission and within 2 business days of an emergency or maternity hospital admission; otherwise, an additional $500 copay applies.

**There is no copay for outpatient preventive endoscopic surgical procedures such as colonoscopies.

*If you choose a non-formulary drug when a generic is available, you pay the cost difference between them in addition to the copay.

This sheet only highlights the benefit plans. For additional information, contact the District Office of Human Resources, Benefits Division.

Dental Plan

The purpose of City Colleges of Chicago's dental plan is to provide affordable protection from large out-of-pocket dental expenses and encourage preventive care. CCC pays approximately 85% of your monthly cost for dental plan coverage. You may go to the dentist of your choice or to a provider in the BCBS Blue Care dental network. To see if your current dentist is in the BlueCross BlueShield Blue Care Dental network or to find a network dentist, search the Provider Locator at www.bcbsil.com, or call (855) 557-5488. You may choose different dental providers for each family member.

Program Basics	Contracting Provider*	Non-Contracting Provider*
Benefit Period Maximum	$1,500 per calendar year	
Deductible Applies to all covered dental services, except for Oral Exams, Cleanings, and X-Rays	$10 per person per calendar year	
Dependent Coverage	Up to age 26	
Services	**Contracting Provider***	**Non-Contracting Provider***
Diagnostic & Preventive Services Dental exams Cleanings (2 visits per calendar year) X-rays	100% of Maximum Allowance No Deductible	100% of Usual and Customary No Deductible
Miscellaneous Services Fluoride treatment Space maintainers Sealants for children up to age 19 Emergency Care (Relief of pain)	100% of Maximum Allowance No Deductible	100% of Usual and Customary No Deductible
Restorative Services Routine fillings (amalgams and resins) Pin retention Simple extractions	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
General Services Intravenous sedation General anesthesia Reline/rebase of dentures Repair of bridges and dentures	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Endodontic Services Root canals Pulp caps Apicoectomy/apexification	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Periodontic Services Scaling and root planing Gingivectomy/gingivoplasty Osseous surgery	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Oral Surgery Services Surgical extractions, including complete bony impactions Alveoloplasty Vestibuloplasty	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Crowns, Veneers, Inlays/Onlays Services Dental implants Crowns, including stainless steel inlays/onlays Repairs and replacement of Veneers after 60 months Prefabricated posts and cores Repair and recementation of crown, inlays/onlays	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Prosthodontic Services Bridges, dentures Addition of tooth or clasp	80% of Maximum Allowance After Deductible	80% of Usual and Customary After Deductible
Orthodontics Coverage for adults and for eligible dependent children to age 26	50% Orthodontia – Separate Lifetime Maximum of $2,000 for Adults and Children	50% Orthodontia – Separate Lifetime Maximum of $2,000 for Adults and Children

*** Schedule of Maximum Allowances:** Contracting providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. Non-contracting providers do not accept the Schedule of Maximum Allowances as payment in full. For services received from a non-contracting provider, member will be liable for the difference between the dentist's charge and covered benefits.

For more info, visit bcbsil.com or contact Customers Service Center, toll free at (855) 557-5488, Monday through Friday, 8 a.m. to 6 p.m.

Vision Plan

The purpose of City Colleges of Chicago's vision plan is to provide affordable protection from large out-of-pocket vision expenses and encourage preventive care. CCC pays approximately 85% of your monthly cost for vision plan coverage. The Vision Service Plan (VSP) offers you flexibility in choosing your vision provider. You may choose between a VSP provider or an out-of-network provider. Benefits are better if you select a VSP in-network provider. The plan benefits include examinations and lenses every 12 months, and frames every 24 months. There is an individual $10 copayment each calendar year for all covered services.

Benefit	Description	Copay
	Your Coverage with a VSP Doctor	
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10 for exam and glasses
	Prescription Glasses	
Frame	• $120 allowance for a wide selection of frames • 20% off amount over your allowance • Every 24 months	Combined with Exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Combined with Exam
Lens Options	• Tints/Photochromic lenses • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35-40% off other lens options • Every 12 months	$0 $50 $80 - $90 $120 - $160
Contacts (Instead of Glasses)	• $300 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Diabetic Eyecare Plus Program	
Extra Savings and Discounts	**Glasses and Sunglasses** • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	

Your Coverage with Other Providers

Visit vsp.com for details if you plan to see a provider other than a VSP doctor.

Exam – Up to $35	Lined Trifocal Lenses – Up to $50
Frame – Up to $40	Progressive Lenses – Up to $50
Single Vision Lenses – Up to $30	Contacts – Up to $105
Lined Bifocal Lenses – Up to $40	Tints – Up to $5

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

CITY COLLEGES of CHICAGO
Education that Works

Appendix 1

Terms & Conditions Regarding Compliance with the Minority Business Commitment and the Women Business Enterprise Commitment

Terms & Conditions Regarding
Compliance with the City Colleges of Chicago's
Minority Business Enterprise (MBE) and
Women Business Enterprise (WBE) Participation Plan

SECTION 1: INTRODUCTION

1. The Board of Trustees of Community College District No. 508. (The "Board") has adopted the amended Minority and Women Business Enterprise Plan (The "Plan") to ensure that Minority Businesses and Women Businesses shall have maximum feasible opportunities to participate on City Colleges of Chicago contracts, and to remedy the effects of historical discrimination while minimizing its impact upon Non-MBE and Non-WBE businesses. The Plan includes goals for participation of certified MBE and WBE firms, and the Bidders/Proposers utilization of such firms is considered in determining responsibility in performing this contract.

1.1 The purpose of the revised Terms and Conditions is to describe the current requirements of the Plan including the MBE and WBE goals that have been established for this contract and certain administrative and procedural provisions.

Bidders/Proposers are required to submit information specifying the percentage of the total contract that will be performed by certified MBE and WBE firms on the attached Schedules.

SECTION 2: POLICY STATEMENT AND TERMS

2.1 It is the policy of the Board to ensure that the City Colleges of Chicago take all possible steps consistent with applicable law to insure that Minority Business Enterprises and Women Business Enterprises are afforded a fair and representative opportunity to participate fully in this institution's contracting.

2.2 Consistent with this policy it shall be the responsibility of all contractors to exhaust all feasible means to ensure significant participation by certified MBEs and WBEs.

2.3 Failure to carry out the commitments and policies set forth in this Plan shall constitute a material breach of contract and may result in termination of the contract or such other remedy as the Board deems appropriate.

SECTION 3: DEFINITIONS

3.1 The following words as used herein shall have the meanings indicated below unless the context clearly indicates otherwise:

a. **Board of Trustees or Board** shall mean the Board of Trustees of Community College District No. 508.

b. **Certified** means any business or individual which has been certified by any of the CCC approved certifying agency to be an MBE or WBE and is on the Board's list of certified MBEs or WBEs.

c. **Chancellor** shall mean the Chancellor of City Colleges of Chicago or his/her designee.

d. **City College** shall mean the City Colleges of Chicago.

e. **Commercially Useful Function** shall mean the execution of a distinct element of work with actual performance, resources, management and supervision.

f. **Financial and Administrative Service Committee** shall mean the Financial and Administrative Service Committee of the Board of Trustees of Community College District No.508 or such other committee as the Board of Trustees may from time to time designate.

g. **General Contractor** shall mean a firm that has entered into a contract with the Board to provide goods or services.

h. **Joint Venture shall** mean an association between two or more independent businesses formed to perform a specific contract.

i. **Minority or Minority person** shall mean a person who is a citizen or lawful permanent resident of the United States, who is a member of an identified racial/ethnic population group, specifically, Black, Hispanic, Asian, or any other racial/ethnic population group that the Chancellor determines, after notice and hearing, to suffer discrimination in the Chicago area and who has participated, or has attempted to participate, in the Chicago area market.

j. **MBE or Minority Business Enterprise** shall mean a certified business that is owned and controlled by a Minority or Minorities that is certified as an MBE as defined in Section III (Definitions, 3.1) and has participated, or has attempted to participate, in the Chicago area market.

k. **Person** shall mean a natural person, or partnership, corporation or joint venture.

l. **Subcontractor** shall mean a business that has entered into a contract with a General Contractor to provide goods or services pursuant to a contract between the General Contractor and the Board.

m. **WBE or Women Business Enterprise** shall mean a certified business that is owned and controlled by a woman or women, that is certified as a WBE as provided in Section III (Definitions, 3.1) and has participated, or has attempted to participate, in the Chicago area market.

n. **Woman or Female** shall mean a person who is a citizen or lawful permanent resident of the United States who us of female gender.

SECTION 4: PARTICIPATION GOALS

4.1 **Percentages of Participation**
Goals for participation by certified MBE and WBE firms for this Contract shall be not less than the following percentage of the **total contract value:**

MBE Participation goal: 25%
WBE Participation goal: 7%

4.2 **Bidder/Proposer's Commitment and Responsibility**
Each Bidder's commitment to the utilization of certified MBE and WBE firms shall be considered as further evidence of the responsibility of the Bidder/Proposer. Further, the Contractor agrees to use its best efforts to include certified MBE and WBE firms in any Contract modifications, amendments and renewals.

SECTION 5: PROCEDURE TO DETERMINE BID & PROPOSAL COMPLIANCE

5.1 The following documents constitute the Bidder/Proposer's MBE/WBE Compliance Plan and must be submitted with the bid or proposal:

A. **Schedule A: Affidavit of MBE/WBE Goal Implementation Plan**
Bidders/Proposers must submit, together with the bid/proposal, a completed Schedule A committing them to the utilization of each certified MBE/WBE firm listed.

Except in cases where the bidder/proposer has submitted a complete request for a waiver or variance of the MBE or WBE goals in accordance with Section 8 (below), the bidder/proposer must commit to the expenditure of an estimated percentage of their proposed contract value. Specific dollar amounts of participation by each certified MBE/WBE firm should also be included on the Schedule A as practicable.

Additionally, the total dollar commitments proposed for certified MBE firm(s) must at least equal the MBE goal, and the total dollar commitment to propose certified WBEs must at least equal the WBE goal.

All commitments made on the bidder/proposer's Schedule A must correspond with those presented on the Schedule C documents that are described below.

Additionally, a fully completed and executed Schedule A must be submitted with the bid/proposal when due. Failure to submit the completed Schedule A or a waiver request in accordance with this section will be cause for finding bid/proposal non-responsive and may result in rejection of bid/proposal.

B. **Schedule C: Letter of Intent**
A Schedule C [Schedule C-1 (MBE/WBE Bidder/Proposer or Schedule C-2 (Joint Venture Partner) as described herein] must be completed in its entirety and executed by each certified MBE and WBE firm listed on the Schedule A and submitted with the bid/proposal.

The Schedule C must accurately detail the work to be performed by the certified MBE or WBE firm at the agreed rates and prices to be paid. Additionally, the certified MBE and WBE firm's scope of work, as detailed on their Schedule C must conform to their area of specialty included in the certification letter as described below.

Additionally, all fully completed and executed Schedule Cs must be submitted with the bid/proposal when due. Failure to submit the completed Schedule C(s) in accordance with this section will be cause for finding bid/proposal non-responsive and may result in rejection of bid/proposal.

C. **Letters of Certification & Certification Determination**
A copy of each proposed MBE and WBE firm's current letter of certification must be submitted with the bid/proposal as a complement to the Schedule A and C. All letters of certification must include a statement of the certified MBE/WBE firm's area of specialty.

In order to be designated as a certified Minority Business Enterprise (MBE) or as a Women Business Enterprise (WBE) in City Colleges of Chicago contracting activity a firm must be verified as such by agencies known and accepted by CCC.

Specifically, the following agencies confer the designation and are accepted by the Office of Contract Compliance:

1) The City of Chicago;
2) Cook County;
3) The State of IL—CMS ;
4) National Minority Supplier Development Council and its regional affiliates including the Chicago Minority Supplier Development Council and
5) Women Business Enterprise National Council and its regional partner organizations including the Women's Business Development Center in Chicago and

Certifications will also be considered from conferring government agencies in other states and major metropolitan cities on a case by case basis.

D. **Schedule C-2 & Joint Venture Agreements**
If the bidder/proposer's MBE/WBE proposal includes the participation of certified MBE or WBE firms as a joint venture on any tier (either as the bidder/proposer or as a subcontractor), the bidder/proposer must provide a copy of the joint venture agreement, as a part of Schedule A submission.

In order to demonstrate the certified MBE or WBE partner's share in the ownership, control, management responsibilities, risks and profits of the joint venture, the MBE or WBE firm that is a party to the Joint Venture must complete the Schedule C-2.

Additionally, the joint venture agreement must complement the Schedule C-2 and include specific details related to: (1) contributions of capital and equipment (2) work responsibilities or other performance to be undertaken by the certified MBE/WBE firm; (3) the commitment of management, supervisory and operative personnel employed by the certified MBE/WBE to be dedicated to the performance of the contract. The joint venture agreement must also clearly define each partner's authority to contractually obligate the joint venture and each partner's authority to expend joint venture funds (e.g. check signing authority).

5.2 **Correct Completion of Schedules**
The MBE/WBE Compliance Plan must have all blank spaces on both of the Schedules applicable to the Contract correctly filled in.

Agreements between a Bidder/Proposer and a certified MBE and certified WBE in which the certified MBE/WBE promises not to provide subcontracting quotations to other Bidders/Proposers are prohibited.

5.3 **Deficient Compliance Plans**

Upon receipt of the Compliance Plan submitted with the bid/proposal, the Office of MBE/WBE Compliance will determine if the bid/proposal is responsive. A bid/proposal may be treated as non-responsive by reason of the determination that the Bidder/Proposer's response did not contain a sufficient level of certified MBE or WBE participation or an approved waiver request.

During the period between bid opening/proposal due date and contract award the MBE/WBE Plan will be evaluated by the Office of M/WBE Contract Compliance for the following:

1) MBE and WBE Performance of a commercially useful function
2) Analysis of industry standard for sub-contracting (if applicable)
3) Scope of services versus certification letter specialty area
4) Accurate levels of compliance
5) Due diligence efforts to support waiver request (if applicable)
6) Certification renewal status
7) MBE/WBE execution of Schedule C
8) Compliance history on previous contracts with CCC and its sister agencies

The Bidder/Proposer agrees to provide, upon request, earnest and prompt cooperation to the Office of M/WBE Contract Compliance in submitting to interviews that may be necessary, in allowing entry to places of business, in providing further documentation, or in soliciting the cooperation of a proposed certified MBE or WBE firm in providing such assistance.

Additionally, a bid/proposal may be treated as non-responsive by reason of the determination that the Bidder/Proposer was unresponsive or uncooperative when asked for further information relative to the bid/proposal, or that false statements were made in the Schedules.

SECTION 6: COUNTING MBE/WBE PARTICIPATION TOWARD CONTRACT GOALS

6.1 Only certified MBE and WBE participation shall be counted toward the MBE and WBE goals set in this Contract and applied as follows:

A. **Direct Participation**

An MBE or WBE firm should be used directly in the performance of the scope of services that the Bidder/Proposer is providing for the District. The MBE or WBE's total contract value can be credited towards the participation goals for direct participation.

B. **Indirect Participation**
In the event the Bidder/Proposer's specific scope of services does not provide an opportunity for direct subcontracting, the Bidder/Proposer must consider other ways to engage MBEs and WBEs to meet the contract participation goals.

The expenditures with MBE and WBE vendors that are being used in the Bidder/Proposer's overall business operations for goods or services that are ancillary to the CCC contract such as transportation, advertising, accounting, landscaping, office supply can be credited at 100%.

C. **Commercially Useful Function (CUF)**
A Bidder/Proposer may count toward its MBE and WBE goal only expenditures to certified firms that will perform a commercially useful function in the work of a contract. A firm is considered to perform a commercially useful function when it is responsible for a distinct element of work of a contract and carries out the responsibilities by actually performing, managing, and supervising the work involved using its own resources.

The Office of M/WBE Contract Compliance will use a variety of methods to determine whether or not an MBE or WBE is performing a CUF at any time (pre-award, during contract execution and/or during the contract close-out phase) including but not limited to:

1) Project site visits;
2) Documentation requests and/or
3) Interviews with MBE or WBE owners or employees

D. **MBE/WBE Subletting**
Consistent with normal industry practices, a certified MBE or WBE subcontractor may enter into further subcontracts. If a certified MBE/WBE contractor subcontracts a significantly greater portion of the work of the contract than would be expected on the basis of normal industry practices, the certified MBE or WBE shall be presumed not to be performing a commercially useful function. Evidence may be presented, in writing, to the Office of M/WBE Contract Compliance by the contractors involved to rebut this presumption.

E. **Counting MBE/WBE Manufacturers**
A Contractor may count toward its goals expenditures to certified MBE or WBE manufacturers (i.e., suppliers that produce goods from raw materials or substantially alters them before resale) at 100%.

F. **Counting MBE/WBE Suppliers**
A Contractor may count 100% of its expenditures with certified MBE or WBE suppliers toward its compliance goals provided that the supplier performs a commercially useful function in the supply chain process and is a regular dealer.

G. **Counting Total Dollar Value Awarded To Certified MBEs/WBEs**
The total dollar value of contract awarded to a certified MBE or WBE firm shall only be credited to one of the respective certification statuses. The Contractor employing the certified firm may choose the goal to which the contract value is applied—either MBE or WBE; not both.

Work done by one and the same subcontractor shall be considered, for the purpose of this principle, as work effectively under one subcontract only, in which the subcontractor may be counted toward only one of the goals, but not toward both.

H. **MBE/WBE Controlled Firms**
If the Bidder or Proposer is a certified MBE most of the total contract value can be counted toward the fulfillment of the MBE goal and similarly, if a WBE is the Bidder or Proposer, most of the total contract value can be counted toward the fulfillment of the WBE goal. However, MBE Bidders/Proposers must obtain a certified WBE subcontractor and a WBE Bidder/Proposer must obtain a certified MBE subcontractor to meet the respective goals.

Additionally, if a firm is certified as both an MBE and WBE, they can only use one of the certification statuses to fulfill one of the goals; not both.

MBE and WBE Bidder/Proposers must submit a Schedule C-1 which outlines their intent to subcontract any portion of their work they do not plan to self-perform.

Moreover, an MBE or WBE Bidder/Proposer must submit a Schedule A, Schedule C(s) for MBE or WBE subcontractors, and certification letters for themselves and any other MBE or WBE they may be utilizing on the contract.

I. **Counting Total Dollar Value of Eligible Joint Ventures**
A Contractor may count toward its MBE or WBE goal the portion of the total dollar value of a contract with an eligible joint venture equal to the percentage of the ownership and control of the MBE or WBE partner in the joint venture. A joint venture seeking to be credited for MBE participation may be formed among certified MBE and WBE firms, or between certified MBE and WBE firms and a non-MBE/WBE firm. A joint venture satisfies the eligibility standards of this Plan if the certified MBE or WBE participant of the joint venture:

1. Shares in the ownership, control, management responsibilities, risks and profits of the joint venture; and

2. Is responsible for a clearly defined portion of work to be performed in proportion to the certified MBE or WBE ownership percentage.

A Schedule C-2 and Joint Venture agreement must be submitted to support utilizing an MBE or WBE as a Joint-Venture participant.

6.2 A Contractor may count toward its MBE/WBE goal the following expenditures to certified firms that are not manufacturers or regular dealers:

A. **Fees or Commissions For Providing Services**
The fees or commissions charged for providing a bona fide service, such as professional, technical, consultant or managerial services and assistance in the procurement of essential personnel, facilities, equipment, materials or supplies required for performance of the contract, provided that the fee or commission is determined by the Office of M/WBE Contract Compliance to be reasonable and not excessive as compared with fees customarily allowed for similar services.

B. **Fees For Delivering Materials and Supplies**
The fees charged for delivery of materials and supplies required on a job site (but not the cost of the materials and supplies themselves) when the hauler, trucker, or delivery service is not also the manufacturer of or a regular dealer in the materials and supplies, provided that the fee is determined by the Office of M/WBE Contract Compliance to be reasonable and not excessive as compared with fees customarily allowed for similar services.

C. **Fees or Commissions For Bonds or Insurance**
The fees or commissions charged for providing any bonds or insurance specifically required for the performance of the contract, provided that the fee or commission is determined by the Office of M/WBE Contract Compliance to be reasonable and not excessive as compared with fees customarily allowed for similar services.

SECTION 7: CHANGES TO MBE/WBE PARTICIPATION PLAN

7.1 **Termination of Scope of Work Not Permitted**
After submitting executed MBE and/or WBE sub-agreements to the Office of M/WBE Contract Compliance, the Contractor shall thereafter neither terminate the sub-agreement, nor reduce the scope of the work to be performed by the certified MBE or WBE firm, nor decrease the price to the MBE or WBE firm, without in each instance receiving the prior written approval of the Office of M/WBE Contract Compliance.

7.2 **Substitutions**

If it becomes necessary to substitute an MBE and/or WBE to fulfill the Contractor's MBE and/or WBE commitments, the Office of M/WBE Contract Compliance must be given reasons justifying the release of prior specific MBE and/or WBE commitments established in the Contractor's bid/proposal in order to review the propriety of the proposed substitution.

A substitution of MBE or WBE firms cannot be made without prior approval from the Office of MBE/WBE Compliance. In addition to the explanation provide above, the approval process must include a revised Schedule A, a Schedule C for the replacement firm(s) and current certification letter(s).

The approval process should also include concurrence from the affected MBE or WBE received either proactively from the Prime Vendor or by the Office of MBE/WBE Compliance.

SECTION 8: WAIVERS of MBE and WBE GOALS

8.1 **Inability to Meet Participation Goals**

If a Bidder/Proposer is unable to identify certified MBE and WBE firms to perform sufficient work to fulfill the MBE or WBE percentage goals for a contract, the bid/proposal must include a Schedule D (written request for waiver).

Submission of the Schedule D is not an automatic approval of the requested waiver. The approval of the requested waiver will be based, in part by the supporting documentation demonstrating the Bidder/Proposer's inability to obtain sufficient certified MBE and WBE firms, notwithstanding good faith attempts to achieve such participation.

Examples of such good faith efforts may include, but are not limited to, the following:

a) Attendance at the Pre-bid/proposal conference.

b) The Bidder/Proposer's general affirmative action policies regarding the utilization of MBE and WBE firms, plus a description of the methods used to carry out those policies.

c) Advertisement in trade association newsletters and minority-oriented and general circulation media for specific sub-bids/proposals.

d) Timely notification of specific sub-bids/proposals to minority and women assistance agencies and associations.

e) Description of direct negotiations with certified MBE and WBE firms for specific sub-bids/proposals, including:

f) the name, address and telephone number of the certified MBE and WBE firms contacted;

g) a description of the information provided to certified MBE and WBE firms regarding the portions of the work to be performed; and

h) the reasons why additional certified MBE and WBE firms were not obtained in spite of negotiations.

i) A statement of the efforts made to select portions of the work proposed to be performed by certified MBE and WBE firms (such as sub-supplier, transport, engineering, distribution, or any other roles contributing to production and delivery as specified in the Contract) in order to increase the likelihood of achieving such participation.

j) A detailed statement of the reasons for the Bidder/Proposer's conclusion that each certified MBE and WBE contacted, were not qualified.

k) Efforts made by the Bidder/Proposer to expand its search for certified MBE and/or WBE firms beyond usual geographic boundaries.

l) General efforts made to assist MBE and WBE firms to overcome participation barriers.

8.2 **Unacceptable Basis for Waiver Request**

If the bidder/proposer does not meet the MBE/WBE goal, price alone shall not be an acceptable basis for which the bidder may reject a certified MBE/WBE sub-bid/proposal unless the bidder can show to the satisfaction of the Office of M/WBE Contract Compliance that no reasonable price can be obtained from a certified MBE/WBE.

A determination of reasonable price is based on such factors as the estimate for the work under a specific subcontract, the bidder's own estimate for the specific subcontract, and the average of the bona fide prices quoted for the specific subcontract. A bid from a certified MBE/WBE for a subcontract will be presumed to be unreasonable if the MBE/WBE price exceeds the average price quoted by more than 15 percent.

8.3 **Subsequent Waiver by Request of Contractor**
During the performance of a contract, a contractor may request a partial waiver from compliance with its original MBE or WBE proposal for the following reasons:

a) Due to substantially changed circumstances the contractor is unable to meet the previously stated MBE or WBE goal(s);

b) Despite every good faith effort on the part of the contractor, it is unable to meet the previously stated MBE or WBE goal(s)

8.4 **Waiver Initiated by City Colleges of Chicago**
The Chancellor or their designee may grant a waiver from MBE or WBE requirements for an individual contract upon a determination that there are insufficient certified MBEs or WBEs available to fulfill such requirements for that particular contract.

A determination by the Chancellor to waive MBE or WBE requirements for an individual contract must be stated in writing, and placed in the appropriate project file.

SECTION 9: REPORTING AND RECORD-KEEPING REQUIREMENTS

9.1 **Execution of Subcontract By Contractor**
The Contractor, within five (5) working days after Contract award, shall execute a formal subcontract or purchase order in compliance with the terms of the Contractor's bid/proposal and MBE and WBE assurances and should be submitted to the Office of MBE/WBE Compliance within three (3) business days if requested by the Office of MBE/WBE Compliance.

In addition, each subcontract between the Bidder/Proposers and any certified MBE or WBE firm performing work on the Contract shall include remedies for non-compliance with the commitment to MBE and WBE participation, including an agreement to pay damages to the certified MBE and WBE firms which were underutilized.

9.2 **Payments to MBE and WBES**
During the performance of the Contract, the Contractor shall file regular MBE and WBE payment reports, on the form entitled "Monthly and Quarterly Report of Payments to MBE and WBE Subcontractors."

Additionally, invoices and/or other documentation must be submitted to the Office of MBE/WBE Compliance within five (5) days upon request to support the utilization of MBEs and WBEs.

9.3 **Maintenance of Relevant Records**

The Contractor shall maintain records of all relevant data with respect to the utilization of certified MBE and WBE firms, including without limitation payroll records, tax returns and records, and book of accounts, and retain such records for a period of at least three (3) years after final acceptance of the work. Full access to such records shall be granted to the Office of M/WBE Contract Compliance or its designee, on five (5) business days' notice in order to determine the Contractor's compliance with its MBE and WBE commitments and the status of any certified MBE or WBE firm performing any portion of the Contract.

SECTION 10: NON-COMPLIANCE WITH MBE and WBE PARTICIPATION GOALS

10.1 **Compliance Audits**

Whenever the Office of M/WBE Contract Compliance believes that the contractor or any of its subcontractors may not be operating in compliance with this Plan, it shall conduct an appropriate investigation.

10.2 **Notification regarding Non-compliance**

Upon indications of inadequate compliance or non-compliance, the Office of M/WBE Contract Compliance will notify the contractor and the subcontractor, in writing.

The Office of M/WBE Contract Compliance, the contractor or subcontractor may request an opportunity to meet to discuss MBE/WBE contract compliance. The contractor or subcontractor shall make such request to the Office of M/WBE Contract Compliance in writing within five (5) working days of receiving notice. The meeting shall be scheduled by the Office of M/WBE Contract Compliance at a reasonable date, time and place, with notice to contractor and subcontractor.

10.3 **Determination of non-compliance**

If after notification and subsequent discussions, the Office of M/WBE Contract Compliance determines that a contractor is not meeting or has not met applicable MBE or WBE goals and is not demonstrating or has not demonstrated every good faith to meet the goals, the contractor shall be subject to suitable sanctions as set forth in paragraph 10.3 A (Sanctions) below.

10.4 **MBE and WBE Remedies For Prime Vendor Non-Compliance**

The unexcused reduction of certified MBE or WBE participation in connection with the Contract including any modification thereof, shall entitle the affected certified MBE and WBE firms to payments pursuant to such agreement. Such provisions shall include an undertaking by the Contractor to submit any dispute concerning such damages to binding arbitration by an independent arbitrator, other than the City Colleges of Chicago, with reasonable expenses, including attorneys' fees, being

recoverable by a prevailing certified MBE or WBE. Nothing herein shall be construed to limit the rights of and remedies available to the City Colleges of Chicago.

10.5 **Sanctions for Non-compliance**

A. **Terms and Conditions of Plan Applying To All Contracts**
The MBE/WBE requirements of these Terms and Conditions shall be incorporated into all of the contracts between City Colleges and its vendors. In addition to any other remedies City Colleges may have, the following apply:

Where the Office of M/WBE Contract Compliance determines the conditions set forth in Section 10.3 above to exist during the term of the contract, the Office of M/WBE Contract Compliance may recommend that the Board suspend or terminate the contract, in whole or in part, and may also declare the contractor ineligible for future contracts for a period of two (2) years.

The Contractor shall be liable to the City Colleges for any consequential damages incurred as a result of suspension or termination of the contract including damages arising either from delay or increased price in securing performance of the work by other contractors, attorney's fees and court cost.

Where the Office of M/WBE Contract Compliance determines the conditions set forth in paragraph 10.3 above to exist at the conclusion of a contract, the Office of M/WBE Contract Compliance may declare the contractor ineligible for future contracts for a period of two (2) years.

If a Contractor has provided false or misleading information in connection with certification, bid or proposal documents, compliance progress reports, or any other aspect of this Plan, the Office of M/WBE Contract Compliance may impose any of the sanction described in paragraph 10.5 (Sanctions) and all its subsections.

If there is a bona fide payment dispute between a Contractor and its certified M/WBE subcontractor for work performed under the Plan, the City Colleges may withhold payment of the disputed amount from the Contractor and place such funds in an interest bearing account pending resolution of the dispute, by judicial or other means.

B. **Contractor's Right To Appeal Decision**
A contractor shall have the right to appeal a decision from the Office of M/WBE Contract Compliance declaring it ineligible for future City College contracts. Such appeal shall be made to the Chancellor or his/her designee.

C. **Sanctions Available To The City Colleges of Chicago**
The failure of City Colleges to impose any sanction it may have under this Section shall not be deemed a waiver of its right to impose such a sanction for subsequent violations. The listing of sanctions available to City Colleges in paragraph 10.5 A shall not be deemed to exclude any other sanctions or remedies available at law or in equity.

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE A

MBE / WBE Goal Implementation Plan

NOTE: The bidder/proposer shall, in determining the manner of MBE/WBE participation, must first consider involvement with MBE/WBE firms as joint venture partners, direct subcontractors, and suppliers of goods and services directly related to the performance of this contract. A service not directly related to the scope of services, but utilized during the bidder/proposer's normal course of business is considered indirect.

Additionally, all MBE/WBE firms included in this plan must be currently certified as such by at least one of the following agencies acknowledged by the City Colleges of Chicago (City of Chicago, Cook County, State of IL, Chicago Minority Supplier Development Council and regional affiliates and/or the Women's Business Development Center and its regional affiliates).

Project Name& Number_____

In connection with the above referenced project I HEREBY DECLARE AND AFFIRM that I am a duly authorized representative of:

_____
(Company Name)

_____
(Printed Name and Signature of bidder/proposer's authorized representative)

located at: _____
(Address, City & Zip)

and I can reached at _____ or via email at _____
(phone number)

The certified MBE and WBE participants on this project include (attach additional sheets as necessary):

Name of MBE/WBE Vendor:	Street Address:	City, State & Zip:
Contact Name:	Contact Title:	Contact Phone:
Contact Email:	MBE ☐ WBE ☐ Supplier ☐ (100% credit)	Certification Agencies:
Contract $:	Contract %:	Indirect Participation ☐ Direct Participation ☐
Description of Services:		

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE A

MBE / WBE Goal Implementation Plan

Name of MBE/WBE Vendor:	Street Address:	City, State & Zip:
Contact Name:	Contact Title:	Contact Phone:
Contact Email:	MBE ☐ WBE ☐ Supplier ☐	Certification Agencies:
Contract $:	Contract %:	Indirect Participation ☐ Direct Participation ☐
Description of Services:		

Name of MBE/WBE Vendor:	Street Address:	City, State & Zip:
Contact Name:	Contact Title:	Contact Phone:
Contact Email:	MBE ☐ WBE ☐ Supplier ☐	Certification Agencies:
Contract $:	Contract %:	Indirect Participation ☐ Direct Participation ☐
Description of Services:		

Name of MBE/WBE Vendor:	Street Address:	City, State & Zip:
Contact Name:	Contact Title:	Contact Phone:
Contact Email:	MBE ☐ WBE ☐ Supplier ☐	Certification Agencies:
Contract $:	Contract %:	Indirect Participation ☐ Direct Participation ☐
Description of Services:		

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE A

MBE / WBE Goal Implementation Plan

Total MBE Direct	$	%	Total MBE Indirect	$	%
Total WBE Direct	$	%	Total WBE Indirect	$	%

Bidder/Proposer's M/WBE Liaison (if other than the submitter of the Schedule):

_____

(Please print—Name, phone & email address)

Affidavit of Bidder/Proposer:

I affirm that I have personally reviewed the material and facts set forth herein describing the Bidder/Proposer's plan to achieve the City Colleges of Chicago's MBE/WBE goals and that to the best of my knowledge the information contained herein is true and no material facts have been omitted. Additionally I understand that material misrepresentation will be grounds for contract termination if the Bidder/Proposer is so selected and will be subject to all laws relative to false statements.

On this _____ day of _____,20____, the

_____

(Title of Affiant) (Name of Company)

appeared before me to acknowledge the execution of the terms contained herein.

IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEAL.

_____

(Signature of Notary Public)

My Commission Expires: _____ (Seal)

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE C
Letter of Intent to Perform as Subcontractor, Subconsultant and/or Material Supplier

Project Name and Number: _____

From: _____ ❒MBE ❒WBE
(Name of Certified Firm/ MBE or WBE)

To: _____
(Name of Bidder/Proposer)

The undersigned intends to perform work in connection with the above-referenced project as (check all that apply):

❒ a Sole Proprietor ❒ a Corporation

❒ a Partnership ❒ a Joint Venture → STOP → ***If proposing a Joint Venture with an MBE or WBE, submit Schedule C-2***

❒ a supplier ❒ a Consultant ❒ a Sub-contractor

The undersigned is prepared to provide the following described service(s) and or goods in connection with the above-named project:

_____

_____

_____

The above described service(s) or goods from the above-named certified MBE or WBE are offered for the following price, with terms of payment as stipulated in the Contract Documents, provided below:

Price $_____ % of Bidder/Proposer contract_____

Terms of Payment: _____

If more space is needed to add additional scopes of services or more fully describe the certified MBE or WBE firm's proposed scope of work and/or payment schedule, please attach additional sheet(s).

Sub-Contracting Levels

If the MBE or WBE firm ***will not*** be sub-contracting any of the work described in this Schedule, a zero (0) **must** be filled in each blank below in order for the form to be considered complete.

_____% of the dollar value of the certified MBE/WBE subcontract will be sublet to non-MBE contractors.

_____% of the dollar value of the certified MBE/WBE subcontract to other certified MBE/WBE contractors.

NOTE: If more than 10% percent of the value of the certified MBE or WBE subcontractor's scope of work will be sublet, a brief explanation and description of the work to be sublet **must** be provided on a separate sheet on the firm's letterhead.

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE C
Letter of Intent to Perform as Subcontractor, Subconsultant and/or Material Supplier

The undersigned hereby affirms:

- The **current** MBE or WBE status of the undersigned is confirmed by the attached Letter(s) of Certification.
- A formal agreement for the above work will be executed with the Prime Contractor, contingent upon their receipt of a contract award notification from the City Colleges of Chicago, within five (5) working days of said notice.
- The undersigned understands that any misrepresentation of the information contained herein may be grounds for terminating any resulting subcontracts and could result in the pursuit of action relative to local, state and/or federal laws regarding false statements.

By: _____
Print Name of MBE or WBE Firm

_____
Printed Name & Signature of MBE or WBE's Authorized Representative Date

On this _____ day of _____,20____, the

_____
(Title of Affiant) (Name of Company)

appeared before me to acknowledge the execution of the terms contained herein.

IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEAL.

_____
(Signature of Notary Public)

My Commission Expires: _____ (Seal)

CITY COLLEGES of CHICAGO
Education that Works

SCHEDULE C-1
Letter of Intent to Perform as an MBE or WBE
Prime Contractor, Consultant and/or Material

If an MBE or WBE will perform as a Prime Contractor, the firm must certify the portion of work they intend to self-peform with their own resources and accurately indicate subcontracting levels. This form must be completed in its entirety.

Project Name and Number: _____

MBE or WBE Bidder or Proposer: _____ ☐MBE ☐WBE
(Name of Certified Firm/ MBE or WBE)

The undersigned intends to perform work in connection with the above-referenced project as (check one):

☐ a Sole Proprietor ☐ a Corporation

☐ a Partnership ☐ a Joint Venture → STOP → ***If proposing a Joint Venture as an MBE or WBE in addition to the Schedule A, a corresponding Schedule C-2 must be submitted.***

☐ a supplier ☐ a Consultant ☐ a Sub-contractor

Self-Performance Levels

_____% of the dollar value the MBE or WBE firm named above will self-perform.

Sub-Contracting Levels

_____% of the dollar value of the certified MBE/WBE subcontract will be sublet to ***non-MBE contractors***.

_____% of the dollar value of the certified MBE/WBE subcontract to other certified MBE/WBE contractors.

The undersigned hereby affirms:

- The **current** MBE or WBE status of the above named firm is confirmed by the attached Letter(s) of certification.
- The undersigned understands that any misrepresentation of the information contained herein may be grounds for terminating any resulting subcontracts and could result in the pursuit of action relative to local, state and/or federal laws regarding false statements.

By: _____
Print Name of MBE or WBE Firm

_____
Printed Name & Signature of MBE or WBE's Authorized Representative Date

On this _____ day of _____, 20_____, the

_____
(Title of Affiant) (Name of Company)

appeared before me to acknowledge the execution of the terms contained herein.

IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEAL.

_____
(Signature of Notary Public)

My Commission Expires: _____ (Seal)

CITY COLLEGES of CHICAGO
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SCHEDULE C-2
Letter of Intent to Perform as an MBE or WBE Joint Venture Partner

Please complete this form in its entirety with the specific information requested (consistent referral to the joint venture agreement will be unacceptable). A copy of the Joint Venture agreement and the letters of certification for each MBE or WBE Joint Venture partner must be attached.

Project Name and Number: _____

A. Joint Venture Name: _____

Address: _____

Phone: _____

Contact: _____

B. MBE or WBE Joint Venture Partner: _____

MBE ☐ **WBE** ☐ **Certifying Agency(s)** _____

Address: _____

Phone: _____

Contact: _____

C. Non-MBE/WBE Joint Venture Partner: _____

Address: _____

Phone: _____

Contact: _____

D. Ownership of Joint Venture

	MBE/WBE Partner %	Non-MBE/WBE %
MBE WBE ownership of the joint-venture		
Profit		
Loss		
Capital contribution		
Capital contribution	$	$
Equipment contribution	Attach a list of equipment being provided by each Joint Venture partner on a separate sheet of paper.	
Other ownership interests	Attach a list of ownership interests of each JV partner that may restrict or limit the participation in the JV being formed for this project.	

E. Control of Joint Venture

Indicate which Joint Venture partner is responsible for the activities noted below and notate if there are any limitations or restrictions.

Activity	Name of responsible Joint Venture Partner	Comments (restrictions or limitations)
JV check signing		
Authority to enter contracts on behalf of the JV		
Obligate the JV for insurance, bonding and/or other financial commitments		
Accounting		
Major purchases		
Negotiation and signing labor agreements		
Supervise field operations		
Estimating		
Engineering		
Hire JV personnel		
Submit JV payrolls		

F. Joint Venture personnel

Indicate the approximate number of employees needed to perform the work of the joint venture and the approximate number of employees that will be contributed by each partner and if any will be hired directly by the JV:

Trade	Non-M/WBE JV Partner (#)	MBE/WBE JV Partner (#)	Joint Venture (indicate if new hire or if employed by which partner)

CITY COLLEGES of CHICAGO
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SCHEDULE C-2

Letter of Intent to Perform as an MBE or WBE Joint Venture Partner

The undersigned hereby affirms:

- The **current** MBE or WBE status of the undersigned is confirmed by the attached Letter(s) of Certification.
- A formal agreement for the above work will be executed with the Prime Contractor, contingent upon their receipt of a contract award notification from the City Colleges of Chicago, within five (5) working days of said notice.
- The undersigned understands that any misrepresentation of the information contained herein may be grounds for terminating any resulting subcontracts and could result in the pursuit of action relative to local, state and/or federal laws regarding false statements.

By: _____
Print Name of MBE or WBE Joint-Venture Partner

_____
Printed Name & Signature of MBE or WBE's Authorized Representative Date

By: _____
Print Name of non-MBE/WBE Joint Venture Partner

_____
Printed Name & Signature of non-MBE/WBE Joint Venture Partner's Authorized Representative Date

On this _____ day of _____,20____, the

_____
(Title of Affiant) (Name of Company)

appeared before me to acknowledge the execution of the terms contained herein.

IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEAL.

_____
(Signature of Notary Public)

My Commission Expires: _____ (Seal)

CITY COLLEGES of CHICAGO
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SCHEDULE D—WAIVER REQUEST

NOTE: *Please refer to the attached instructions regarding the Good Faith Efforts required to support a waiver request.*

To: City Colleges of Chicago Office of M/WBE Contract Compliance

Re: **Request for waiver from the City Colleges of Chicago MBE/WBE Contract Participation Plan**

The undersigned respectfully requests a waiver of the City Colleges of Chicago's M/WBE Contract Participation Plan as detailed below. The request is made with the express understanding that the approval is not automatic and the circumstances and supporting documentation will be reviewed accordingly.

Project Name & Number: _____

Type of waiver: Full MBE (25%) ☐ Partial MBE (percentage to be waived) ☐ ____ %

Full WBE (7 %) ☐ Partial WBE (percentage to be waived) ☐ ____ %

Reason for waiver:

- ☐ Sole Source Manufacturer
- ☐ Distributor – No Subcontractors
- ☐ Limited subcontracting opportunities
- ☐ Other _____

Submitted by: _____
Name and Title of authorized representative

_____
Name of Bidder/Proposer Company

For CCC use only:

Granted: Full MBE ☐ Partial MBE ☐ ____ % Full WBE ☐ Partial WBE ☐ ____ %

Denied: ☐ Insufficient supporting documentation ☐ Sufficient pool of direct M/WBE vendors

User Department concurrence (for scope issues): _____

CCO initials/date:_____ Compliance Director/date_____

CITY COLLEGES of CHICAGO
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SCHEDULE D—WAIVER REQUEST

Instructions regarding Good Faith Efforts for supporting a waiver request:

In addition to completing the Schedule D document, the Bidder/Proposer must provide a detailed narrative citing the reason they are seeking a waiver of the MBE/WBE Plan. The narrative must include reference to and attachments (where appropriate) of the following:

a) Attendance at the Pre-bid/proposal conference.

b) The Bidder/Proposer's supplier diversity policies regarding the utilization of MBE and WBE firms, plus a description of the procedures used to carry out those policies.

c) Advertisement in trade association newsletters and minority-oriented and general circulation media for specific sub-bids/proposals.

d) Timely notification of available sub-bids/proposals to minority and women assistance agencies and associations.

e) Description of direct negotiations with certified MBE and WBE firms for specific sub-bids/proposals, including:

- Names, addresses and telephone numbers of certified MBE and WBE firms contacted;
- A description of the information provided to certified MBE and WBE firms regarding the portions of the work to be performed; and
- The reasons why additional certified MBE and WBE firms were not obtained in spite of negotiations.

f) A description of the efforts made to select portions of the work proposed to be performed by certified MBE and WBE firms (such as sub-supplier, transport, engineering, distribution, or any other roles contributing to production and delivery as specified in the Contract) in order to increase the likelihood of achieving such participation.

g) A detailed statement of the reasons for the Bidder/Proposer's conclusion that each certified MBE and WBE contacted, were not qualified.

h) Efforts made by the Bidder/Proposer to expand its search for certified MBE and/or WBE firms beyond usual geographic boundaries.

i) General efforts made to assist MBE and WBE firms to overcome barriers in the marketplace.

ETHICS ORIENTATION
CONTRACTORS/VENDORS

12/08

CITY COLLEGES OF CHICAGO ETHICS ORIENTATION
CONTRACTORS/VENDORS

INTRODUCTION/GENERAL PRINCIPLES

As a City Colleges of Chicago (CCC) vendor/contract worker you are subject to the City Colleges of Chicago Ethics Policy. The purpose of this policy is to promote public confidence in the integrity of CCC by establishing consistent standards for the conduct of CCC business by Board members and employees.

The CCC Ethics Policy applies to full-time, part-time, temporary and seasonal employees, as well as to appointees to the Board of Trustees and contract workers.

As a CCC vendor/contract worker, you are expected to work on behalf of CCC in a manner that always complies with laws, rules, regulations and policies. By doing so and by always acting with honesty and integrity you are allowing established values to guide your actions and decisions. That is what it means to follow the principles of ethics.

The information that follows is intended to make you aware of selected elements of the CCC Ethics Policy and other laws and rules that relate to ethical conduct. If you have questions you may contact the CCC Procurement Office.

ETHICS OFFICER

The City Colleges Ethics Officer is designated by the Chancellor to provide guidance to the officials and employees of the District concerning the interpretation and compliance with the provisions of the City Colleges of Chicago Ethics Policy. The Ethics Officer shall also perform such other duties as may be delegated by the City Colleges of Chicago Board.

ANNUAL ETHICS TRAINING

All CCC employees are required to complete at least annually an ethics training program conducted by the City Colleges of Chicago. This requirement applies to any person employed full-time, part-time, or pursuant to a contract, as well as to any appointee – i.e. Board members. The ethics training reflects aspects of the City Colleges of Chicago Ethics Policy. The City Colleges Ethics Training Administrator will notify you and provide instructions to you concerning when and how to participate in the annual ethics training.

EXCERPTS FROM CCC ETHICS POLICY

GIFT BAN

In many instances, it is unlawful for a CCC employee to accept gifts that are offered in connection with his or her job. An employee cannot solicit or accept a gift from certain individuals or entities that are defined by law as a "prohibited source." Current vendors, as well as vendors interested in doing work for CCC are considered prohibited sources.

As a contractor or vendor doing business with the City Colleges of Chicago you are required to comply with the Gift Ban prohibition of the CCC Ethics Policy. Under the Gift Ban Section of the Policy (Section 1aa) current vendors, as well as vendors interested in doing work for CCC are considered prohibited sources and thereby precluded from providing gifts to CCC employees except as provided in the CCC Policy at Section 4-2(a-l). If you are in doubt about a gift, contact your Ethics Officer and read the City Colleges of Chicago Ethics Policy on Gift Ban. The City Colleges of Chicago Ethics Policy can be found at **www.ccc.edu/departments/pages/ethics.aspx**.

FIDUCIARY RESPONSIBILITY

All vendor/contract workers, Board members and student officers of the District owe fiduciary responsibility to the Board, District and residents of the District. Fiduciary responsibility is defined as a relationship imposed by law where someone has voluntarily agreed to act in the capacity of a "caretaker" of another's rights, assets and/or well being. The fiduciary owes an obligation to carry out the responsibilities with the utmost degree of "good faith, honesty, integrity, loyalty and undivided service of the beneficiaries' interest."

USE OF DISTRICT PROPERTY

CCC full-time, part-time, temporary and seasonal employees, as well as appointees to the Board of Trustees and contract workers shall not engage in or permit unauthorized use of District property.

POLITICAL ACTIVITY

No person who has done business with the City Colleges of Chicago within the preceding four years or is seeking to do business with the City Colleges of Chicago shall make contributions in an aggregate amount exceeding $1500.00: (i) to any candidate for city office during a single candidacy; or (ii) to an elected official of the government of the city during any reporting year of his term; or (iii) any official or employee of the City Colleges of Chicago who is seeking election to any other office.

PENALITIES

Any contractor doing business with City Colleges of Chicago found to have violated the City Colleges of Chicago Ethics Policy, may be barred from doing business with City Colleges of Chicago, along with any other penalty provided for in this Policy.

CITY COLLEGES OF CHICAGO ETHICS POLICY

All vendor/contractors workers are required to read and will be held accountable to the City Colleges of Chicago Ethics Policy. The City Colleges of Chicago Ethics Policy can be found at **www.ccc.edu/departments/pages/ethics.aspx**.

All vendor/contract workers are required to sign the attached acknowledgment and return it to the Procurement Office. The executed acknowledgment will be on file in the Procurement Office.

VENDOR/CONTRACTOR ACKNOWLEDGEMENT

I affirm that I have received the above Ethics Orientation Training for Contractors/Vendors. I further affirm that I will read the full text of the City Colleges of Chicago Ethics Policy and be available for yearly ethics training.

FIRM NAME	SUBMITTED BY
	TITLE

Contact Information for the City Colleges of Chicago Ethics Office

Telephone: 312/553-2925
Email: ethicsoffice@ccc.edu
Web Page: www.ccc.edu/departments/pages/ethics.aspx.

IRS W-9 Form

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Economic Disclosure Statment

INSTRUCTIONS FOR COMPLETING
CITY COLLEGES OF CHICAGO
ECONOMIC DISCLOSURE STATEMENT
AND AFFIDAVIT

Community College District No. 508 ("CCC") requires disclosure of the information requested in this Economic Disclosure Statement and Affidavit ("EDS") before any CCC department or CCC Board action regarding the matter that is the subject of this EDS. Please fully complete each statement, with all information current as of the date this EDS is signed. If a question is not applicable, answer with "N.A." An incomplete EDS will be returned and any CCC action will be delayed.

Please print or type all responses clearly and legibly. Add additional pages if needed, being careful to identify the portion of the EDS to which each additional page refers.

For purposes of the EDS:

"Applicant" means any entity or person making an application to CCC for action requiring CCC or CCC Board approval including bids, solicitations and other contract and lease proposals.

"Disclosing Party" means any entity or person submitting an EDS. If the Disclosing Party is participating in a matter in more than one capacity, please indicate each such capacity in Section I.F. of the EDS.

"Entity" or **"Legal Entity"** means a legal entity (for example, a corporation, partnership, joint venture, limited liability company or trust).

"Person" means a human being.

WHO MUST SUBMIT AN EDS:

An EDS must be submitted by Persons or Entities that are:

1. Applicants: An Applicant must always file this EDS. If the Applicant is a Legal Entity, state the full name of that Legal Entity. If the Applicant is a Person acting on his/her own behalf, state his/her name.

2. Entities holding an interest in the Applicant: Whenever a Legal Entity has a beneficial interest (i.e. direct or indirect ownership) of more than 7.5% in the Applicant, each such Legal Entity must file a separate EDS on its own behalf; and

3. Controlling entities: Whenever a Legal Entity directly or indirectly controls the Applicant, each such controlling Legal Entity must file a separate EDS on its own behalf.

CITY COLLEGES OF CHICAGO
Community College District No. 508 ("CCC")
ECONOMIC DISCLOSURE
STATEMENT AND AFFIDAVIT

SECTION I -- GENERAL INFORMATION

A. **Legal name of Disclosing Party submitting this EDS. Include d/b/a/ if applicable:**

_____

Check ONE of the following three boxes:

Indicate whether Disclosing Party submitting this EDS is:

1. ☐ the Applicant

OR

2. ☐ a legal entity holding a direct or indirect interest in the Applicant. State the legal name of the Applicant in which Disclosing Party holds an interest:

_____

OR

3. ☐ a specified legal entity with a right of control (see Section II.B.1.b.). State the legal name of the entity in which Disclosing Party holds a right of control:

_____

B. **Business address of Disclosing Party:**

_____
_____
_____

C. **Telephone:** _____ **Fax:** _____ **Email:** _____

D. **Name of contact person:** _____

E. **Federal Employer Identification No. (if you have one):** _____

F. **Brief description of contract, transaction or other undertaking** (referred to below as the "**Matter**") to which this EDS pertains. (Include project number and location of property, if applicable):

_____
_____
_____

SECTION II -- DISCLOSURE OF OWNERSHIP INTERESTS

A. NATURE OF DISCLOSING PARTY

1. Indicate the nature of the Disclosing Party:

- ○ Individual
- ○ Publicly registered business corporation
- ○ Privately held business corporation
- ○ Sole proprietorship
- ○ General partnership*
- ○ Limited partnership*
- ○ Trust
- ○ Limited liability company*
- ○ Limited liability partnership*
- ○ Joint venture*
- ○ Not-for-profit corporation
  (Is the not-for-profit corporation also a 501(c)(3))?
  ☐ Yes ☐ No
- ○ Other (please specify)

* Note and complete B.1.b below.

2. For legal entities, the state (or foreign country) of incorporation or organization, if applicable:

_____

3. For legal entities not organized in the State of Illinois: Has the organization registered to do business in the State of Illinois as a foreign entity? ☐ Yes ☐ No ☐ N/A

B. IF THE DISCLOSING PARTY IS A LEGAL ENTITY:

1.a. List below the full names and titles of all executive officers and all directors of the entity. For not-for-profit corporations, also list below all members, if any, that are legal entities. If there are no such members, write "no members." For trusts, estates or other similar entities, list below the legal titleholder(s).

Name	Title

1.b. If you checked "General partnership," "Limited partnership," "Limited liability company," "Limited liability partnership" or "Joint venture" in response to Item A.1. above (Nature of Disclosing Party), list below the name and title of each general partner, managing member, manager or any other person or entity that controls the day-to-day management of the Disclosing Party. **NOTE:** Each legal entity listed below must submit an EDS on its own behalf.

Name	Title

2. Please provide the following information concerning each person or entity having a direct or indirect beneficial interest (including ownership) in excess of 7.5% of the Disclosing Party. Examples of such an interest include shares in a corporation, partnership interest in a partnership or joint venture, interest of a member or manager in a limited liability company, or interest of a beneficiary of a trust, estate or other similar entity whether held in its or their own name or through intermediaries or nominees. **If none, state "None."**

   NOTE: CCC may require any such additional information from any applicant which is reasonably intended to achieve full or additional disclosure of ownership.

Name	Business Address	Percentage Interest in the Disclosing Party

(Add sheets if necessary)

SECTION III -- COMPLIANCE WITH CCC ETHICS POLICY

The CCC Ethics Policy imposes certain duties and obligations on persons or entities seeking CCC contracts, work, business, or transactions. The full text of CCCs Ethics Policy and a training program is available on line at http://www.ccc.edu/files/Ethics_Policy.pdf and may also be obtained from CCC Ethics Office at 180 N Wabash Ave, 3rd Floor, Chicago, Illinois, 60601.

By signing this EDS, the Disclosing Party certifies that it and its officers, agents and employees have not by action or omission, breached the CCC Ethics Policy or induced, caused to result in or caused a breach of CCC Ethics Policy by a CCC officer, contractor, agent or employee and will not do so.

SECTION IV -- DISCLOSURE OF SUBCONTRACTORS AND OTHER RETAINED PARTIES

On the next page, the Disclosing Party must disclose the name and business address of each subcontractor, attorney, lobbyist, accountant, or consultant whom the Disclosing Party has retained or expects to retain in connection with the Matter and any other person who will be paid a fee for communicating with CCC employees of officials when such communications are intended to influence the issuance of a contract or lease, as well as the nature of the relationship, and the total amount of the fees paid or estimated to be paid. The Disclosing Party is not required to disclose employees other than Lobbyists who are paid solely through the Disclosing Party's regular payroll. **"Lobbyist"** means any person or entity who undertakes to influence any legislative or administrative action on behalf of any person or entity other than: (1) a not-for-profit entity, on an unpaid basis, or (2) himself. "Lobbyist" also means any person or entity any part of whose duties as an employee of another includes undertaking to influence any legislative or administrative action.

If the Disclosing Party is uncertain whether a disclosure is required under this Section, the Disclosing Party must either ask the CCC whether disclosure is required or make the disclosure. (Add sheets if necessary)

Name (indicate whether retained or anticipated to be retained)	Business Address	Relationship to Disclosing Party (subcontractor, attorney, lobbyist, etc.)	Fees (indicate whether paid or estimated)

[ ] Check here if the Disclosing party has not retained, nor expects to retain, any such persons or entities.

SECTION V -- CERTIFICATIONS

A. COURT-ORDERED CHILD SUPPORT COMPLIANCE

Substantial owners of business entities that contract with CCC must remain in compliance with their child support obligations throughout the term of the contract.

Has any person who directly or indirectly owns 10% or more of the Disclosing Party been declared in arrearage on any child support obligations by any Illinois court of competent jurisdiction?

☐ Yes ☐ No ☐ No person owns 10% or more of the Disclosing Party.

If "Yes," has the person entered into a court-approved agreement for payment of all support owed and is the person in compliance with that agreement?

☐ Yes ☐ No

All of the Contractor's Substantial Owners who directly or indirectly owns 10% or more of the Contractor must remain in compliance with any such child support obligations (1) throughout the term of the contract and any extensions thereof; or (2) until the performance of the contract is completed, as applicable. Failure of Contractor's Substantial Owners to remain in compliance with their child support obligations in the manner set forth in either 1 or 2 constitutes an event of default.

B. CERTAIN OFFENSES INVOLVING CCC AND SISTER AGENCIES

1. Neither the Disclosing Party nor any Controlling Person (as defined below) of the Disclosing Party has ever been convicted or in custody, under parole or under any other non-custodial supervision resulting from a conviction in a court of any jurisdiction for the commission of a felony of any kind, or of a criminal offense of whatever degree, involving;

   (a) bribery or attempted bribery, or its equivalent under any local, state or federal law, of any public officer or employee of the CCC or of any Sister Agency (as defined below); or

   (b) theft, fraud, forgery, perjury, dishonesty or deceit, or attempted theft, fraud, forgery, perjury, dishonesty or deceit, or its equivalent under any local, state or federal law, against the CCC or any Sister Agency; or

   (c) conspiring to engage in any of the acts set forth in items (a) or (b) of this Section V.B.1

2. Neither the Disclosing Party nor any Controlling Person of the Disclosing Party has made in any civil or criminal proceeding an admission of guilt of any of the conduct set forth in items (a) through (c),inclusive, of Section V.B.1 above, under circumstances where such admission of guilt is a matter of record but has not resulted in criminal prosecution for such conduct.

3. Neither the Disclosing Party nor any Controlling Person of the Disclosing Party is charged with or

indicted for any felony or criminal offense set forth in items (a) through (c), inclusive, of Section V.B.1 above.

As used in this Section V.B, "**Controlling Person**" means any person who (1) is an officer, director, limited liability company manager, managing member, partner, general partner or limited partner of any business entity; or (2) owns, directly or indirectly through one or more intermediate ownership entities, more than 7.5% of the ownership interest in any business entity; or (3) controls, directly or indirectly through one or more intermediate ownership entities, the day-to-day management of any business entity. Indicia of control include, without limitation:

- interlocking management or ownership; identity of interests among family members;
- shared facilities and equipment;
- common use of employees; or
- organization of a business entity following the ineligibility of a business entity under this section, using substantially the same management, ownership or principals as the ineligible entity.

As used in this Section V.B., "**Sister Agency**" means (1) the Board of Education of the City of Chicago; (2) Chicago Park District; (3) Chicago Transit Authority; (4) the City of Chicago; (5) Chicago Housing Authority; or (6) the Public Building Commission of Chicago.

C. FURTHER CERTIFICATIONS

1. The Disclosing Party and, if the Disclosing Party is a legal entity, all of those persons or entities identified in Section II.B.1. of this EDS:

   a. are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from any transactions by any federal, state or local unit of government;

   b. have not, within a five-year period preceding the date of this EDS, been convicted of a criminal offense, adjudged guilty, or had a civil judgment rendered against them in connection with: obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; a violation of federal or state antitrust statutes; fraud; embezzlement; theft; forgery; bribery; falsification or destruction of records; making false statements; or receiving stolen property;

   c. are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in clause C.1.b. of this Section V;

   d. have not, within a five-year period preceding the date of this EDS, had one or more public transactions (federal, state or local) terminated for cause or default; and

   e. have not, within a five-year period preceding the date of this EDS, been convicted, adjudged guilty, or found liable in a civil proceeding, or in any criminal or civil action, including actions concerning environmental violations, instituted by the federal government, any state, or any other unit of local government.

2. The certifications in subparts 3, 4 and 5 of this Section V.C., concern:

   • the Disclosing Party;

   • any "**Applicable Party**" (meaning any party participating in the performance of the Matter, including but not limited to any persons or legal entities disclosed under Section IV, "Disclosure of Subcontractors and Other Retained Parties");

• any "**Affiliated Entity**" (meaning a person or entity that, directly or indirectly: controls the Disclosing Party, is controlled by the Disclosing Party, or is, with the Disclosing Party, under common control of another person or entity. Indicia of control include, without limitation:

- interlocking management or ownership; identity of interests among family members, shared facilities and equipment;
- common use of employees;
- or organization of a business entity following the ineligibility of a business entity to do business with federal or state or local government, including CCC, using substantially the same management, ownership, or principals as the ineligible entity);
- with respect to Applicable Parties, the term Affiliated Entity means a person or entity that directly or indirectly controls the Applicable Party, is controlled by it, or, with the Applicable Party, is under common control of another person or entity;

• any responsible official of the Disclosing Party, any Applicable Party or any Affiliated Entity or any other official, agent or employee of the Disclosing Party, any Applicable Party or any Affiliated Entity, acting pursuant to the direction or authorization of a responsible official of the Disclosing Party, any Applicable Party or any Affiliated Entity (collectively "**Agents**").

3. Neither the Disclosing Party, nor any Applicable Party, nor any Affiliated Entity of either the Disclosing Party or any Applicable Party nor any Agents have, during the five years before the date this EDS is signed, or, with respect to an Applicable Party, an Affiliated Entity, or an Affiliated Entity of an Applicable Party during the five years before the date of such Applicable Party's or Affiliated Entity's contract or engagement in connection with the Matter:

   a. bribed or attempted to bribe, or been convicted or adjudged guilty of bribery or attempting to bribe, a public officer or employee of the CCC, the State of Illinois, or any agency of the federal government or of any state or local government in the United States of America, in that officer's or employee's official capacity;

   b. agreed or colluded with other bidders or prospective bidders, or been a party to any such agreement, or been convicted or adjudged guilty of agreement or collusion among bidders or prospective bidders, in restraint of freedom of competition by agreement to bid a fixed price or otherwise; or

   c. made an admission of such conduct described in a. or b. above that is a matter of record, but have not been prosecuted for such conduct.

4. Neither the Disclosing Party, Affiliated Entity or Applicable Party, or any of their employees, officials, agents or partners, is barred from contracting with any unit of state or local government as a result of engaging in or being convicted of (1) bid-rigging in violation of 720 ILCS 5/33E-3; (2) bid-rotating in violation of 720 ILCS 5/33E-4; or (3) any similar offense of any state or of the United States of America that contains the same elements as the offense of bid-rigging or bid-rotating.

5. Neither the Disclosing Party, Affiliated Entity or Applicable Party is listed on any of the following lists maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the Bureau of Industry and Security of the U.S. Department of Commerce or their successors: the Specially Designated Nationals List, the Denied Persons List, the Unverified List, the Entity List and the Debarred List.

6. The Disclosing Party understands and shall comply with all the applicable rules and regulations of the Board of Trustees of CCC now in effect or hereafter adopted by the Board.

7. If the Disclosing Party is unable to certify to any of the above statements in Parts V.B. (Certain Offenses

Involving CCC and Sister Agencies) or V.C. (Further Certifications), the Disclosing Party must explain below:

_____

_____

If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Disclosing Party certified to the above statements.

D. CERTIFICATION OF STATUS AS FINANCIAL INSTITUTION

For purposes of this Part D, under the Municipal Code of Chicago ("**CMC**") Section 2-32-455(b), the term "**financial institution**" means a bank, savings and loan association, thrift, credit union, mortgage banker, mortgage broker, trust company, savings bank, investment bank, securities broker, municipal securities broker, securities dealer, municipal securities dealer, securities underwriter, municipal securities underwriter, investment trust, venture capital company, bank holding company, financial services holding company, or any licensee under the Consumer Installment Loan Act, the Sales Finance Agency Act, or the Residential Mortgage Licensing Act. However, "financial institution" specifically shall not include any entity whose predominant business is the providing of tax deferred, defined contribution, pension plans to public employees in accordance with Sections 403(b) and 457 of the Internal Revenue Code. (Additional definitions may be found in CMC Section 2-32-455(b).)

1. CERTIFICATION

   The Disclosing Party certifies that the Disclosing Party (check one)

   ☐ is ☐ is not

   a "financial institution" as defined in Section 2-32-455(b) of the CMC.

2. If the Disclosing Party IS a financial institution, then the Disclosing Party pledges:

   "We are not and will not become a predatory lender as defined in Chapter 2-32 of the CMC. We further pledge that none of our affiliates is, and none of them will become, a predatory lender as defined in Chapter 2-32 of the CMC. We understand that becoming a predatory lender or becoming an affiliate of a predatory lender may result in the loss of the privilege of doing business with the CCC.

   If the Disclosing Party is unable to make this pledge because it or any of its affiliates (as defined in Section 2-32-455(b) of the CMC) is a predatory lender within the meaning of Chapter 2-32 of the CMC, explain here (attach additional pages if necessary):

   _____

   If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Disclosing Party certified to the above statements.

E. CERTIFICATION REGARDING INTEREST IN CCC BUSINESS

Any words or terms that are defined in CCC Ethics Policy have the same meanings when used in this Part E.

1. In accordance with CCC Ethics Policy: To the best of your knowledge after diligent inquiry does any Board Member, official or employee of CCC have a "**special interest**" in his or her own name or in the name of any other person or entity in the Matter?

   ☐ Yes ☐ No

   NOTE: If you checked "Yes" to Item E.1., proceed to Items E.2. and E.3. If you checked "No" to Item

E.1., proceed to E.4.

2. Unless sold pursuant to a process of competitive bidding following public notice, no employee or Board member shall have a financial interest in the purchase of any property that belongs to the Board. Before participating in the competitive process, the employee or Board member shall disclose his financial interest.

   Does the Matter involve a CCC Property Sale? ☐ Yes ☐ No

3. If you checked "Yes" to Item E.1., provide the names and business addresses of the CCC officials or employees having such interest and identify the nature of such interest:

   Name Business Address Nature of Interest

   _____

   _____

   _____

4. No employee or spouse of any employee, or entity in which an employee or his or her spouse has a financial interest, has applied for, solicited, accepted or received a loan of any amount from the Disclosing Party, any Applicable Party or any Affiliated Entity; provided, however, that nothing in this section prohibits application for, solicitation for, acceptance of or receipt of a loan from a financial lending institution, if the loan is negotiated at arm's length and is made at a market rate in the ordinary course of the lender's business.

   ☐ Yes ☐ No

5. If you checked "Yes" to Item E.4., provide the names and addresses of the CCC officials or employees who applied for, solicited, accepted or received such loan:

   Name Business Address Amount of loan

   _____

   _____

6. The Disclosing Party further certifies that no prohibited financial or special interest in the Matter will be acquired by any CCC official or employee.

SECTION VI -- ACKNOWLEDGMENTS, CONTRACT INCORPORATION, COMPLIANCE, PENALTIES, DISCLOSURE

A. The Disclosing Party understands and agrees that:

1. By completing and filing this EDS, the Disclosing Party acknowledges, on behalf of itself and the persons or entities named in this EDS, that the CCC may investigate the creditworthiness of and the information provided about some or all of the persons or entities named in this EDS.

2. The certifications, disclosures, and acknowledgments contained in this EDS will become part of any contract or other agreement between the Applicant and the CCC in connection with the Matter, whether procurement or other CCC action, and are material inducements to the CCCs execution of any contract or taking other action with respect to the Matter. The Disclosing Party understands that it must comply with all statutes, ordinances, and regulations on which this EDS is based.

3. If CCC determines that any information provided in this EDS is false, incomplete or inaccurate, any contract or other agreement in connection with which it is submitted may be rescinded or be void or voidable, and CCC may pursue any remedies under the contract or agreement (if not rescinded, void

or voidable), at law, or in equity, including terminating the Disclosing Party's participation in the Matter and/or declining to allow the Disclosing Party to participate in other transactions with CCC..

4. CCC may make this document available to the public on its Internet site and/or upon request. Some or all of the information provided on this EDS and any attachments to this EDS may be made available to the public on the Internet, in response to a Freedom of Information Act request, or otherwise. By completing and signing this EDS, the Disclosing Party waives and releases any possible rights or claims which it may have against CCC in connection with the public release of information contained in this EDS and also authorizes CCC to verify the accuracy of any information submitted in this EDS.

5. The information provided in this EDS must be kept current. In the event of changes, the Disclosing Party must supplement this EDS up to the time the CCC takes action on the Matter. If the Matter is a contract or other agreement being entered into by the CCC's Board of Trustees, the Disclosing Party must also update this EDS as the contract or agreement requires.

B. The Disclosing Party represents and warrants that:

1. The Disclosing Party has not withheld or reserved any disclosures as to economic interests in the Disclosing Party, or as to the Matter, or any information required by this Disclosure Affidavit.

   For purposes of the certifications in VI.B.2. and B.3., the term "**affiliate**" means any person or entity that, directly or indirectly: controls the Disclosing Party, is controlled by the Disclosing Party, or is, with the Disclosing Party, under common control of another person or entity. Indicia of control include, without limitation: interlocking management or ownership; identity of interests among family members; shared facilities and equipment; common use of employees; or organization of a business entity following the ineligibility of a business entity to do business with the federal government or a state or local government, including CCC, using substantially the same management, ownership, or principals as the ineligible entity.

2. The Disclosing Party is not delinquent in the payment of any tax administered by the Illinois Department of Revenue, nor are the Disclosing Party or its affiliates delinquent in paying any fine, fee, tax or other charge owed to CCC or a Sister Agency (as defined in Section V,B). This includes, but is not limited to, all water charges, sewer charges, license fees, parking tickets, property taxes or sales taxes.

3. If the Disclosing Party is the Applicant, the Disclosing Party and its affiliates will not use, nor permit their subcontractors to use, any facility on the U.S. EPA's List of Violating Facilities in connection with the Matter for the duration of time that such facility remains on the list.

4. If the Disclosing Party is the Applicant, the Disclosing Party will obtain from any contractors/subcontractors hired or to be hired in connection with the Matter certifications equal in form and substance to those contained in this Disclosure Affidavit and will not, without the prior written consent of the CCC, use any such contractor/subcontractor that does not provide such certifications or that the Disclosing Party has reason to believe has not provided or cannot provide truthful certifications.

   NOTE: If the Disclosing Party cannot certify as to any of the items in VI.B.2., B.3. or B.4. above, an explanatory statement must be attached to this EDS.

CERTIFICATION

Under penalty of perjury, the person signing below: (1) warrants that he/she is authorized to execute this EDS on behalf of the Disclosing Party, and (2) warrants that all certifications and statements contained in this EDS are true, accurate and complete as of the date furnished to the CCC.

Date: _____

_____

(Print or type name of Disclosing Party)

By: _____

(sign here)

_____

(Print or type name of person signing)

_____

(Print or type title of person signing)

State of _____

County of _____

Signed and sworn to before me on (date) _____ , by__ _____.

_____ Notary Public.

Commission expires: _____

I. Confidentiality.

All materials, including, but not limited to, Work Product, documents, studies, reports, information, or data, prepared by or provided to Vendor under this Agreement ("Materials") are confidential. Vendor shall not make the Materials available to a third party without the Institution's prior written consent. Vendor shall not issue press releases or grant press interviews related to the Services, or disseminate any information regarding the Services without the Institution's prior written consent. If Vendor is presented with a ***subpoena duces tecum*** or a request for documents by any administrative agency regarding any records, data or documents related to the Services, Vendor shall immediately give notice to the Institution and agrees that the Institution may contest the subpoena or request before the Materials are submitted to a court or other third party, provided, however, that Vendor shall not be obligated to withhold such delivery beyond that time as may be ordered by the court or administrative agency unless the subpoena or request is quashed or the time to produce is otherwise extended.

II. Indemnity

Notwithstanding any other terms and conditions, including any obligations regarding insurance coverage, Vendor agrees to defend, indemnify, save and hold harmless fully the Institution, its Board of Trustees of Community College District No. 508, its colleges, satellite campus', officers, employees, agents, students, volunteers and contractors against any and all claims, suits or judgments, costs or expenses, including attorney's reasonable fees, (collectively ("Loss")) in connection with this Agreement. This indemnification obligation does not extend to that portion of a Loss caused by Institution's negligence, as determined by a court of competent jurisdiction in a final, non-appealable judicial order. The Vendor must acknowledge in their submission their willingness to indemnify City Colleges of Chicago.

The requirements listed below are mandatory for protecting the interests of the City Colleges of Chicago.

1. The successful Proposer shall indemnify and hold CCC harmless from all providers' performance or failure of performance under the resulting contract.
2. The successful Proposer shall keep CCC free and clear from all liens asserted by any person or firm for any reason arising out of the furnishing of services or materials by or to the provider.
3. The action of the successful Proposer with third parties is not binding upon CCC.

III. Termination

Termination for Convenience. This contract can be terminated upon ten (30) days written notice by City Colleges of Chicago on the grounds of Proposer's violation of any terms and conditions of the Contract, procedures or guidelines or inadequacy of Proposer's performance or if there is no further need for the requirements. In the event that no funds or insufficient funds are appropriated and budgeted in any fiscal period of the City Colleges of Chicago for payments to be made under this agreement, then the City Colleges of Chicago will notify the contractor of such occurrence and this agreement shall terminate

on the earliest of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for payment under this Agreement are exhausted. No payments will be made or due to the contractor under this contract beyond those amounts appropriated and budgeted by the City Colleges of Chicago to fund payment under this contract.

City Colleges of Chicago may terminate this Contract, or any portion of the Services to be performed under it, at any time for convenience by a notice in writing from CCC to the Proposer when the Contract may be deemed no longer in the best interest of CCC.

Termination for Default. Subject to Section 10(a) herein, this Agreement may also be terminated for default. Each of the following shall constitute an event of default by Consultant ("Default").

i. Any material misrepresentation, whether in the inducement or in the performance, made by the Consultant to the Institution; and

ii. A breach of a representation or warranty contained in this Agreement; and

iii. The insolvency, bankruptcy or committing of any act of bankruptcy or insolvency, or making an assignment for the benefit of creditors; and

iv. Failure to comply with or perform any material provision of this Agreement; and

v. Failure or refusal to provide enough properly skilled personnel, adequate supervision, or adequate materials and equipment of the proper quality to perform the Services; and

vi. Causing, by any action or omission, the stoppage, delay of, or interference with, the work of any other Consultant or subconsultant.

If a court of competent jurisdiction rules that termination of this Agreement by the Institution for default of Consultant was wrongful, then the termination shall be deemed to have been a termination for convenience.

a. **Curable and Incurable Defaults.** Time-sensitive defaults (e.g., failure to meet deadlines) are not curable unless the Institution, in its sole and absolute discretion, extends the deadline. Such extension, however, does not relieve Consultant of liability for any damages the Institution may suffer. Consultant shall cure any default that is not time-sensitive with ten (10) calendar days after Consultant is given notice of the default.

b. **Remedies.** In addition to any other remedies contained herein, the Institution may invoke any or all of the following remedies for a Default:

i. Complete the Services at Consultant's expense, either directly or through the use of contractors and subcontractors; or

ii. Receive a refund or withhold all or any portion of the Fee; or

iii. Demand specific performance, an injunction or any other appropriate equitable remedy; or

iv. Terminate this Agreement.

c. **Right to Offset.** All costs incurred by the Institution due to: (i) termination of this Agreement for default; or (ii) Consultant's performance of the Services; or (iii) Institution's exercise of any of the remedies available herein, may be offset by: (i) any credits due to or overpayments made by the Institution; or (ii) any payments due to Consultant for Services completed. If such amount offset is insufficient to cover those excess costs, Consultant shall be liable for and promptly remit to the Institution the balance upon written demand. This right to offset is in addition to and not a limitation on any other remedies available to the Institution.

No remedy hereunder is exclusive of any other remedy, but each remedy shall be cumulative and in addition to any other remedies at law, in equity or by statute existing now or hereafter. No delay or omission to exercise any right or power accruing upon any Default shall impair any such right or power nor shall it be construed to be a waiver of any Default or acquiescence therein, and every such right and power may be exercised periodically and as often as may be deemed expedient. If the Institution considers it to be in the Institutions best interest, it may choose not to declare a default or terminate the Agreement. The parties acknowledge that this provision is solely for the benefit of the Institution and that if the Institution permits Consultant to continue providing Services despite one or more events of default, the Consultant is in no way relieved of any of its duties and obligations under the Agreement and the Institution does not waive or relinquish any of its rights.

Additional Provisions. The parties further agree to the following provisions:

a. **Names/Logos.** Institution owns all rights to the name City Colleges of Chicago and its individual colleges and to certain logos, servicemarks, trademarks and likenesses ("Marks"). Vendor must not use the Marks as part of Vendor's business or trade name, and Vendor must not use the Marks or sell merchandise or services with the Marks without the Institution's express written consent. Also, Vendor must not permit anyone else to do so.

b. **Inspector General**. It shall be the duty of each party to the agreement to cooperate with the Inspector General for City Colleges of Chicago in any investigation conducted pursuant to the Inspector General's authority under Article 2, Section 2.7.4(b) of the Board Bylaws.

c. **Notices.** All notices hereunder shall be in writing and either (i) delivered personally; or (ii) sent by nationally recognized express courier; or (iii) sent by certified mail (return receipt requested). Any such notice will be deemed given when actually received and addressed as follows:

If to Institution:

City Colleges of Chicago
Office of the Chancellor
Attn: Juan Salgado
180 N. Wabash Ave, Suite 200
Chicago, IL 60601

with a copy to:

City Colleges of Chicago
Office of the General Counsel
Attn: General Counsel
180 N. Wabash Ave, Suite 200
Chicago, IL 60601

CITY COLLEGES OF CHICAGO
CONTRACT INSURANCE LANGAUAGE

9. **Insurance.** Throughout the Term, Consultant at its own expense, shall provide and maintain the following insurance coverage:

   a. **Workers' Compensation and Employer's Liability**
   Workers' Compensation as prescribed by applicable law, covering all employees who are providing the Services and Employer's Liability coverage with limits of not less than $1,000,000 each accident or illiness; and

   b. **Commercial General Liability**
   Commercial General Liability Insurance or equivalent with limits of not less than $5,000,000 per occurrence, for bodily injury, personal injury, and property damage liability. Coverage shall include the following: All premises and operations, products/completed operations, separation of insured, defense and contractual liability (with no limitation endorsement); and

   c. **Automobile Liability**
   When any motor vehicles (owned, non-owned and hired) are used in connection with work to be performed, the Consultant shall provide Comprehensive Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence, for bodily injury and property damage; and

   d. **Fidelity, EPLI and Professional Liability (E&O)**
   Professional liability insurance covering errors, omissions or negligent acts must be maintained with limits of not less than $5,000,000. Coverage must include contractual liability. When policies are renewed or replaced, the policy retroactive date must coincide with, or proceed, start of work on this Agreement, on a Claims-Made Policy, which is not renewed or replaced, must have an extended reporting period of two (2) years.

   e. **Cyber Liability**
   A Cyber and Privacy Policy shall be maintained with limits of not less than $5,000,000 to address liability for a data breach which may result in the compromise of personal data pertaining to District Trustees, Employees, Students, Administrators, Staff, Visitors and Guests. The Policy shall cover a variety of expenses associated with data breaches, including, but not limited to: notification costs, credit monitoring, costs to defend claims by state regulators, fines and penalties, and loss resulting from identity theft.

Prior to the execution of this Agreement, Licensee shall furnish the Institution with original insurance certificates evidencing the required coverage. The above referenced coverage limits are at levels consistent with Illinois statutory requirements and are within reasonable levels to insure the District's requirements, interests and operations. The Insurance Carriers underwriting said Policies shall reflect an AM Best Rating Guide of "A-", VIII or better. All insurance certificates shall name the Board of Trustees of Community College District No. 508, County of Cook and State of Illinois, and its officers, directors, agents, students, employees, contractors and volunteers as additional insured on a primary, non-contributory basis. Institution's failure to obtain certificates or others insurance evidence from Consultant shall not be deemed a waiver of this provision by the Institution. This Agreement, at Institution's sole discretion, may be terminated if Licensee fails to comply with this provision. All insurance policies required hereunder shall include a provision which requires the Institution to receive sixty (60) days prior written notice before coverage is substantially changed, cancelled or non-renewed. Any insurance or self-insurance programs maintained by Institution shall apply in excess of and not contribute with insurance provided by Licensee.

CHICAGO PARK DISTRICT

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ECONOMIC DISCLOSURE STATEMENT & AFFIDAVIT

APPLICANTS: Any entity or individual (the" Applicant') making an application to the Chicago Park District for action requiring approval of the Chicago Park District's Board of Commissioners ("Board of Commissioners").

ENTITIES HOLDING AN INTEREST IN THE APPLICANT: Generally, whenever an ownership interest in the Applicant (for example, shares of stock of the Applicant or a limited partnership interest in the Applicant) is held or owned by a legal entity (for example, a corporation or partnership, rather than an individual) each such legal entity must also file an EDS on its own behalf, and any parent of that legal entity must do so until individual owners are disclosed. However, if an entity filing an EDS is a corporation (or a direct or indirect, wholly-owned subsidiary of such corporation) whose shares are registered on a national securities exchange pursuant to the Securities Exchange Act of1934 as amended**,** only those shareholders that own ten percent (10%) or more of that filing entity's stock must file EDSs on their own behalf.

REQUIREMENT: The Chicago Park District (the "Park District") requires disclosure of the information requested in this Economic Disclosure Statement and Affidavit ("EDS") before any Park District action may be taken regarding the matter that is the subject of this EDS. Please fully complete each statement, with all information current as of the date this EDS is signed. If a question is not applicable, answer with "N.A." An incomplete EDS will be returned and any Park District action will be interrupted.

EXECUTION: Please print or type all responses clearly and legibly. Add additional pages if needed, being careful to identify the portion of the EDS to which each additional page refers.

ACKNOWLEDGMENT OF POSSIBLE CREDIT AND OTHER CHECKS: By completing and filing this EDS, the Undersigned acknowledges and agrees, on behalf of itself and the entities or individuals named in this EDS that the Park District may investigate the creditworthiness of some or all of the entities or individuals named in this EDS.

CERTIFYING THIS EDS: Execute the certification on the date of the initial submission of this EDS. You may be asked to re-certify this EDS on the last page as of the date of submission of any related ordinance to the Board of Commissioners, or as of the date of the closing of your transaction.

ECONOMIC DISCLOSURE STATEMENT UPDATE OBLIGATION. The applicant, if pre-qualified, is required to notify the Park District and update the EDS whenever there is a change in circumstances that makes any certification or information provided in the awardee's EDS inaccurate, obsolete, or misleading. If the applicant is pre-qualified, failure to notify the Park District and update the EDS is grounds for declaring the pre-qualified firm in default, termination of the contract for default, and declaring the awardee is ineligible for future contracts.

PUBLIC DISCLOSURE: It is the Park District's policy to make this document available to the public on its internet site and/or upon request.

SECTION 0: GENERAL INFORMATION

Date this EDS is completed: _____

1. Who is submitting this EDS? That entity or individual will be the "Undersigned" throughout this EDS.

_____

NAME OF ENTITY OR INDIVIDUAL

NOTE: The Undersigned is the entity or individual submitting this EDS, whether the Undersigned is an Applicant or is an entity holding an interest in the Applicant. This EDS requires certain disclosures and certifications from Applicants that are not required from entities holding an interest in the Applicant. When completing this EDS, please observe whether the section you are completing applies only to Applicants.

[ ] Check here if the Undersigned is filing this EDS as an Applicant
[ ] Check here if the Undersigned is filing as an entity holding an interest in an Applicant.

Identify the Applicant in which this entity holds an interest: _____

2. Business address of the Undersigned: _____

_____

_____

3. Telephone: _____ Fax: _____ E-mail: _____

4. Name of contact person: _____

5. Tax identification number (optional): _____

6. Brief description of contract, transaction or other undertaking (referred to below as the "Matter") to which this EDS pertains (Include specification number and location if applicable):

_____

_____

_____

SECTION I: DISCLOSURE OF OWNERSHIP INTERESTS

A. NATURE OF ENTITY

1. Indicate whether the Undersigned is an individual or legal entity:

[ ] Individual
[ ] Business corporation
[ ] Sole proprietorship
[ ] Limited Liability Company
[ ] Joint venture
[ ] General partnership
[ ] Limited partnership
[ ] Not-for-profit corporation
Is the not-for-profit corporation also a 501(c)(3)?
[ ] Yes [ ] No

[ ] Other entity (please specify) _____

2. State of incorporation or organization, if applicable: _____

3. For legal entities not organized in the State of Illinois: Is the organization authorized to do business in the State of Illinois as a foreign entity?

[ ] Yes [ ] No [ ] N/A

B. ORGANIZATION INFORMATION

1. IF THE UNDERSIGNED IS A CORPORATION:

a. Date of incorporation: _____

b. List below the names and titles of all executive officers and all directors of the corporation. For not-for-profit corporations, also list below any executive director of the corporation, and indicate all members, if any, who are legal entities. If there are no such members, write "no members."

NAME	TITLE

c. If the Undersigned is a corporation (or a direct or indirect wholly owned subsidiary of such corporation) whose shares are registered on a national securities exchange pursuant to the Securities Exchange Act of 1934, please provide the following information concerning shareholders who own shares equal to or in excess of 7.5% of the corporation's outstanding shares.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

d. For corporations that are NOT registered on a national securities exchange pursuant to the Securities Exchange Act of 1934, list below the name, business address and percentage of ownership interest of each shareholder.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

2. IF THE UNDERSIGNED IS A PARTNERSHIP OR JOINT VENTURE:

For general or limited partnerships or joint ventures: list below the name, business address and percentage of ownership interest of each partner. For limited partnerships, indicate whether each partner is a general partner or a limited partner.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

3. IF THE UNDERSIGNED IS A LIMITED LIABILITY COMPANY:

a. List below the name, business address, and percentage of ownership interest of each (1) member and (2) manager. If there are no managers, write "no managers," and indicate how the company is managed.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

b. List below the names and titles of all officers, if any. If there are no officers, write "no officers."

NAME	TITLE

4. IF THE UNDERSIGNED IS A LAND TRUST, BUSINESS TRUST, ESTATE OR OTHER SIMILAR ENTITY

a. List below the name and business address of each individual or legal entity holding legal title to the property that is the subject of the trust.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

b. List below the name, business address and percentage of beneficial interest of each beneficiary on whose behalf title is held.

NAME	BUSINESS ADDRESS	PERCENTAGE INTEREST

5. IF THE UNDERSIGNED IS ANY OTHER LEGAL ENTITY

First describe the entity, then provide the name, business address, and the percentage of interest of all individuals or legal entities having an ownership or other beneficial interest in the entity.

Describe the entity:

NAME BUSINESS ADDRESS PERCENTAGE INTEREST

SECTION II: BUSINESS RELATIONSHIPS WITH PARK DISTRICT AND CHICAGO PARKS FOUNDATION OFFICIALS

A. DEFINITIONS AND DISCLOSURE REQUIREMENT

1. The Undersigned must indicate whether it had a "business relationship" with a Park District Commissioner and/or Chicago Parks Foundation Board Member in the twelve (12) months before the date this EDS is signed.

2. For the purposes of this EDS, a "business relationship" means any contractual or other private business dealing of a Commissioner and/or Board Member, or his or her spouse, or of any entity in which the Commissioner and/or Board Member or his or her spouse has a financial interest with a person or entity which entitles the Commissioner and/or Board Member to compensation or payment in the amount of $2,500 or more during the prior twelve months; but a "financial interest" does not include: (a) any interest of the spouse or of an employee or Commissioner and/or Board Member which interest is related to the spouse's independent occupation, profession, or employment; (b) any ownership through purchase at fair market value or inheritance of less than 1 % of the shares of a corporation, or any corporate subsidiary, parent or affiliate thereof, regardless of the value of or dividends on such shares, if such shares are registered on a securities exchange pursuant to the Securities Exchange Act of 1934, as amended, (c) the authorized compensation paid to an Employee or a Commissioner or Board Member for his office or employment; (d) any economic interest not distinguishable from the economic interests of the public generally ; (e) a time or demand deposit in a financial institution; (f) a money market mutual fund account; or (g) an endowment or insurance policy or annuity contract purchased from an insurance company. A "contractual or other private business dealing" does not include any employment relationship of a Commissioner's or Board Member's spouse with an entity when such spouse has no discretion concerning or input relating to the relationship between that entity and the Park District and/or the Chicago Parks Foundation.

B. CERTIFICATION

1. Has the Undersigned had a "business relationship" with a Park District Commissioner or Chicago Parks Foundation Board Member in the twelve (12) months before the date this EDS is signed?

   [ ]Yes [ ]No

   If yes, please identify below the name(s) of the Park District Commissioner(s) or Chicago Parks Foundation Board Member(s) and describe the relationship(s):

SECTION III: DISCLOSURE OF RETAINED PARTIES

A. DEFINITIONS AND DISCLOSURE REQUIREMENTS

"Lobbyist" means any person (a) who, for compensation or on behalf of any person other than himself, undertakes to influence any legislative or administrative action, or (b) any part of whose duty as an employee of another includes undertaking to influence any legislative or administrative action.

1. The Undersigned must disclose certain information about attorneys, lobbyists, accountants, consultants, subcontractors, and any other person whom the Undersigned has retained or expects to retain in connection with the Matter. In particular, the Undersigned must disclose the name of each such person, his/her business address, the nature of the relationship, and the total amount of the fees paid or estimated to be paid. The Undersigned is not required to disclose employees who are paid solely through the Undersigned's regular payroll.

2. If the Undersigned is uncertain whether a disclosure is required under this Section, the Undersigned must either (a) ask the Park District's Director of Purchasing whether disclosure is required, or (b) make the disclosure.

B. CERTIFICATION

Each and every attorney, lobbyist, accountant, consultant, subcontractor, or other person retained or anticipated to be retained directly by the Undersigned with respect to or in connection with the Matter is listed below (begin list here, add sheets as necessary):

NAME (indicate whether retained or anticipated to be retained)	BUSINESS ADDRESS	RELATIONSHIP TO UNDERSIGNED (attorney, lobbyist, etc.)	FEES (indicate whether paid or estimated)

[ ] Check here if no such individuals have been retained by the undersigned or are anticipated to be retained by the undersigned.

SECTION IV: CERTIFICATIONS

A. CERTIFICATION OF COMPLIANCE

For purposes of the certifications in this Section IV, the term "affiliate" means any individual or entity that, directly or indirectly controls the Undersigned, is controlled by the Undersigned, or is, with the Undersigned, under common control of another individual or entity. Indicia of control include, without limitation: interlocking management or ownership; identity of interests among family members; shared facilities and equipment; common use of employees; or organization of a business entity following the ineligibility of a business entity to do business with the federal government or a state or local government, including the Park District and the City of Chicago, using substantially the same management, ownership, or principals as the ineligible entity.

1. The Undersigned is not delinquent in the payment of any tax administered by the Illinois Department of Revenue, nor are the Undersigned or its affiliates delinquent in paying any fine, fee, tax or other charge owed to the City of Chicago or the Park District. This includes all water charges, sewer charges, license fees, parking tickets, property taxes or sales taxes. If there are any such delinquencies, note them below:

_____

_____

_____

If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Undersigned certified to the above statements.

2. The Undersigned and its affiliates have not, in the past five (5) years, been found in violation of any Park District, City, state or federal environmental law or regulation. If there have been any such violations, note them below:

   If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Undersigned certified to the above statements.

3. If the Undersigned is the Applicant, the Undersigned and its affiliates will not use, nor permit their subcontractors to use, any facility on the U.S. EPA's List of Violating Facilities in connection with the Matter for the duration of time that such facility remains on the list.

4. If the Undersigned is the Applicant, the Undersigned will obtain from any contractors / subcontractors hired, or to be hired in connection with the Matter, certifications equal in form and substance to those in this Section IV, and will not, without the prior written consent of the Park District, use any such contractor/subcontractor that does not provide such certifications or that the Undersigned has reason to believe has not provided or cannot provide truthful certifications.

5. If the Undersigned is unable to make the certifications required in this Section IV, A, provide an explanation:

_____

_____

_____

If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Undersigned certified to the above statements.

B: CHILD SUPPORT OBLIGATIONS: CERTIFICATION REGARDING COURT-ORDERED CHILD SUPPORT COMPLIANCE

For purposes of this part, "Substantial Owner" means any individual who, directly or indirectly, owns or holds a 10% or more interest in the Undersigned. Note: This may include individuals disclosed in Section I (Disclosure of Ownership Interests), and individuals disclosed in an EDS filed by an entity holding an interest in the Applicant.

If the Undersigned's response below is #1 or #2, then all of the Undersigned's Substantial Owners must remain in compliance with any such child support obligations until the Matter is completed. Failure of the Undersigned's Substantial Owners to remain in compliance with their child support obligations in the manner set forth in either #1 or #2 constitutes an event of default.

Check one:

____1. No Substantial Owner has been declared in arrearage on any child support obligations by the Circuit Court of Cook County, Illinois, or by another Illinois court of competent jurisdiction.

____2. The Circuit Court of Cook County, Illinois or another Illinois court of competent jurisdiction has issued an order declaring one or more Substantial Owners in arrearage on child support obligations. All such Substantial Owners, however, have entered into court-approved agreements for the payment of all such child support owed, and all such Substantial Owners are in compliance with such agreements.

____3. The Circuit Court of Cook County, Illinois or another Illinois court of competent jurisdiction has issued an order declaring one or more Substantial Owners in arrearage on child support obligations and (a) at least one such Substantial Owner has not entered into a court-approved agreement for the payment of all such child support owed; or (b) at least one such Substantial Owner is not in compliance with a court approved agreement for the payment of all such child support owed; or both (a) and (b).

____4. There are no Substantial Owners.

C. FURTHER CERTIFICATIONS

For purposes of this part, "Affiliated Entity" means an individual or entity that, directly or indirectly: controls the Undersigned, is controlled by the Undersigned, or is, with the Undersigned, under common control of another individual or entity. Indicia of control include, without limitation: interlocking management or ownership; identity of interests among family members; shared facilities and equipment; common use of employees; or organization of a business entity following the ineligibility of a business entity to do business with federal or state or local government or unit thereof, including the Park District and the City of Chicago, using substantially the same management, ownership, or principals as the ineligible entity.

With respect to Applicable Parties, the term Affiliated Entity means an individual or entity that directly or indirectly controls the Applicable Party, is controlled by it, or, with the Applicable Party, is under common control of another individual or entity; any responsible official of the Undersigned; any Applicable Party or any Affiliated Entity or any other official, agent or employee of the Undersigned; any Applicable Party or any Affiliated Entity acting pursuant to the direction or authorization of a responsible official of the Undersigned; any Applicable Party, or any Affiliated Entity (collectively "Agents").

1. The Undersigned, and, if the Undersigned is a legal entity, its principals (officers, directors, partners, members, managers, executive director):

    a. are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from any transactions by any federal, state or local unit of government;

    b. have not, within a five year period preceding the date of this EDS, been convicted of a criminal offense, adjudged guilty, or had a civil judgment rendered against them in connection with: obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; a violation of federal or state antitrust statutes; fraud; embezzlement; theft; forgery; bribery; falsification or destruction of records; making false statements; or receiving stolen property;

    c. are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in C, 1, b of this section;

    d. have not, within a five (5) year period preceding the date of this EDS, had one or more public transactions (federal, state or local) terminated for cause or default; and

    e. have not, within a five (5) year period preceding the date of this EDS, been convicted, adjudged guilty, or found liable in a civil proceeding, in any criminal or civil action instituted by the Park District**,** City of Chicago or by the federal

government, any state, or any other unit of local government.

2. Neither the Undersigned, nor any Applicable Party, nor any Affiliated Entity of either the Undersigned or any Applicable Party nor any Agents have, during the five (5) years before the date this EDS is signed, or, with respect to an Applicable Party, an Affiliated Entity, or an Affiliated Entity of an Applicable Party during the five (5) years before the date of such Applicable Party's or Affiliated Entity's contract or engagement in connection with the Matter:

   a. bribed or attempted to bribe, or been convicted or adjudged guilty of bribery or attempting to bribe, a public officer or employee of the Park District, the City of Chicago, the State of Illinois, or any agency of the federal government or of any state or local government in the United States of America, in that officer's or employee's official capacity;

   b. agreed or colluded with other bidders or prospective bidders, or been a party to any such agreement, or been convicted or adjudged guilty of agreement or collusion among bidders or prospective bidders, in restraint of freedom of competition by agreement to bid a fixed price or otherwise; or

   c. made an admission of such conduct described in a or b above that is a matter of record, but have not been prosecuted for such conduct.

3. The Undersigned understands and shall comply with (a) all applicable requirements of Governmental Ethics under Park District Code, and (b) all the applicable provisions of the Park District Purchasing and Contracting Code**.**

4. Neither the Undersigned, Affiliated Entity or Applicable Party, or any of their employees, officials, agents or partners, is barred from contracting with any unit of state or local government as a result of engaging in or being convicted of (a) bid-rigging in violation of 720 ILCS 5/33E-3; (b) bid-rotating in violation of 720 ILCS 5/33E-4; or (c) any similar offense of any state or of the United States of America that contains the same elements as the offense of bid-rigging or bid-rotating.

5. If the Undersigned is unable to certify to any of the above statements in this Part C, the Undersigned must explain below:

_____

_____

_____

If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Undersigned certified to the above statements.

D. CERTIFICATION OF STATUS AS FINANCIAL INSTITUTION

For purposes of this Part D, the term "financial institution" means a bank, savings and loan association, thrift, credit union, mortgage banker, mortgage broker, trust company, savings bank, investment bank, securities broker, municipal securities broker, securities dealer, municipal securities dealer, securities underwriter, municipal securities underwriter, investment trust, venture capital company, bank holding company, financial services holding company, or any licensee under the Consumer Installment Loan Act, the Sales Finance Agency Act, or the Residential Mortgage Licensing Act. However, "financial institution" specifically shall not include any entity whose predominant business is the providing of tax deferred, defined contribution, or pension plans to public employees in accordance with Sections 403(b) and 457 of the Internal Revenue Code.

1. CERTIFICATION

The Undersigned certifies that the Undersigned (check one)

_____ is

_____ is not

a "financial institution" as defined above.

2. IF THE UNDERSIGNED IS A FINANCIAL INSTITUTION, THEN THE UNDERSIGNED PLEDGES:

"We are not and will not become a predatory lender as defined in Chapter 2 -32 of the Municipal Code of the City of Chicago. We further pledge that none of our affiliates is, and none of them will become, a predatory lender as defined in Chapter 2-32 of the Municipal Code. We understand that becoming a predatory lender or becoming an affiliate of a predatory lender may result in the loss of the privilege of doing business with the Park District."

If the Undersigned is unable to make this pledge because it or any of its affiliates (as defined in Section 2-32- 455(b) of the Municipal Code) is a predatory lender within the meaning of Chapter 2-32 of the Municipal Code of the City of Chicago, explain here (attach additional pages if necessary):

If the letters "NA," the word "None," or no response appears on the lines above, it will be conclusively presumed that the Undersigned certified to the above statements.

E. CERTIFICATION REGARDING INTEREST IN PARK DISTRICT BUSINESS

Any words or terms defined in the Code of the Chicago Park District have the same meanings when used in this Section IV.

1. Does any Commissioner or Employee of the Park District have a financial interest in his or her own name or in the name of any other person in the Matter?

[ ] Yes [ ]No

NOTE: If you answered "No" to Item IV, E, 1, you are not required to answer Items IV, E, 2 or IV, E, 3 below. Instead, review the certification in Item IV, E, 4 and then proceed to Section V. If you answered "Yes" to Item IV, E, 1, you must first respond to Item IV, E, 2 and provide the information requested in Item IV, E, 3. After responding to those items, review the certification in Item IV, E, 4 and proceed to Section V.

2. Unless sold pursuant to a process of competitive bidding, no Park District Commissioner or Employee shall have a financial interest in his or her own name or in the name of any other person in the purchase of any property that (a) belongs to the Park District, or (b) is sold for taxes or assessments, or (c) is sold by virtue of legal process at the suit of the Park District (collectively, "Park District Property Sale"). Compensation for property taken pursuant to the exercise of any power of eminent domain does not constitute a financial interest within the meaning of this Section IV.

Does the Matter involve a Park District Property Sale?

[ ] Yes [ ] No

3. If you answered "yes" to Item IV, E, 1, provide the names and business addresses of the Park District Commissioners or Employees having such interest and identify the nature of such interest:

NAME	BUSINESS ADDRESS	NATURE OF INTEREST

4. The Undersigned further certifies that no prohibited financial interest in the Matter will be acquired by any Park District Commissioner or employee.

SECTION V: CERTIFICATIONS FOR FEDERALLY - FUNDED MATTERS

A. CERTIFICATION REGARDING LOBBYING

1. List below the names of all individuals registered under the federal Lobbying Disclosure Act of 1995 who have made lobbying contacts on behalf of the Undersigned with respect to the Matter (Begin list here, add sheets as necessary):

If no explanation appears or begins on the lines above, or if the letters "NA" or if the word “None" appear, it will be conclusively presumed that the Undersigned means that NO individuals registered under the Lobbying Disclosure Act of 1995 have made lobbying contacts on behalf of the Undersigned with respect to the Matter.

2. The Undersigned has not spent and will not expend any federally appropriated funds to pay any individual listed in Section V, A, 1, above, for his or her lobbying activities or to pay any individual to influence or attempt to influence an officer or employee of any agency, as defined by applicable federal law, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress, in connection with the award of any federally funded contract, making any federally funded grant or loan, entering into any cooperative agreement, or to extend, continue, renew, amend, or modify any federally funded contract, grant, loan, or cooperative agreement.

3. The Undersigned will submit an updated certification at the end of each calendar quarter in which there occurs any event that materially affects the accuracy of the statements and information set forth in parts 1 and 2 above.

If the Matter is federally funded and any funds other than federally appropriated funds have been or will be paid to any individual for influencing or attempting to influence an officer or employee of any agency (as defined by applicable federal law), a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the Matter, the Undersigned must complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. The form may be obtained online from the federal Office of Management and Budget (OMB) web site at:

http://www.whitehouse.gov/omb/grants/sfillin.pdf, linked on the page
http://www.whitehouse.gov/omb/grants/grantsforms.html.

4. The Undersigned certifies that either (a) it is not an organization described in section 501(c)(4) of the Internal Revenue Code of 1986, as amended; or (b) it is an organization described in section 501 (c)(4) of the Internal Revenue Code of 1986, as amended but has not engaged and will not engage in "Lobbying Activities".

5. If the Undersigned is the Applicant, the Undersigned must obtain certifications equal in form and substance to those in Section V, A, 1-4 above from all subcontractors before it awards any subcontract and the Undersigned must maintain all such subcontractors' certifications for the duration of the Matter and must make such certifications promptly available to the Park District upon request.

B. CERTIFICATION REGARDING NON-SEGREGATED FACILITIES

"Segregated facilities," as used in this provision, means any waiting rooms,' work areas, restrooms, washrooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, sex, or national origin because of habit, local or employee custom, or otherwise.

1. If the Undersigned is the Applicant, the Undersigned does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained.

   However, separated or single-user restrooms and necessary dressing or sleeping areas must be provided to assure privacy between the sexes.

2. If the Undersigned is the Applicant and the Matter is federally funded, the Undersigned will, before the award of subcontracts (if any), obtain identical certifications from proposed subcontractors under which the subcontractor will be subject to the Equal Opportunity Clause. Contracts and subcontracts exceeding $10,000, or having an aggregate value exceeding $10,000 in any twelve- (12) month period, are generally subject to the Equal Opportunity Clause. See 41 CFR Part 60 for further information regarding the Equal Opportunity Clause. The Undersigned must retain the certifications required by this paragraph for the duration of the contract (if any) and must make such certifications promptly available to the Park District upon request.

3. If the Undersigned is the Applicant and the Matter is federally funded, the Applicant will forward the notice set forth below to proposed subcontractors:

NOTICE TO PROSPECTIVE SUBCONTRACTORS OF REQUIREMENTS FOR CERTIFICATIONS OF NON-SEGREGATED FACILITIES

Subcontractors must submit to the Contractor a Certification of Non-segregated Facilities before the award of any subcontract under which the subcontractor will be subject to the federal Equal Opportunity Clause. The subcontractor may submit such certifications either for each subcontract or for all subcontracts during a period (e.g., quarterly, semiannually, or annually).

C. CERTIFICATION REGARDING EQUAL EMPLOYMENT OPPORTUNITY

Federal regulations require prospective contractors for federally funded Matters (e.g., the Applicant) and proposed subcontractors to submit the following information with their bids or in writing at the outset of negotiations. (NOTE: This Part C is to be completed only if the Undersigned is the Applicant.)

1. Have you developed and do you have on file affirmative action programs pursuant to applicable federal regulations? (See 41 CFR Part 60-2.)

   [ ] Yes [ ] No [ ] N/A

2. Have you participated in any previous contracts or subcontracts subject to the equal opportunity clause?

   [ ] Yes [ ] No [ ] N/A

3. Have you filed with the Joint Reporting Committee, the Director of the Office of Federal Contract Compliance Programs, or the Equal Employment Opportunity Commission all reports due under the applicable filing requirements?

   [ ] Yes [ ] No [ ] N/A

SECTION VI: NOTICE AND ACKNOWLEDGMENT REGARDING PARK DISTRICT ETHICS AND CAMPAIGN FINANCE ORDINANCES

The Park District's Governmental Ethics Code, Chapter III of the Code of the Chicago Park District, imposes certain duties and obligations on individuals or entities seeking Park District contracts, work, business, or transactions. The Undersigned must comply fully with the applicable codes.

[ ] By checking this box the undersigned acknowledges and understands that the Park District's Governmental Ethics Code, among other things:

1. Provides that any contract negotiated, entered into or performed in violation of the Park District's Governmental Ethics Code can be voided by the Park District.

2. Limits the gifts and favors any individual or entity can give, or offer to give, to any Park District Commissioner, employee, contractor or the spouse or minor child of any of them, including:

   a. Any cash gift or any anonymous gift; and

   b. Any gift based on a mutual understanding that the Commissioner's or employee's or Park District contractor's actions or decisions will be influenced in any way by the gift.

3. Prohibits any Park District Commissioner or employee from having a financial interest, directly or indirectly, in any contract, work, transaction or business of the Park District, if that interest has a cost or present value of $5,000 or more, or if that interest entitles the owner to receive more than $2,500 per year.

4. Prohibits any appointed Park District Commissioner from engaging in any contract, work, transaction or business of the Park District, unless the matter is wholly unrelated to the appointed official's duties or responsibilities.

5. Provides that Park District Commissioners and employees or their spouses or minor children, cannot receive compensation or anything of value in return for advice or assistance on matters concerning the operation or business of the Park District, unless their services are wholly unrelated to their Park District duties and responsibilities.

6. Provides that former Park District Commissioners and employees cannot, for a period of one year after their Park District employment ceases, assist or represent another on any matter involving the Park District, if, while with the Park District, they were personally and substantially involved in the same matter.

7. Provides that former Park District employees and Commissioners cannot ever assist or represent another on a Park District contract if, while with the Park District, they were personally involved in or directly supervised the formulation, negotiation or execution of that contract.

SECTION VII: CONTRACT INCORPORATION, COMPLIANCE, PENALTIES, DISCLOSURE

THE UNDERSIGNED UNDERSTANDS AND AGREES THAT:

A. The certifications, disclosures, and acknowledgments contained in this EDS will become part of any contract or other agreement between the Applicant and the Park District in connection with the Matter, whether procurement, Park District assistance, or other Park District action, and are material inducements to the Park District's execution of any contract or taking other action with respect to the Matter. The Undersigned understands that it must comply with all statutes, ordinances, and regulations on which this EDS is based.

B. If the Park District determines that any information provided in this EDS is false, incomplete or inaccurate, any contract or other agreement in connection with which it is submitted may be rescinded or be void or voidable, and the Park District may pursue any remedies under the contract or agreement (if not rescinded, void or voidable), at law, or in equity, including terminating the Undersigned's participation in the Matter and/or declining to allow the Undersigned to participate in other transactions with the Park District.

C. Some or all of the information provided on this EDS and any attachments to this EDS may be made available to the public on the Internet, in response to a Freedom of Information Act request, or otherwise. By completing and signing this EDS, the Undersigned waives and releases any possible rights or claims which it may have against the Park District in connection with the public release of information contained in this EDS and also authorizes the Park District to verify the accuracy of any information submitted in this EDS.

D. The Undersigned has not withheld or reserved any disclosures as to economic interests in the Undersigned, or as to the Matter, or any information, data or plan as to the intended use or purpose for which the Applicant seeks Park District action**.**

E. The information provided in this EDS must be kept current. In the event of changes, the Undersigned must supplement this EDS up to the time the Park District takes action on the Matter.

EDS CERTIFICATION

Under penalty of perjury, the person signing below: (1) warrants that he/she is authorized to execute this EDS on behalf of the Undersigned, and (2) warrants that all certifications and statements contained in this EDS are true, accurate and complete as of the date furnished to the Park District.

_____ Date:_____

(Print or type name of legal entity or individual submitting this EDS)

By:

_____

(Sign here)

Print or type name of signatory:

_____

Title of signatory:

_____

Subscribed to before me on [date] _____, at _____County,

_____ [state].

_____ Notary Public

Commission expires: _____

SEAL

INSTRUCTIONS FOR COMPLETING SCHEDULES A & B

CHICAGO PARK DISTRICT

A. SCHEDULE A [STATEMENT OF PRIME SUBMITTER]

1. Completion of Schedule A

a. Schedule A must be completed and signed by the submitter who is the prospective awardee.

b. That submitter must commit to the expenditure of a specific dollar amount of participation by each MBE/WBE listed on the Schedule A.

2. Joint Venture Attachment to Schedule A (Joint Venture only)

a. If the submitter's MBE/WBE proposal includes the participation of any MBE/WBE as a joint venture partner, the submitter must submit, with the Schedule A, a copy of the parties' Joint Venture Agreement.

b. The Alternate Signature Page of the Schedule A must be signed by the joint venture partners.

3. Non-compliant Submittal

Failure to submit a properly completed and signed Schedule A (and joint venture documentation, if applicable) will render the submittal non-compliant, which will remove the submitter from further award consideration.

B. SCHEDULE B [STATEMENT OF MBE/WBE FIRM(S)]

1. Completion of Schedule B

a. A Schedule B form must be completed and signed by each MBE/WBE firm listed on the Schedule A as participating in the contract as a subcontractor. Only that subcontractor shall sign the Schedule B.

b. That MBE/WBE firm also must submit, with their Schedule B, all of their current Letters of Certification obtained from public or private entities such as the City of Chicago, the Chicago Minority Supplier Development Council (CMSDC), the Women's Business Development Center (WBDC), or the Small Business Administration.

.

2. Non-compliant Submittal

Failure of the prime submitter to submit a completed and signed Schedule B and current certification letter(s) for each subcontractor listed on the Schedule A will render the submittal non-compliant, which will remove the prime submitter from further award consideration.

SCHEDULE A

Statement of Prime Submitter Regarding Its MBE/WBE Utilization Plan

TO BE COMPLETED BY SUBMITTER ONLY

Submitter: _____ Project: _____

Is the submitter a certified MBE/WBE? MBE: ❑ Yes ❑ No WBE: ❑ Yes ❑ No

If yes, attach all current Letters of Certification.

NOTE:

CERTIFICATION OF THE SUBMITTER AS AN **MBE** SATISFIES ONLY THE MBE GOAL; THE **WBE** GOAL MUST STILL BE MET. CERTIFICATION OF THE SUBMITTER AS A **WBE** SATISFIES ONLY THE WBE GOAL; THE **MBE** GOAL MUST STILL BE MET. CERTIFICATION OF THE SUBMITTER AS BOTH **MBE** AND **WBE** MAY SATISFY **ONE GOAL** ONLY.

The submitter intends to perform work in connection with this project as a:

GENDER:
- ❑ Male
- ❑ Female

RACE/ETHNICITY:
- ❑ Black/African American
- ❑ Hispanic American
- ❑ Asian American
- ❑ White American
- ❑ Other _____

TYPE OF FIRM:
- ❑ Partnership
- ❑ Sole Proprietorship
- ❑ Corporation
- ❑ Joint Venturer
- ❑ Other _____

All MBE/WBE firms included in the following plan must be certified as such by a public or private organization such as the City of Chicago, Chicago Minority Supplier Development Council (CMSDC), Women Business Development Center (WBDC), and the Small Business Administration.

I. Participation of MBE/WBE Firms

In determining the manner of MBE/WBE participation in the performance of this contract, the submitter shall consider involvement with MBE/WBE firms as joint venture partners, subcontractors, and suppliers of goods and services, either directly or indirectly.

A. If submitter is a joint venturer and one or more joint venture partners are certified MBEs or WBEs, attach copies of Letters of Certification and a copy of the Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the joint venture.

B. Proposing MBE/WBE subcontractors/suppliers/consultants to perform work or supply goods or services not directly related to the performance of this contract is considered to be indirect participation.

MBE/WBE Subcontractors/Suppliers/Consultants:

1. Name of MBE/WBE: _____

   Address: _____

   Contact Person: _____ Phone: _____

   E-mail: _____ Fax: _____

   MBE/WBE Participation: Dollars $_____ Percent: _____%

   Will this subcontractor be used for direct or indirect participation? (circle one)

   Schedule B and all current certification letters attached? ❑ Yes ❑ No

2. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

3. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

4. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

5. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

6. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used as direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

7. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

8. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

9. Name of MBE/WBE: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

MBE/WBE Participation: Dollars $_____ Percent: _____%

Will this subcontractor be used for direct or indirect participation? (circle one)
Schedule B and all current certification letters attached? ❑ Yes ❑ No

Attach additional sheets as needed.

II. Summary of MBE/WBE Proposal:

A. MBE Proposal:

1. MBE Participation:

MBE Firm Name	Dollar Amount of Participation	Percent Amount of Participation	Direct (check √ one)	Indirect (check √ one)
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
Total MBE Participation:	$_____	_____%		

2. WBE Participation:

WBE Firm Name	Dollar Amount of Participation	Percent Amount of Participation		
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
_____	$_____	_____%	____	____
Total WBE Participation:	$_____	_____%		

The submitter designates the following person as its MBE/WBE Liaison Officer:

_____ (_____)_____

(Name and Title) *(Phone Number)*

_____

(E-mail address)

The Contractor certifies to the best of its knowledge and belief that it, its principals and any subcontractors used in the performance of this contract, meet the Park District requirements and have not violated any City or Sister Agency policy, codes, state, federal, or local laws, rules or regulations and have not been subject to any debarment, suspension or other disciplinary action by any government agency. Additionally, if at any time the contractor becomes aware of such information, it must immediately disclose it to the Park District.

Submitter: _____
(Print or Type Name of Business)

Signature: _____ Date: _____
(Written Signature of Authorized Officer/Representative)

Name/Title: _____
(Print or Type Name and Title of Person Signing Statement)

NOTE

If submitter is an MBE/WBE joint venture with a non-MBE/WBE firm, use the following signature page instead:

End of Schedule A

ALTERNATE
SCHEDULE A SIGNATURE PAGE
FOR MBE/WBE JOINT VENTURE WITH A NON-MBE/WBE FIRM

Complete this signature page only if you are an MBE/WBE operating as a joint venture with a non-MBE/WBE Firm

---

To the best of my knowledge, information and belief, the facts and representations contained in this Schedule are true, and no material facts have been omitted.

Any material misrepresentation will be grounds for terminating any contract that may be awarded and for initiating action under federal or state laws concerning false statements.

NOTE:
After filing this statement and before the completion of the joint venture's work on this project, if there is any change in the information submitted, the joint venturer must inform the Chicago Park District.

(Name of MBE/WBE Partner Firm)	*(Name of Non-MBE/WBE Partner Firm)*
(Written Signature of Authorized Officer/Representative)	*(Written Signature of Authorized Officer/Representative)*
(Print or Type Name and Title)	*(Print or Type Name and Title)*
(Date)	*(Date)*

SCHEDULE B

Statement of Intent from MBE/WBE to Perform as Subcontractor, Supplier and/or Consultant
MBE/WBE PRIME CONTRACTOR MUST SUBMIT A SCHEDULE B, IF SELF-PERFORMING ANY WORK, TO RECEIVE MBE/WBE CREDIT

Project: _____

From: _____ MBE: ❑ Yes ❑ No
(Name of MBE/WBE Firm) WBE: ❑ Yes ❑ No

To: _____ and the Chicago Park District:
(Name of Prime Contractor-Submitter)

The undersigned intends to perform work in connection with the above projects as a:

GENDER:	**RACE/ETHNICITY**:	**TYPE OF FIRM:**
❑ Male	❑ Black/African American	❑ Partnership
❑ Female	❑ Hispanic American	❑ Sole Proprietorship
	❑ Asian American	❑ Corporation
	❑ White American	❑ Joint Venturer
	❑ Other_____	❑ Other_____

The MBE/WBE status of the undersigned is confirmed by the attached current Letters of Certification from public or private entities such as the City of Chicago, the Chicago Minority Supplier Development Council (CMSDC), the Women's Business Development Center (WBDC), and the Small Business Administration.
Attach all current certification letters behind Schedule B.

The undersigned is prepared to provide the following services or supply the following goods in connection with the above project/contract:

_____
_____
_____

The above described performance is offered for the following price and described terms of payment:

_____
_____
_____

If more space is needed to fully describe the MBE/WBE firm's proposed scope of work and/or payment schedule, attach additional sheets.

The undersigned will enter into a written agreement for the above work with you as prime contractor, conditioned upon your execution of a contract with the Chicago Park District, and will do so within (3) three working days of receipt of a signed contract from the Chicago Park District.

Signature: _____ Date: _____
(Signature of Owner or Authorized Agent of MBE/WBE)

Name/Title: _____
(Print or Type Name and Title)

Address: _____

Telephone: _____ Fax: _____

End of Schedule B

MBE/WBE UTILIZATION REPORTING REQUIREMENTS

CHICAGO PARK DISTRICT

Construction Contracts

The prime bidder shall, within 30 days of receiving the contract award, execute contracts or purchase orders with the MBE and WBE firms included in its approved MBE/WBE Utilization Plan. These written agreements shall be made available to the Department of Purchasing upon request.

The prime bidder shall submit the "MBE/WBE Utilization Report" with every progress payment request.

Term Agreement Contracts

For term agreement contracts for materials, supplies, equipment, services, etc., the Director of Purchasing will determine the frequency with which utilization reports are to be submitted. In the absence of written notice from the Director of Purchasing, the submitter's first "MBE/WBE Utilization Report" will be due no later than ninety (90) days after the date of contract execution.

Submission Address: MBE/WBE Utilization Reports are to be submitted directly to:

Compliance Officer
Department of Purchasing
Chicago Park District
541 N. Fairbanks Court
3rd Floor
Chicago, IL. 60611

Do not submit invoices with the "MBE/WBE Utilization Report."

COMPLIANCE CONDITIONS

REGARDING PARTICIPATION BY MINORITY- AND WOMEN-OWNED BUSINESS ENTERPRISES

These Compliance Conditions form a part of the contract documents.
Failure to carry out any of the commitments contained herein shall constitute a material breach of the contract.

DEFINITIONS

All terms not specifically defined in the Compliance Conditions will be governed by the definitions in the General Conditions unless the context indicates otherwise.

Broker means a person or entity that fills orders by purchasing or receiving supplies from a third party supplier rather than out of its own existing inventory, and provides no commercially useful function other than acting as a conduit between the supplier and the customer. Brokerage will not be counted toward MBE/WBE goals.

Certification or "certified" means official recognition of the MBE or WBE status of a business by a public or private entity such as the City of Chicago, the Chicago Minority Business Development Council (CMBDC), the Women's Business Development Center (WBDC), or the Small Business Administration (SBA).

Commercially useful function means that a firm is responsible for the execution of a distinct element of the work of the contract and carries out its responsibilities by actually performing, managing, and supervising the work involved, or by fulfilling its responsibilities as joint venturer. To determine whether a firm is performing a commercially useful function, the Chicago Park District will evaluate the amount of work subcontracted, industry practices, and other relevant factors.

Contract means any contract, purchase order, or agreement awarded by any officer or agency of the Chicago Park District, or whose cost is to be paid from funds belonging to or administered by the Park District, regardless of the source.

Direct participation means the participation by an MBE or WBE as (1) the prime contractor, (2) a joint venture partner, or (3) a subcontractor of a portion of the work of the contract.

Established business means a business entity which, by virtue of its size and capacity for competing in the markets in which it operates, does not need to be a participant in the MBE/WBE program in order to effectuate the purposes of the program as determined by the Park District. In general, a business entity shall be presumed to be an established business if it meets local and other nationally recognized standards for such status.

Indirect participation means the participation by an MBE or WBE in ancillary aspects of the work of the contractor.

Joint venture means an association of two or more businesses formed to carry out a single business enterprise for profit, and for which purposes they combine their expertise, property, capital, efforts, skills and knowledge.

Local business means a business entity located within the counties of Cook, DuPage, Kane, Lake, McHenry or Will in the State of Illinois (the "Six-County Region") which has the majority of its regular, full-time work force located within the six-county region.

Minority group means any of the following racial or ethnic groups:

- African-Americans or Blacks (persons having origins in any of the Black racial groups in Africa)
- Hispanics (persons of Spanish culture with origins in Mexico, South or Central America or the Caribbean Islands, regardless of race)
- Asian-Americans (persons having origins in any of the original peoples of East Asia, Southeast Asia, the Indian subcontinent, or the Pacific Islands)
- Other groups, or other individuals, found by the General Superintendent to be socially and economically disadvantaged and to have suffered actual racial or ethnic discrimination and decreased opportunities to compete in Chicago area markets and to do business with the Chicago Park District

- For purposes of contracts funded by state or federal government sources, groups found to be eligible for the designation of DBE (Disadvantaged Business Enterprise) by such governmental sources

Minority-owned business or **MBE** means a local business that is certifiably at least 51% owned by one or more members of one or more minority groups, or, in the case of a publicly-held corporation, a corporation in which at least 51% of the stock is owned by one or more members of one or more minority groups, and whose management and daily business operations are controlled by one or more members of one or more minority groups, and which is not an established business.

Minority-owned business enterprise goal or **MBE goal** means the goal adopted for participation by MBEs by the Chicago Park District Code, Chapter XI, Section F.

Owned means having all of the customary incidents of ownership, including the right of disposition and the sharing of all risks and profits, commensurate with the degree of ownership interest.

Program means the Minority and Women-owned Business Enterprise Program enacted by Chapter XI, Section F of the Code of the Chicago Park District, and all rules, regulations, forms, and schedules promulgated thereunder.

Schedules means the Schedule A and Schedule B prepared by the Park District.

Women-owned business or **WBE** means a local business that is certifiably at least 51% owned by one or more women, or, in the case of a publicly held corporation, a corporation in which 51% of the stock is owned by one or more women, and whose management and daily business operations are controlled by one or more women, and which is not an established business.

Women-owned business enterprise goal or **WBE goal** means the goal adopted for participation by WBEs by the Chicago Park District Code, Chapter XI, Section F.

I. POLICY: It is the policy of the Chicago Park District that members of minority groups and women participate to the maximum feasible extent in the performance of Park District contracts. During the performance of this contract, the submitter agrees that it shall not discriminate on the basis of race, color, religion, sex, national origin, ancestry, age, marital status, physical or mental disability, unfavorable discharge from military service, parental status, or sexual orientation in the solicitation for or purchase of goods or services, or the subcontracting of work in the performance of this contract.

II. COMMITMENT TO MBE/WBE PARTICIPATION

A. In order to be considered responsive, the submitter shall commit to the expenditure of at least 25% of the total contract price with MBEs ("MBE goal") and at least 5% with WBEs ("WBE goal"), and identify by category the type of work, goods, or service that will be provided by MBE/WBE firms, unless, **prior to the submission of the proposal,** the Park District grants a percentage reduction or a waiver through the process detailed in Section II.F below. The Director of Purchasing, subject to the approval of the General Superintendent, may extend the period for the granting of reductions or waivers in order to increase the opportunities for the participation of MBEs and/or WBEs in the performance of the contract.

B. If the submitter is a certified MBE firm, the WBE requirement **must still be met**. If the submitter is a certified WBE firm, the MBE requirement **must still be met**. A business enterprise owned by a woman who is a member of a minority group may be counted on a particular contract as an MBE or a WBE, **but not both**.

C. The total dollar value of the submitter's MBE or WBE direct participation and indirect participation shall be counted toward the MBE and/or WBE goals.

D. If the contract value is increased through a change order or contract modification, the MBE and WBE expenditures must increase proportionally.

E. The commitment to achieve the MBE goal and the WBE goal may be met by:

1. the submitter's status as a MBE or a WBE; or

2. the submitter's status as a joint venturer with one or more MBEs and/or WBEs. The percentage of the ownership and control of the MBE joint venturer or WBE joint venturer shall be the percentage of participation counted toward the MBE goal and/or the WBE goal. A joint venture

is eligible for participation as an MBE and/or WBE, if, and only if, all of the following requirements are satisfied:

a. the MBE or WBE venturer(s) participates in the ownership, control, management responsibilities, risks and profits of the joint venture in proportion with the MBE and/or WBE ownership percentage;

b. the MBE and/or WBE venturer(s) is responsible for a clearly defined portion of the work of the contract in proportion with the MBE's and/or WBE's ownership percentage; and

c. the MBE and/or WBE venturer(s) actually performs with its own forces and using its own equipment, work equal to at least 75% of the value of its ownership of the joint venture.

The Director of Purchasing, in consultation with appropriate Park District staff, will evaluate the proposed joint venture agreement and all other relevant documents to determine whether these requirements have been satisfied; or

3. subcontracting a portion of the work of the contract to one or more MBEs and/or WBEs:

a. A submitter may count toward its MBE or WBE goal only expenditures to firms that perform a commercially useful function in the work of the contact.

b. Brokering will not be counted toward the Program's goals. Consistent with normal industry practices, a MBE or WBE may enter into subcontracts; however, if an MBE or WBE subcontracts a significantly greater portion of the work of the contract than would be expected on the basis of normal industry practices, the MBE or WBE shall be presumed not to be performing a commercially useful function. The submitter may present evidence to rebut this presumption. Where an MBE or WBE, consistent with industry practices, intends to enter into further subcontracts totaling more than 25% of the value of the MBE's or WBE's subcontract, the MBE or WBE must submit all documents required by Section IV of these Conditions regarding all further subcontracts, except that reductions or waivers of the MBE goal or WBE goal need not be obtained. However, the dollar value of any work that is further subcontracted to other than MBEs and/or WBEs shall not be counted toward the attainment of the bidder's MBE and/or WBE goals. This provision does not apply to MBEs or WBEs who represent manufacturers. Agreements between a submitter and an MBE or WBE in which the MBE or WBE promises not to provide subcontracting quotations to other submitters are prohibited.

4. the purchase of materials or services used in or related to the performance of the contract from one or more MBEs and/or WBEs; or

5. Any combination of the foregoing.

F. Reduction or Waiver of the MBE goal and/or WBE goal

The Director of Purchasing, in consultation with appropriate Park District staff, shall consider any request for a reduction or a waiver of the MBE goal and/or the WBE goal when necessary. A reduction or waiver may be granted if, among other things, the reasonable and necessary requirements of the contract render sufficient subcontracting, joint venturing or other participation of MBEs and/or WBEs unfeasible or excessively costly; or, sufficient MBEs and/or WBEs capable of providing the goods and services required by the contract are not readily available despite affirmative efforts to locate such businesses.

1. If a submitter determines that it is unable to meet the required MBE goal and/or the WBE goal through direct subcontracts, the submitter should attempt to meet the goals through indirect subcontracts.

2. In the rare instance in which indirect subcontracting also is not possible, the submitter must request a reduction or a waiver of the goal(s) **prior to submission of its proposal**. In order to obtain a reduction or waiver, the submitter must document its unsuccessful solicitation (as either subcontractors or joint venturers) of a reasonable number of the appropriately certified MBEs and WBEs. Documentation must include, but is not necessarily limited to:

a. a detailed statement of efforts to identify and select portions of work identified in the proposal solicitation for subcontracting to or joint venturing with MBEs and WBEs; and

b. a listing of all MBEs and WBEs contacted and not utilized, including:

i. names, addresses and telephone numbers of MBEs and WBEs solicited;

ii. date, time and method of contact;

iii. a statement from each contacted MBE or WBE explaining why it was not available to do the work, or a statement that the MBE or WBE did not respond; and

iv. where relevant, documentation of all prices quoted by all subcontractors.

III. COMPLIANCE WITH MBE/WBE REQUIREMENTS

A. Proposal

1. In the MBE/WBE Affidavit provided in the submittal documents, the submitter must commit to a minimum of 25% MBE and 5% WBE participation in any contract awarded to the submitter as a result of this proposal solicitation, and identify by category the type of work, goods, or service that will be provided by MBE/WBE firms.

2. After the Park District's proposal evaluation, if the submitter is being considered for contract award, the prospective awardee will be required to complete and submit the MBE/WBE Schedule A, Schedule Bs, and certification letters, as set out below.

B. Prior to award

1. Schedule A: Statement of Prime Submitter Regarding MBE/WBE Utilization. During the pre-award evaluation period, the potential awardee will be required to submit a completed Schedule A, committing to the utilization of each listed MBE and WBE, including MBE and WBE joint venturers. That submitter must commit to the expenditure of a specific dollar and/or percentage amount of participation by each MBE and WBE firm. The total dollar or percentage commitment to proposed MBE firms must at least equal the MBE goal of 25%. The total dollar or percentage commitment to proposed WBE firms must at least equal the WBE goal of 5%. The submitter is responsible for calculating the dollar equivalent of the MBE and WBE goals. All commitments made in Schedule A must conform to the submitted Schedule Bs. The submitter will not be permitted to substitute another firm for the MBEs and/or WBEs listed in Schedule A, except as described in Section IV. C. of these Conditions.

2. Schedule B: Letter of Intent from MBE or WBE to Perform as Subcontractor, Supplier and/or Consultant as included in the Submitter's Schedule A. Each Schedule B must accurately detail the work to be performed by the MBE or WBE and the agreed rates and prices, and must be completed and signed by the MBE or WBE firm.

3. Letters of Certification: A copy of each proposed MBE's and WBE's current letters of certification (or other certification documents) must be submitted with the Schedule B. The Park District accepts certification by public or private entities such as the City of Chicago, the Chicago Minority Supplier Development Council [CMSDC], the Women's Business Development Center [WBDC], or the Small Business Administration [SBA]. The Park District reserves the right to determine that even if an entity is certified, its inclusion in the Program does not further the Program's purposes. The Park District – not the bidder – shall determine the adequacy of the letters of certification or other certification documents.

a. A receipt for the submittal of an application for certification is NOT AN ACCEPTABLE alternative to a current certification letter.

b. The only ACCEPTABLE alternative to a current certification letter is a "courtesy extension letter" from the same certifying agency.

C. Evaluation of the Schedules

If the potential awardee fails to meet the MBE goal and/or the WBE goal and no reduction or waiver was granted before the proposal was submitted; or if the submitter is found to be unresponsive or uncooperative; or if false statements were made in the Schedules; or if the submitter fails to cooperate promptly with the Park District; the submitter may be deemed unresponsive and eliminated from award consideration.

IV. CONTRACT PERFORMANCE

A. MBE and WBE Utilization Reports

The awardee shall maintain records of all relevant data with respect to the utilization of MBEs and WBEs, retaining these records for a period of at least three years after expiration of the contract. The awardee shall file quarterly MBE and WBE Utilization Reports. Each MBE and WBE Utilization Report will reflect the current status of current and projected payments to MBEs and WBEs. Such reports shall include the following: the name, business address, telephone number and contact person of each MBE and WBE actually involved in the performance of the contract; a description of the work performed and/or product or service supplied by each MBE or WBE; the date and amount of each payment; and such other information as may assist the Director of Purchasing in determining the awardee's compliance with the provisions of the Program.

B. Access to Records

During the term of the contract and for a period of three years after the expiration date of the contract, the Director of Purchasing shall have access to the awardee's books and records, including without limitation payroll records, tax returns and records, and books of account, on five business days notice, to allow the Director of Purchasing to determine the awardee's compliance with its commitment to MBE and WBE participation and the status of any MBE or WBE performing any portion of the contract. This provision shall be in addition to, and not a substitute for, any other provision allowing inspection of the awardee's records by any officer or official of the Chicago Park District for any purpose.

C. Substitution of MBEs and WBEs Listed in the Schedules

When the awardee believes it has become necessary to substitute a new MBE or WBE in order to actually fulfill the MBE goal or WBE goal, or to complete the work of the contract, the awardee must submit to the Director of Purchasing a written request for permission to substitute a different MBE or WBE. Any substitution must receive prior approval from the Director of Purchasing. If the participation of MBEs and/or WBEs in the contract would be reduced by the substitution, the awardee must utilize MBEs and/or WBEs in other areas of the contract to meet the MBE goal and/or WBE goal, unless a reduction or waiver is granted. Such a request must include specific reasons for the proposed substitution, including an affidavit from the MBE or WBE listed in Schedule A and not utilized, stating why the MBE or WBE is unable to complete the work. Acceptable reasons include, but are not limited to, the following:

1. the MBE or WBE was found not to be able to perform the work as described in the Schedules, or was not able to perform on time;

2. the MBE or WBE was found not to be able to produce acceptable work;

3. the MBE or WBE was discovered to be improperly certified; or

4. the MBE or WBE later demands an unreasonable escalation of price.

The awardee's substitution request should include the names, addresses, and officials of any proposed substitute MBE or WBE and the dollar value and scope of work of the proposed subcontract. Such notification shall also include documents that are required for the determination of proposal compliance, including the Schedules and current certification letters. The Park District will not approve extra payment for escalated costs incurred by the awardee when a substitution becomes necessary for the awardee in order to comply with the MBE goal and/or the WBE goal.

V. NON-COMPLIANCE

The following constitute material breaches of the contract and shall entitle the Park District to declare a default, terminate the contract and exercise those remedies provided for in the contract and at law or in equity: (1) failure to satisfy the MBE goal and/or the WBE goal required by the contract; or (2) the disqualification of the MBE or WBE when such status was a factor in the contract award and was misrepresented by the submitter

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A. In the event of an awardee's non-compliance with the commitment to MBE and/or WBE participation, the awardee agrees to pay damages to the MBEs and WBEs that were underutilized due to no fault of the MBE or WBE. The unexcused reduction of MBE and/or WBE participation in connection with a contract, including any modification thereof, shall entitle the affected MBEs and WBEs to damages. The awardee agrees to submit any dispute concerning such damages to binding arbitration by an independent arbitrator, other than any department or agency of the Chicago Park District, with reasonable expenses, including attorneys' fees and costs being recoverable by a prevailing MBE or WBE.

B. In the event that an awardee is determined by the Director of Purchasing not to have been involved in any misrepresentation of the status of a disqualified MBE or WBE included in the Schedules, the Director of Purchasing may allow the awardee to discharge the MBE or WBE and, if possible, identify and engage a qualified MBE or WBE as a replacement. A MBE must be replaced by another MBE and a WBE must be replaced by another WBE, unless a reduction or waiver is granted.

C. If, after notice and a hearing before the Director of Purchasing, the General Superintendent determines that an awardee or a MBE or WBE has made fraudulent misrepresentations to the Director of Purchasing regarding the utilization of MBEs or WBEs, or has colluded with another making such fraudulent misrepresentations, the awardee or MBE or WBE shall be disqualified from contracting or subcontracting on additional contracts with the Park District for a period of three years.

D. The consequences provided herein shall be in addition to any other criminal or civil liability to which such entities may be subject. The General Superintendent, through the General Counsel of the Park District, shall inform the appropriate law enforcement officers of instances of fraudulent misrepresentation and collusion.

End of Compliance Conditions

These General Conditions form a part of the contract documents.

DEFINITIONS

All terms are defined in the General or the Compliance Conditions.

Addendum (plural **addenda**) means an addition, correction, deletion, modification, or clarification of or to this specification, issued to prospective submitters prior to the date and time proposals are due.

Awardee means the submitter (or submitters) whose proposal, with or without further negotiation, has been formally accepted for contract by the Board of Commissioners or the General Superintendent of the Park District.

General Superintendent means the General Superintendent of the Chicago Park District. The General Superintendent shall represent and act for the Park District in all matters pertaining to this contract in conjunction therewith. The term General Superintendent shall include any person designated in writing by the General Superintendent to act in his/her stead with respect to this contract and shall also include, with respect to any actions taken prior to the award of this contract, the Director of Purchasing.

Losses means, individually and collectively, liabilities of every kind, including losses, damages, and reasonable costs, payments, and expenses (such as, but not limited to, court costs and reasonable attorneys' fees and disbursements), claims, demands, actions, suits, proceedings, judgments, or settlements, any or all of which in any way arise out of or relate to any act, error, or omission of submitter, submitter's breach of the Agreement, or submitter's negligent or otherwise wrongful acts or omissions or those of its officers, agents, employees, consultants, subcontractors, or licensees.

Proposal means a response submitted pursuant to this Request for Proposal, compliant with all of the requirements of the specification documents.

Submitter means a party or entity that submits a proposal in response to this Request for Proposal.

I. COMPLIANCE WITH ALL LAWS

A. The awardee(s) shall comply with all applicable laws, ordinances, executive orders and regulations of the federal, state, local and city government, which may in any manner affect the performance of this contract. Further, the awardee, including all of its employees, servants, agents, subcontractors, and concessionaires, shall abide by the "Conduct Prohibited" provisions of the Park District Code, IV, B.

B. To demonstrate compliance with all of the above-mentioned laws, rules, regulations or orders, the awardee and subcontractors will furnish such reports and information as may be required. In the event of the awardee's non-compliance, this contract may be canceled, terminated, or suspended in whole or in part, and the awardee may be declared ineligible for further contracts with the Chicago Park District. Other sanctions may be imposed and remedies invoked as otherwise provided by law.

II. NON-DISCRIMINATION

A. Awardee shall comply with the Illinois Human Rights Act, 775 ILCS 5/1-101 et seq., as amended, and any rules and regulations promulgated in accordance therewith, including, but not limited to the Equal Employment Opportunity Clause, Illinois Administrative Code, Title 44, Part 750 (Appendix A), which is incorporated herein by reference. Furthermore, the awardee shall comply with the Public Works Employment Discrimination Act, 775 ILCS 10/0.01 et seq., as amended.

B. During the performance of this contract, the awardee agrees that it shall not discriminate against any worker, employee or applicant, or any member of the public, on the basis of race, color, religion, sex, national origin, ancestry, age, marital status, physical or mental handicap, unfavorable discharge from military services, parental status, or sexual orientation. Upon request of the Chicago Park District, the awardee also agrees to submit in writing a plan demonstrating compliance with equal employment opportunity laws and Chicago Park District policy requiring equal employment opportunity to all. Awardee further agrees that this clause will be incorporated by the contractor in all contracts entered

into with suppliers of materials or services, subcontractors, and all labor organization furnishing skilled, unskilled and craft union skilled labor, or any other person or organization performing labor or services in connection with this contract.

C. Minority and Women Business Enterprise Participation

1. The awardee shall comply with the Compliance Conditions regarding participation by minority- and women-owned business enterprises, which is incorporated into this contract document.

2. During the term of the contract and any extension thereof, the awardee shall complete and submit quarterly MBE/WBE Utilization Reports, as requested to do so by the Park District.

III. ETHICAL CONDUCT. Any effort to influence any public employee to breach the standards of ethical conduct constitutes a breach of ethical standards. It shall be a breach of ethical standards for any person to offer, give or agree to give any employee or former employee, or for any employee or former employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, or in any other solicitation or proposal therefore.

IV. CONFLICTS OF INTEREST

A. No member of the governing body of the Park District or other unit of government and no other officer, employee, or agent of the Park District or other unit of government who exercises any functions or responsibilities in connection with the carrying out of the project shall have any personal interest, direct or indirect, in the contract.

B. The submitter covenants that it presently has no interest and shall not acquire any interest, direct or indirect, in the project to which the contract pertains which would conflict in any manner or degree with the performance of its work hereunder. The submitter further covenants that, in its performance of the contract, no person having any such interest shall be employed.

V. NON-COLLUSION. Neither the awardee (or each joint venture partner) nor its agents, employees, officers and any subcontractors, has been engaged in or been convicted of collusion activities as defined on the Signature Page submitted with the proposal.

VI. SELF PERFORMANCE: The contractor shall perform at least 25% of the work of the contract with its own forces.

VII. PROHIBITION OF ASSIGNMENT. The awardee shall not delegate the performance of any obligation hereunder to any third party, or subcontract or assign this contract, in whole or in part, without the prior written consent of the Director of Purchasing of the Chicago Park District. Such consent, if granted, shall not relieve the contractor of any responsibilities under the contract.

VIII. PREVAILING WAGE RATES. The awardee shall pay prevailing wages when applicable. As a condition of making payment to the awardee, the Chicago Park District may request that the awardee submit an affidavit or other evidence to the effect that not less than the prevailing hourly wage rate is being paid to those employed on contracts in accordance with Illinois law.

IX. AWARDEE'S EMPLOYEES

A. The Park District has the right to require the awardee to remove from his workforce assigned to a Park District location any employees deemed incompetent, careless, or otherwise objectionable, or any personnel whose actions are deemed to be contrary to public interests or inconsistent with the best interests of a facility.

B. Damage and/or pilferage to Park District property and/or its contents by employees of the awardee shall be the awardee's responsibility, and losses shall be the liability of the awardee.

C. Awardee's employees are to be considered the employees of the awardee and not of the Park District; therefore, awardee shall comply with all federal and state tax requirements and government regulations.

X. INDEMNIFICATION. Awardee must defend, indemnify, keep and hold harmless the Park District, its Commissioners, officers, representatives, agents, volunteers and employees from and against any and all lawsuits, claims, demands, liabilities, losses, and expenses, including court costs and attorneys' fees, for or on account of any injury to any person or any death at any time resulting from such injury, or any damage to property which may arise or which may be alleged to have arisen out of, or in connection with, the work, goods, and/or services covered by this contract. The obligation to indemnify the Park District shall survive the termination or expiration of this contract.

XI. WARRANTIES, LAWS, AND REGULATIONS. In addition to the warranties provided by law, submitter hereby expressly represents and warrants the following, when applicable:

A. That any goods and/or services to be delivered hereunder shall be in full conformity with all manufacturer and seller express warranties and that the goods and/or services shall be free from defects in material, workmanship, or performance and shall conform to the specifications, drawings, and/or samples. Submitter agrees that this warranty shall survive inspection, acceptance, and payment.

B. That no article sold and delivered hereunder shall infringe any trademark, trade name, patent, copyright, or application therefore. In the event that any article sold and delivered hereunder shall be covered by any trademark, trade name, patent, copyright, or application therefore, awardee shall indemnify and save harmless the Chicago Park District, its commissioners, officers, employees and agents from any and all loss, cost, or expense on account of any and all claims, suits, or judgments on account of the use or sale of such article in violation of rights under such trademark, trade name, patent, copyright, or application.

C. That any goods to be delivered hereunder shall be manufactured, sold, and installed in compliance with the provisions of all applicable federal, state, and local laws and regulations.

D. That any goods to be delivered hereunder shall be free and clear of all liens, claims, or encumbrances of any kind.

E. That nothing contained herein shall exclude or affect the operation of any implied warranties otherwise arising in favor of the Chicago Park District.

XII. PROTECTION OF WORK, DAMAGES, AND REPAIRS. If applicable, awardee shall be responsible for any financial losses incurred by improper or negligent work performance at a site and shall repair or replace and pay for any replacement or damages to pavement, lawns, landscaping, new and existing structures, material, equipment, fixtures, appliances, and apparatus during the course of work, where such damage is directly due to work under this contract, or where such damage is the result of the neglect or carelessness on the part of the awardee or his employees, or on the part of the awardee's subcontractor or his employees.

XIII. OWNERSHIP OF DOCUMENTS. If applicable, all drawings, tracings, specifications, reports, test results, models, electronic media, renderings, and all such other documents to be prepared and furnished by the awardee, including copyrights, are and shall become and remain the sole property of the Park District, whether the project for which they are made is executed or not. The Park District shall have the right to use such documents on additional projects as the Park District sees fit. If such documents are used on another project, awardee shall not be responsible for such use and shall not receive additional compensation. Without the prior written consent of the Park District, awardee shall not use any documents prepared or furnished for the project by awardee or the Park District for any use other than its performance under this agreement.

XIV. PRICING AND PRICE ESCALATION

A. Pricing will be firm for the initial contract period.

B. After an extension option has been utilized, requests for increases in prices may be submitted in

writing to the Director of Purchasing. Requests must be based on and include documentation of increases in the awardee's cost that are due to (1) direct labor increases, (2) consumer price inflation index increases for appropriate supply items, or (3) if the actual usage levels of the supplies vary substantially from the given usage estimates. Such increased costs must not represent an increase for profits or other overhead. No more than one price increase will be considered during any consecutive twelve-month period. No tied increases should exceed the maximum amounts according to the Producers Index or the Consumer Price Index.

C. If the Director of Purchasing approves price increases, both the Park District and the awardee must sign a properly executed contract modification reflecting the price changes and the date on which such changes are effective. Original prices shall remain in effect until such a contract modification has been fully executed.

D. The Park District reserves the right to reject any proposed price increase and to terminate without cost the future performance of this contract.

XV. PURCHASE ORDERS. A valid order exists only when a written purchase order has been issued and the following two conditions have been met:

A. A typed purchase order number appears in the designated space on the purchase order.

B. The signature of the General Superintendent or the Director of Purchasing (or designee) appears in the designated space on the purchase order.

XVI. INVOICES. The awardee shall submit itemized original invoices in triplicate to the Comptroller's Office, Chicago Park District, 541 North Fairbanks Court, 6th Floor, Chicago, Illinois 60611. All invoices must include the specification number, purchase order number, delivery location, description of goods, materials and/or services, quantity, unit price, extended price and invoice total. Invoices submitted without the above information shall be returned to the awardee for correction.

XVII. TAXES. As a municipal body, the Chicago Park District is not subject to Federal Excise Tax, Illinois Retailer's Occupation Tax, Use Tax, or Municipal Retailer's Occupation Tax. The Illinois Department of Revenue tax exemption number for the Chicago Park District is E-998-0363-02. Upon request, the Comptroller's Office of the Park District will provide a Federal Excise Tax Exemption Certificate. The prices quoted herein shall include all other federal and/or state taxes that apply, direct and/or indirect.

XVIII. PAYMENT. Unless specified otherwise in the contract, the awardee will be paid monthly, beginning thirty (30) days after receipt of invoice. Subsequent payments will be made in the same manner each month in succession for the remaining term of the contract. An audit to reconcile shortage or overpayment will be done at the end of the twelve-month cycle, at which time, if necessary, adjustments will be made for the remaining length of the contract. Any additional costs incurred by the vendor, such as service calls, will be paid on a monthly basis as they arise. Payments shall be made in accordance with applicable provisions of the "Local Government Prompt Payment Act" (50 ILCS 505/1 et seq.).

XIX. MODIFICATIONS, SUBSTITUTIONS, AND AMENDMENTS. The Chicago Park District may from time to time request changes in the scope of services to be performed under this contract, or it may become necessary to substitute one item for another. Such changes, including any increase or decrease in the amount of the awardee's compensation, which are mutually agreed upon by and between the Park District and the awardee, shall be incorporated in written amendments to the contract. No changes, amendments, modifications, substitutions, cancellation or discharge of the proposed contract, or any part hereof, shall be valid unless in writing and signed by the parties hereto, or their respective successors.

XX. DISPUTES. In the event any questions or disputes as to the meaning or requirements of anything in this contract arise, the matter shall at once be referred for consideration and decision to the General Superintendent of the Park District, who shall reduce his/her decision to writing and who shall mail or otherwise furnish a copy to the awardee(s). The decision of the General Superintendent shall be final and binding.

XXI. DEFAULT. Time is of the essence of the contract, and if the rendering of services or the delivery of acceptable items is not completed by the time promised, the Chicago Park District reserves the right, without liability, and in addition to its other rights and remedies, to terminate the contract by notice,

effective when received by the awardee, as to stated items not yet shipped or services not yet rendered, and to secure substitute materials and/or services from any other available source. The awardee shall be liable to and promptly reimburse the Chicago Park District for any difference in price, over and above the contract price, incurred by the Park District in purchasing substitute materials and/or services, from the time of non-performance to the contract expiration date. In addition to the difference in price, the awardee shall promptly reimburse the Park District for expenses in securing alternative goods, materials or services due to the awardee's failure to meet its obligations, and for all attorney's fees and court costs incurred to seek or enforce collection of said difference, costs, fees, and expenses, or any other amounts due the Park District. The Park District reserves the right to hold back any monies due the awardee at the time of the awardee's inability or failure to perform, and to deduct from these funds any said difference, costs, fees and expenses.

XXII. TERMINATION

A. Termination for Convenience: The Chicago Park District reserves the right to terminate a contract in whole or in part, without showing cause, upon giving written notice to the awardee. The Park District shall only pay for the goods delivered and accepted and/or services performed prior to the date of termination at the related contract unit prices. The awardee will not be reimbursed for any anticipatory profits that have not been earned up to the date of termination.

B. Termination for Cause: Failure on the part of the awardee to fulfill contractual obligations shall be considered just cause for termination of the contract, and the Chicago Park District shall have against the awardee all remedies provided by law and equity. The Park District shall have the option of paying for services performed and/or goods delivered and accepted by the Park District that are in compliance with the requirements of the contract documents prior to the date of termination, or the Park District may return the unused or unconsumed goods to the awardee without obligation for payment thereof or for any shipping costs associated therewith.

XXIII. AUDITS. The Park District reserves the right to conduct an audit, at the Park District's expense, for a period of two (2) years after the expiration of the term of the contract. The awardee shall make all records related to the Park District activities available for audit during regular business hours.

XXIV. NON-APPROPRIATION OF FUNDS. Payment and performance obligations for succeeding fiscal periods shall be subject to the availability and appropriation of funds. In the event that no funds or insufficient funds are appropriated and budgeted in any fiscal period, the Park District will notify the awardee of such occurrence.

XXV. SEPARATE CONTRACTS AND COOPERATIONS. The Park District reserves the right to obtain other contracts or to employ its own forces to do work adjacent to or immediately connected with services performed under this contract. Awardee shall cooperate with all other contractors and workmen employed by the Park District in such manner and to such extent as to facilitate the completion of all Park District contracts.

XXVI. OTHER SUPPLIERS. It shall be understood and become a condition of the contract that the Chicago Park District reserves the right to secure services from other suppliers when necessary.

XXVII. CHANGE OF ADDRESS OR BUSINESS INFORMATION. The Director of Purchasing must be notified immediately of any change of address of the awardee, or change in name and/or ownership, or of any change in the awardee's business organization as described in the Economic Disclosure Statement submitted with the proposal.

End of General Conditions

INSURANCE REQUIREMENTS

STANDARD RFP

RATING OF INSURANCE COMPANIES

The insurance company or companies providing the required coverage during the entire term of the contract shall be satisfactory to the Park District and shall carry a minimum policyholder rating of not less than "A" as listed in *Best's Key Rating Guide.*

CERTIFICATES OF INSURANCE

The awardee shall furnish to the Department of Purchasing, Chicago Park District, 541 North Fairbanks Court, 3rd Floor, Chicago, IL, 60611, original certificates of insurance evidencing the required coverage, in force on the effective date of this contract, and renewal certificates of insurance or some such similar evidence if the coverages have an expiration or renewal date occurring during the term of the contract.

The receipt of any certificate does not constitute agreement by the Park District that the insurance requirements for the contract have been fully met or that the insurance policies indicated on the certificate are in compliance with all of the contract requirements. The failure of the Park District to obtain certificates or other insurance evidence from the contractor shall not be construed as a waiver of the requirements by the Park District.

NAMED INSURED

Except for Workman's Compensation and Professional Liability, the awardee shall make the Chicago Park District, its Commissioners, Board members, officers, agents, and employees, individually and collectively, an additional insured.

TYPES AND LIMITS

Worker's Compensation Insurance and Employer's Liability insurance: in accordance with the laws of the State of Illinois, with statutory amounts covering all employees who are to provide a service under this agreement, with limits of not less than **$500,000** for each accident or illness.

Commercial General Liability Insurance: on an occurrence basis or equivalent with limits of not less than **$1,000,000** per occurrence, combined single limit, and **$2,000,000** aggregate, including but not limited to bodily injury, personal injury, property damage, products/completed operation, contractual liability, cross liability and severability of interest. *The Chicago Park District is to be named as an additional insured*.

Automobile Liability Insurance: When any motor vehicles are used in connection with work to be performed under this contract, the awardee or his subcontractors (if any) shall provide **$1,000,000** combined single limit per occurrence for bodily injury and property damage. Hired and non-owned vehicle coverage is to be included with any owned vehicle coverage. *The Chicago Park District is to be named as an additional insured.*

Professional Liability Insurance: with limits of liability no less than **$5,000,000**.

Blanket Crime Insurance or equivalent covering all persons handling funds under this Agreement against loss by employee dishonesty, forgery or alteration, funds transfer fraud, robbery, theft, destruction or disappearance, computer fraud, credit card forgery, and other related crime risks. The policy limit shall be written to cover losses in the amount of the maximum monies collected or received and in the possession of Contractor at any given time under this Agreement.

Cyber Liability Insurance: must be maintained with limits of mot less than **$5,000,000** for each occurrence or claim. Coverage must include but not be limited to network security and privacy liability including computer or

network system attacks (liability arising from the loss or disclosure of confidential information), privacy breach response coverage and costs, regulatory liability including fines and penalties, denial or loss of service, introduction, implantation and/or spread of malicious software code, unauthorized access to or use of computer systems, theft of data, and no exclusion/restriction for unencrypted portable devices/media may be on the policy. The Chicago Park District must be named as an additional insured and if policy contains an insured vs insured exclusion, the exclusion must be amended and not be applicable to the Chicago Park District.

Excess (Umbrella) Liability Insurance shall be maintained with limits not less than **$10,000,000.00**. The policy shall have an extended reporting period of two years.

PROVISIONS

1. Awardee shall advise all insurers of the contract's provisions regarding insurance.

2. Awardee's insurance is to be placed with insurers authorized to do business in the State of Illinois and with a *Best's* rating of no less than A, covering all operations under this contract. Exceptions to this provision are only at the discretion of the Chicago Park District's Director of Risk Management.

3. Awardee's insurance coverage shall be primary insurance as respects the Park District, its officers, officials, employees and volunteers. Further, the awardee agrees that insurers shall waive all rights of subrogation against the Chicago park District.

4 Submitter expressly understands and agrees that any insurance protection furnished by the submitter hereunder shall in no way limit its responsibility to indemnify and save harmless the Chicago Park District under the provisions of the contract.

5. Any insurance or self-insurance maintained by the Chicago Park District, its officers, officials, employees or volunteers shall not contribute to the awardee's insurance. The Chicago Park District shall have no responsibilities whatsoever to awardee with respect to any insurance coverage, its procurement, or the absence thereof.

6. The awardee's insurance shall provide for sixty (60) days prior written notice to be given to the Director of Risk Management in the event coverage is substantially changed, suspended, voided, canceled, or not renewed.

7. Submitter shall furnish separate certificates and endorsements for each subcontractor. Coverages for subcontractors shall be subject to all of the requirements stated herein.

8. The Park District maintains the right to modify, delete, alter or change these requirements.

End of Insurance Requirements

BUSINESS ASSOCIATE AGREEMENT

The Chicago Park District ("CPD") and _____ ("Business Associate") agree to the following terms and conditions, which are intended to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations.

The terms below that are capitalized and in bold have the same meanings as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, which is part of the American Recovery and Reinvestment Act of 2009, and the regulations promulgated thereunder, including the privacy, security, breach, omnibus, and enforcement rules, as each may be amended from time to time (collectively, "HIPAA"). See 45 CFR parts 160 and 164.

Specifically, the following terms used in the Business Associate Agreement shall have the same meaning as in HIPAA: **Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Financial Remuneration, Fundraising, Health Care Operations, Individual, Marketing, Minimum Necessary, Notice of Privacy Practices, Protected Health Information ("PHI"), Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information**, and **Use.** The term "**Breach**" has the meaning as set forth in HIPAA when capitalized below, but has the ordinary dictionary meaning when not capitalized below.

For purposes of this Business Associate Agreement, the term "Protected Health Information" or "PHI" includes electronic PHI, also known as ePHI.

1. Interpretation of this Business Associate Agreement. A reference in this Business Associate Agreement to HIPAA means the section in effect or as amended. If there is a dispute as to whether Business Associate is, in fact, a Business Associate, the Business Associate must provide a legal memorandum to the CPD indicating why the Business Associate does not fall under the definition of Business Associate in HIPAA. If the CPD disagrees with the legal memorandum regarding the Business Associate's conclusion that Business Associate is not a Business Associate, the CPD may choose to report a Breach to the Secretary or take other measures as deemed necessary to ensure the CPD's compliance with HIPAA. Any ambiguity or inconsistency in this Business Associate Agreement shall be resolved in favor of a meaning that permits CPD to comply with HIPAA.

2. Amendment of this Business Associate Agreement. The parties hereto agree to negotiate in good faith to amend this Agreement from time to time as is necessary for CPD to comply with the requirements of HIPAA and for Business Associate to provide services to CPD. However, no change, amendment, or modification of this Agreement shall be valid unless it is set forth in writing and signed by both parties.

3. Designation of HIPAA Officer(s). Business Associate agrees to designate, in writing, a HIPAA Privacy and Security Officer(s) who will communicate with the CPD's HIPAA Privacy and Security Officers for purposes of this Agreement. Business Associate agrees to notify the CPD's HIPAA Privacy and Security Officers of such designation and the contact information of such officer(s):

Nancy Currier
Human Resources Office
312-742-5220
Nancy.currier@chicagoparkdistrict.com

4. Uses and Disclosures of PHI. Business Associate must not use or further disclose Protected Health Information ("PHI") other than as permitted or required by this Agreement, as necessary to perform the services in this Agreement, or as Required By Law.

a. Business Associate will not sell PHI or use or disclose PHI for the purposes of marketing or fundraising.

b. Business Associate shall not directly or indirectly receive financial remuneration in exchange for any PHI of an individual or in exchange for making communications regarding treatment or health care operations purposes, unless otherwise allowed in this Agreement.

c. If Business Associate is authorized to use PHI to provide the CPD with de-identified information, Business Associate is not permitted to use or disclose the de-identified information for purposes other than those specified in the Agreement.

d. Business Associate may use PHI to provide data aggregation services to the CPD, relating to the health care operations of the CPD.

e. Business Associate may use and disclose PHI received by the Business Associate in its capacity as a Business Associate to the CPD, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that, as to any such disclosure, the following requirements are met:

i. The disclosure is required by law; or
ii. The Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been the subject of a Breach.

f. Except as otherwise limited in this Agreement, Business Associate may use and disclose PHI obtained from or on behalf of the CPD to perform functions, activities, or services for, or on behalf of, the CPD as specified in the Agreement, provided that such use or disclosure would not violate HIPAA if done by the CPD.

5. Minimum Necessary. Business Associate shall use, disclose, or request only the minimum necessary PHI necessary to accomplish the intended purpose of the use, disclosure, or request. Business Associate represents that the PHI used, disclosed, or requested by Business

Associate is the minimum necessary to carry out purposes of the Agreement. Prior to any use or disclosure, Business Associate shall determine whether a limited data set would be sufficient for these purposes.

6. Safeguards of PHI. Business Associate must use appropriate safeguards with respect to PHI that it creates, receives, maintains, or transmits on behalf of the CPD to prevent the use or disclosure of PHI other than as provided for in this Agreement. The safeguards must reasonably protect PHI from any intentional or unintentional use or disclosure in violation of HIPAA privacy regulations (45 CFR Part 164, subpart E) and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. The safeguards must also reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that Business Associate creates, receives, maintains, or transmits on the CPD's behalf as required by the HIPAA security regulations (45 CFR Part 164, subpart C). Where applicable, Business Associate must comply with the HIPAA security regulations (45 CFR Part 164, subpart C) with respect to electronic protected health information, to prevent the use or disclosure other than as provided for by this Agreement. Where feasible, PHI will not leave the CPD's facilities and will be accessed under the supervision of CPD employees.

7. Applicability of Business Associate Agreement to Subcontractors and Agents. Business Associate must ensure that any agent, including a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the Business Associate agrees to the same restrictions, conditions, and requirements that apply through this Agreement to Business Associate with respect to such information, by entering into a contract or other arrangement that complies with HIPAA. An agent or subcontractor of a Business Associate is not permitted to use or disclose PHI in a manner that would not be permissible if done by the Business Associate. Business Associate will ensure that its subcontractors and agents to which Business Associate is permitted by this Agreement or in writing by the CPD to disclose PHI agree to implement reasonable and appropriate safeguards to protect PHI. Business Associate will obtain reasonable assurances from any subcontractors and agents to which Business Associate discloses PHI that the subcontractor or agent will hold PHI in confidence and further use or disclose PHI only for the purpose for which Business Associate disclosed PHI to the subcontractor or agent or as Required By Law.

Business Associate will obtain reasonable assurances that any subcontractor or agent to which Business Associate discloses PHI will notify the Business Associate within five (5) calendar days (who will, in turn, notify the CPD within five (5) calendar days, as described below) of any instance in which the subcontractor or agent becomes aware of a Breach of unsecured PHI; possible Breach of unsecured PHI; any security incident of which it becomes aware, including: any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with agent or subcontractor's system operations of which agent/subcontractor becomes aware.

Agent/subcontractor is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on agent/subcontractor's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, agent/subcontractor may delay notification to Business Associate for the time period specified in HIPAA. Agent or subcontractor's report will include the information described in 45 CFR 164.404(c) and such other information as the Business Associate or the CPD may reasonably request.

8. Reporting of Breaches, Potential Breaches, and Security Incidents. Business Associate must report to the CPD any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, as well as any Breach of Unsecured PHI; potential Breach of unsecured PHI; any security incident of which it becomes aware; any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with Business Associate's system operations of which Business Associate becomes aware.

Business Associate will make the report to the CPD's HIPAA Privacy and Security Officers not more than five (5) calendar days after Business Associate discovers such non-permitted use or disclosure, Breach, security incident, or other incident as described above. Business Associate shall provide any reports or notices required by HIPAA as a result of Business Associate's Breach. On behalf of the CPD, Business Associate will provide such reports or notices to any party or entity (including but not limited to media, Secretary, and individuals affected by the Breach) entitled by law to receive the reports or notices. Business Associate agrees to pay the costs associated with notifying individuals affected by the Breach, which may include, but are not limited to, paper, printing, and mailing costs.

Business Associate is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on Business Associate's firewall; port scans; unsuccessful log-on attempts; denial of service attacks; and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, Business Associate may delay notifying CPD for the time period specified in HIPAA. Business Associate's report will include the information described in 45 CFR 164.404(c) and such other information as the CPD may reasonably request.

9. Mitigation and Penalties. Business Associate must mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach or of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement. Business Associate shall take reasonable steps to put corrective measures in place to prevent future Breaches (such as retraining employees and upgrading security systems). At the CPD's request, Business Associate shall take reasonable steps to mitigate the harm to affected Individuals whose PHI has been or may have been compromised as a result of a Breach by Business Associate, including obtaining credit monitoring services and offering identity theft insurance. To the extent that the CPD incurs civil or criminal monetary penalties as a result of a Breach by the Business Associate, the Business Associate agrees to reimburse the CPD for such penalties.

10. Designated Record Sets - Access. If the Business Associate has PHI in a Designated Record Set, then Business Associate must provide access to or otherwise make available, at the request of the CPD, and in the time and manner designated by the CPD, PHI in a Designated

Record Set, to the CPD or, as directed by CPD, to an Individual in order to meet the requirements under 45 CFR 164.524.

11. Designated Record Sets – Amendments. If the Business Associate has PHI in a Designated Record Set, then Business Associate must make any amendments to PHI in a Designated Record Set that the CPD directs or agrees to pursuant to 45 CFR 164.526 at the request of CPD or an Individual, and in the time and manner designated by the CPD.

12. Internal Practices, Books, and Records. Business Associate must make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the CPD available to the Secretary for purposes of determining compliance with HIPAA. Business Associate also must make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, the CPD available to the CPD in a time and manner designated by the CPD, for purposes of the Secretary determining CPD's compliance with HIPAA.

13. Accounting of Disclosures - Documentation. Business Associate must document the disclosures of PHI and information relating to such disclosures as would be required for CPD to respond to a request by an individual for an accounting of disclosures of PHI in accordance with HIPAA, specifically 45 CFR 164.528.

14. Accounting of Disclosures – Provision of Information. Business Associate must provide to CPD or an individual, in time and manner designated by CPD, information collected which relates to the disclosure of PHI, to permit CPD to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. If the Business Associate receives a request for accounting of disclosures directly from the individual, the Business Associate must respond to such request for an accounting of disclosures, provide the accounting of disclosures to the individual within the time required by 45 CFR 164.528, and provide the information regarding such request to the CPD, in the time and manner designated by the CPD.

15. Survival, Termination, and Return or Destruction of PHI. Upon termination of this Agreement for any reason, the Business Associate's obligations under these contractual obligations shall survive termination and remain in effect:

(a) until Business Associate has completed the return or destruction (in accordance with HHS guidance for destruction) of all of the PHI provided by CPD to Business Associate, or created or received by Business Associate on behalf of CPD, and

(b) to the extent that Business Associate retains any PHI.

Upon the expiration or termination of the underlying Agreement, if feasible, the Business Associate must either:

(a) return all PHI received from the CPD, or created, maintained, or received by Business Associate on behalf of the CPD, which the Business Associate still maintains in any form, to the CPD or

(b) destroy it, at the CPD's option (in accordance with the US Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals).

This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If it is infeasible for Business Associate to obtain, from a subcontractor or agent any PHI in the possession of the subcontractor or agent, Business Associate shall require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors' and/or agents' use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

In the event of a breach of the terms of these contractual obligations, the cure and remedies of the Agreement shall govern. HIPAA's privacy rule (45 CFR § 164.504(e)(2)) requires that the Business Associate will authorize termination of the contract by the CPD, if the CPD determines that the Business Associate has violated a material term of these contractual obligations.

16. Compliance with Obligations. To the extent the Business Associate is to carry out one or more of CPD's obligation(s) under Subpart E of 45 CFR Part 164, the Business Associate must comply with the requirements of Subpart E that apply to the CPD in the performance of such obligation(s). Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the CPD.

17. No Third Party Rights. The terms and conditions of this Agreement are intended for the sole benefit of Business Associate and CPD and do not create any third party rights.

18. Governing Law. To the extent not preempted by federal law, the Agreement shall be governed and construed in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective duly authorized officers or agents as of the date first above written.

CHICAGO PARK DISTRICT, AN ILLINOIS MUNICIPAL CORPORATION	NAME OF COMPANY
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

CHICAGO PARK DISTRICT

EMPLOYEE MEDICAL BENEFITS 2019

The attached summary describes certain benefits that the Chicago Park District offers to its employees. The summary is designed to provide employees with a general understanding of the Chicago Park District's benefit programs.

This document briefly summarizes the legal plan documents and in the event of any inconsistencies between the summary and the plan documents, the plan documents will control.

The Chicago Park District reserves the right to change, revise, or eliminate any of the benefits described in the summary at any time and in any manner, with or without notice, as provided by applicable law.

Blue Choice Options PPO

1. Blue Choice OPTIONS PPO, a three tier PPO, is designed in three tiers. ***You save*** *the most when you use doctors and hospitals in tier 1 – the Blue Choice OPT PPO network.* ***You pay*** *the most when you visit those in tier 3 (out of network providers).*
   The Blue Choice OPT PPO network (tier 1) has a variety of doctors and hospitals in the Chicago metropolitan area that can meet all your health care needs. These doctors and hospitals, which all meet BCBSIL's quality criteria, have agreed to offer you the care and services you need for a lower cost. In addition, with your Blue Choice Options benefit plan, you also get the highest level of benefits when you visit the doctors and hospitals in the Blue Choice OPT PPO network. You still have the options of choosing a doctor from a larger, statewide PPO network (tier 2) but you will pay higher out of pocket costs than with the Blue Choice OPT PPO network.

2. Preventive care visits and health screenings are covered at 100% in network only.

3. The emergency room copayment is $150

BLUE CHOICE OPTIONS (OPT) MEDICAL PLAN PPO

Covered Services	Blue Choice Options PPO		
	In Network-tier 1	In Network- tier 2	Out of Network – tier 3
Deductible > Individual > Family	 $300 $900	 $350 $1,050	 $1,500 $4,500
Out of pocket Maximum			
In Network > Individual > Family	 $1,000 $2,000	 $1,500 $3,000	 $3,500 $7,000
Preventive Care Visits and Health Screenings	Covered at 100%	Covered at 100%	Not covered
Office visits – non preventive office visits	$20 primary care $30 specialist	$25 primary care $35 specialist	40% of PPO allowed rate after the deductible plus balance of bill
Annual Deductible must be paid before Plan covers these services:	YOU PAY After Tier 1 deductible	You Pay After Tier 2 deductible	40% PPO allowed rate after out-of-network deductible plus balance billed by provider
Specialized imaging procedures such as CT/CAT scans, MRI and PET • Provided in a hospital setting • Provided in a free standing imaging center	 10% -0-	 25% -0-	 40% PPO allowed rate plus balance
Diagnostic laboratory • In a hospital setting • for covered lab tests with the lab savings program	 10% -0-	 25% -0-	 40% PPO allowed rate plus balance
Outpatient services > Surgical > Outpatient rehab – physical, occupational or speech therapy– limit 60 visits combined each calendar year	In Network 1 10%	In Network 2 25%	Out of Network 40% of PPO allowed rate plus balance of bill
Emergency Room Treatment	$150 plus 10% after the deductible has been met. Copay waived if admitted	$150 plus 10% after the deductible has been met. Copay waived if admitted	$150 plus 10% of PPO allowed rate after the deductible has been met Copay waived if admitted
Hospital Stay including surgery, anesthesiology, diagnostic testing	10%	25%	40% of PPO allowed rate plus the balance
Mental Health & **Substance Abuse** Inpatient hospitalization Office visits	 10% $20/$35	 25% $25/$35	40% of PPO allowed rate plus the balance
Alternatives to Hospital Care Skilled nursing facility Home health care, hospice care	10%	25%	40% of PPO allowed rate plus the balance
Maternity Services **Pre and post-natal visits** **Delivery and Hospital Stay**	 $20 first visit only 10%	 $25 first visit only 25%	40% of PPO allowed rate plus the balance
OTHER SERVICES			
Durable Medical Equipment (DME) Oral surgery	10%	25%	40% of PPO allowed rate plus the balance

Call the Benefit Value Advisor before you receive certain services 1-800-331-8032

Hospital - $500 penalty if Blue Cross not notified	Call before elective admission or within 48 hours of an emergency admission
Surgery – Organ transplant surgery (must be done in a Blue Distinction facility)	Call before surgery is scheduled
CAT SCAN, PET SCAN, Nuclear Imaging or an MRI	Call before the test is scheduled
Lab tests	Call before lab tests are scheduled
Home health care	Call before services start
Skilled nursing facility	Call before being admitted

WAYS TO SAVE MONEY WHEN USING THE PPO

Benefits Value Advisor - 1-800-331-8032
BlueCross BlueShield's Benefits Value Advisors will help you:

- Understand your benefits
- Find in-network doctors and hospitals to help avoid out-of-network costs
- Schedule doctor visits
- Get preauthorization for certain services

Save by using doctors and hospitals in the Blue Choice Options (OPT) PPO network:
The Blue Choice Options PPO gives you freedom to choose from three different network tiers. You can select doctors and hospitals (providers) from Tier 1 for some of your care and use Tier 2 providers for other services. You pay the lowest deductible and coinsurance when you use providers in Tier 1. Use the Provider Finder at ***www.bcbsil.com*** to locate Tier 1 providers or call 1-800-331-8032

Save on Lab TESTS – use a free standing lab:
Get your lab test paid in full by using a free standing lab which is not affiliated with or billed through a hospital. Quest and Labcorp have independent labs throughout the city and the Benefit Value Advisor can help you schedule your appointment. Tell your doctor that you will save money by using a free standing lab and request lab order for tests to be done at a Quest/Labcorp facility. Take this paperwork to the lab and tests results will be sent directly to your doctor. In contrast, deductibles and co-insurance amounts will need to be paid for lab services billed by a hospital.

Save on Scans – use a free-standing imaging center
Scans are covered 100% when done at a free-standing imaging center. When your doctor orders an MRI, CT, or a PET SCAN, call the Benefit Value Advisor to help locate a free standing imaging center near you. In contrast, if you have your SCAN or MRI done at a hospital, deductibles and co-insurance amounts will apply.

Save on time and maybe money – call the Nurseline at 1-800-299-0274
BCBS has nurses available 24 hours a day, 7 days a week to answer questions about your health and to try and help you decide whether you should go to the emergency room, urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma ▪ Dizziness or severe headaches ▪ High fever ▪ A baby's nonstop crying ▪ Cuts or burn ▪

BLUE ADVANTAGE HMO

- Blue Advantage HMO is the HMO offered to Chicago Park District monthly employees.
- Copayments for office visits are $25 with a $10 addition for specialists' visits.
- The hospital admission copayment is $200.
- The emergency room copayment is $150
- In or outpatient surgery has a $200 copayment

BLUE ADVANTAGE HMO – A BLUE CROSS HMO

If care is pre-approved by your HMO primary care physician (PCP) **YOU PAY**	
Doctor Visits	
Primary Care Physician	$25
Specialist	$35 copay when approved by PCP
Pre-natal visits	$25 copay first visit
HOSPITAL (all hospital services must be approved by PCP)	
Inpatient admission	$200 copay for inpatient admission
Surgery (inpatient and outpatient)	$200 copay for inpatient admission/$200 copay for outpatient surgery
Maternity delivery Care in the hospital for mother and baby	$200 admission copay
PREVENTIVE SERVICES	
Routine checkups for adults & children; well-baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing tests	$0 copay
EMERGENCY SERVICES	
Emergency Room treatment	$150 copay (waived if admitted)
Ambulance – life threatening	You pay $0
MENTAL HEALTH AND SUBSTANCE ABUSE (must be pre-approved by PCP)	
Outpatient therapy	$25 copay
Inpatient care	$200 copay each admission
OUTPATIENT REHAB THERAPY (must be pre-approved by PCP)	
Physical, speech and occupational therapy	$0 copay Limit of 60 visits combined each calendar year
OTHER SERVICES (all other services must be pre-approved by PCP)	
Skilled nursing facility	$0 Limited to 120 days a year
Durable Medical equipment Hospice Home health care Ambulance transport between hospitals	$0

For Non-Medicare Eligible Retirees

There are two medical plan options available for Non-Medicare eligible retirees: **BCBS Blue Choice Options PPO or BCBS HMO Blue Advantage.**

BCBS PPO

- The PPO medical plan has an in-network deductible of $400, and a family deductible of $1,200. (The deductible for a couple will be two times the individual deductible.) Out of network deductibles are $1,600 individual and $4,750 family.
- Out of pocket in network maximums is $1,600 for an individual and $3,200 for a family. Out of network maximum are $3,700 individual and $7,400 for family.
- The emergency room copayment is $150 in addition there is 10% coinsurance
- The Summary of Benefits Coverage is available and can be requested from the Benefits Department.

2019 Retiree PPO for Non-Medicare

Retiree PPO			
Network		**Broad Network**	
		YOU PAY	
		In Network	**Out of Network**
Annual Deductible	**Individual**	**$ 400**	**$ 1,600**
	Family	**$ 1,200**	**$ 4,750**
Out of Pocket Limit	**Individual**	**$ 1,600**	**$ 3,700**
	Family	**$ 3,200**	**$ 7,400**
Primary care visit to treat an injury or illness		**$15 then 10% coinsurance**	**40% after deductible**
Specialist visit		**$15 then 10% coinsurance**	**40% after deductible**
Other Practitioner		**20%**	**40% after deductible**
Preventive Care Visits and Health Screenings		**0**	**Not covered**
Annual Deductible Must be Met before Plan Covers These Services			
Inpatient covered services		**20%**	**40%**
Outpatient covered services		**20%**	**40%**
Physical, occupational or speech therapy limited to 60 visits combined per calendar year		**20%**	**40%**
Chiropractic care limited to 20 visits per year		**20%**	**40%**
Non administrator provider		**50%**	**50%**
Physician services		**20%**	**40%**
Emergency Room Services	**$150 copayment**	**10%**	**10%**

WAYS TO SAVE MONEY WHEN USING THE PPO

1. Use the Benefit Value Advisor

2. You save money when you use PPO physicians and hospitals

3. Save on lab tests – use a free standing lab. Hospitals charge much more for lab tests so use an independent lab whenever possible. Ask the benefit value advisor to help you find one

4. Save on high tech diagnostic services – Again, hospitals usually charge more for these services than free standing imaging centers. Again, your benefit value advisor can help you find one.

5. Call customer service at 1-800-299-0274 and ask for the Benefit Value Advisor

6. Save on time and maybe money – call the Nurseline 1-800-299-0274.
   BCBS has nurses available 24 hours a day, 7 days a week to answer questions about your health and to try and help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:
   - Asthma
   - Dizziness or severe headaches
   - High fever
   - A baby's nonstop crying
   - Cuts or burns
   - Sore throat
   - Back pain

BCBS HMO

- Chicago Park District provides access to Blue Advantage HMO.
- Remember that if you are in the Blue Advantage HMO and you want to switch doctors, you need to call the customer service number on your BCBSIL identification card. You do not have to wait until open enrollment to change doctors.
- Copayments for office visits are $25 with a $10 addition for specialists visits.
- The hospital admission copayment is $200.
- The emergency room copayment is $150
- The The Summary of Benefits Coverage is avaialbe and can be requested from the Benefits Department.

BLUE ADVANTAGE HMO – A BLUE CROSS HMO

If care is pre-approved by your HMO primary care physician (PCP) **YOU PAY**	
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HOSPITAL (all hospital services must be approved by PCP)	
Inpatient admission	$200 copay for inpatient admission
Surgery (inpatient and outpatient)	$200 copay for inpatient or outpatient surgery
Maternity delivery Care in the hospital for mother and baby	$200 admission copay
PREVENTIVE SERVICES	
Routine checkups for adults & children; well-baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing tests	$0 copay
EMERGENCY SERVICES	
Emergency Room treatment	$150 copay (waived if admitted)
Ambulance – life threatening	You pay $0
MENTAL HEALTH AND SUBSTANCE ABUSE (must be pre-approved by PCP)	
Outpatient therapy	$25 copay
Inpatient care	$200 copay each admission
OUTPATIENT REHAB THERAPY (must be pre-approved by PCP)	
Physical, speech and occupational therapy	Limit of 60 visits combined each calendar year $0 copay
OTHER SERVICES (all other services must be pre-approved by PCP)	
Skilled nursing facility	Limited to 120 days a year $0 copay
Durable Medical equipment; Hospice; Home health care; Ambulance transport between hospitals	$0 copay

CHICAGO PARK DISTRICT

EMPLOYEE DENTAL BENEFITS 2019

The attached summary describes certain benefits that the Chicago Park District offers to its employees. The summary is designed to provide employees with a general understanding of the Chicago Park District's benefit programs.

This document briefly summarizes the legal plan documents and in the event of any inconsistencies between the summary and the plan documents, the plan documents will control.

The Chicago Park District reserves the right to change, revise, or eliminate any of the benefits described in the summary at any time and in any manner, with or without notice, as provided by applicable law.

HUMANA DENTAL

Basic dental care is important: It prevents tooth decay, prevents gum disease, improves overall health and makes it possible for your teeth to last a lifetime. You have a choice of two Humana dental plans – a dental **HMO** or dental **PPO**.

The Chicago Park District offers the DPPO for the dental PPO and a Humana Dental DHMO HS205 Plan is offered for the dental HMO. This dental HMO has 169 unique general practice locations and 117 unique specialty locations.

Benefits are outlined here:

Plan	**DPPO**		**DHMO**
	In network	Out-of-network	**In network only**
	YOU PAY		
Diagnostic and Preventive Oral exams Cleanings X-rays (limits may apply)	$0	20% plus balance over usual and customary	$0
Deductible (Max of 3 per family)	$50	$50	No deductible
Simple restorative	20%	40% plus balance over usual and customary	Co-payments apply
Major restorative	40%	60% plus balance over usual and customary	Co-payments apply
Orthodontia*	50%	50% plus balance over usual and customary	Co-payments apply

***In the PPO, the orthodontic benefit** is for children **18** years of age or younger. This benefit is limited to a $1,000 lifetime maximum. In the **HMO** there is a $1,900 copayment.

Maximum dental benefits	$1,500	$1,500	**No annual maximum**

***PLEASE NOTE**: The HMO Plan **REQUIRES** you to select a dentist to enroll. If you do not choose a dentist you are only covered for a limited emergency benefit. If you need assistance, contact customer service at 1-800-979-4760 for help picking a dentist.

CHICAGO PARK DISTRICT

EMPLOYEE VISION BENEFITS 2019

The attached summary describes certain benefits that the Chicago Park District offers to its employees. The summary is designed to provide employees with a general understanding of the Chicago Park District's benefit programs.

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VISION PROGRAM

The Chicago Park District offers a voluntary Vision benefit for its full time employees through VSP, Vision Service Plan

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider	**VSP Provider Network: VSP Signature**	
WellVision Exam	Focuses on your eyes and overall wellness	$25 for exam	Every 12 months
	Prescription Glasses		
Frame	$150 allowance for a wide selection of frames $170 allowance for featured frame brands 20% savings on the amount over your allowance	Combined with exam	Every 24 months
Lenses	Single vision, lined bifocal and line trifocal lenses Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 35-40% on other lens enhancements	$50 $80-$90 $120-$160	Every 12 months
Contacts (instead of glasses)	$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	Glasses and Sunglasses • Extra $20 to spend on featured frame brands. Go to vsp.com /special offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider o the same day as your WellVision Exam, or get 20% from any VSP providers within 12 months of your last WellVision Exam. Retinal Screening - No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser Vision Correction - Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities After surgery, use your frame allowance (if eligible) for sunglasses from any VSP provider.		
Your Coverage with Out of Network Providers. Visit vsp.com for details, if you plan to see a provider other than a VSP network provider			
Exam up to $50 Single Vision Lenses up to $50 Lined Trifocal Lenses up to $100 Contacts up to $105	Frame up to $70 Lined Bifocal Lenses up to $75 Progressive Lenses up to $75		
VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.			

CONTACT US: 1-800-877-7195 or *www.VSP.com*.

CHICAGO PARK DISTRICT

PART-TIME EMPLOYEE (30 HOURS) BENEFITS 2019

The attached summary describes certain benefits that the Chicago Park District offers to its employees. The summary is designed to provide employees with a general understanding of the Chicago Park District's benefit programs.

This document briefly summarizes the legal plan documents and in the event of any inconsistencies between the summary and the plan documents, the plan documents will control.

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Part-Time Employee Benefits

The Chicago Park District offers the BCBS of IL Blue Edge HSA (high deductible plan) insurance plan for those part-time employees and their eligible child dependents who qualify for health plan coverage under the Affordable Care Act.

Eligibility requirements:

- Current employees - Worked a total of 1560 hours from the time period of November 1, 2017 – October 31, 2018, averaging 30 hours a week over a period more than 120 days.
- New Hires – Worked an average of 30 hours a week or 1560 hours or more within the 1st year of employment from their hire date.

Covered Services	**BlueEdge HSA**	
	In Network – YOU PAY	Out of Network - YOU PAY
Deductible > Individual > Family	 $6,000 $12,000	 $12,000 $24,000
Out of pocket Maximum In Network > Individual > Family	 $6,370 $12,700	 $12,700 $25,400
Preventive Care Visits and Health Screenings	Covered at 100%	100% until deductible is met; then 20% coinsurance
Office visits – non preventive office visits	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance $35 specialist
Specialized imaging procedures such as CT/CAT scans, MRI and PET	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Diagnostic laboratory	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Surgical >Outpatient rehab – physical, occupational or speech therapy– limit 60 visits combined each	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Emergency Room Treatment	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 20% coinsurance
Hospital Stay including surgery, anesthesiology, diagnostic testing	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Mental Health & **Substance Abuse** Inpatient hospitalization Office visits	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Maternity Services Pre and post-natal visits Delivery and Hospital Stay	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 40% coinsurance
Prescriptions	100% until deductible is met; then 20% coinsurance	100% until deductible is met; then 20% coinsurance. Specialty drugs not covered out of network.