SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Descriptions for Cook County Pension Fund Welfare Benefit Plans

Plan change effective on: January 1, 2020
Group Number: 902956

A Summary Plan Description (SPD) was published effective January 1, 2019. The following are modifications and clarifications that are effective January 1, 2020 unless otherwise noted below. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD is your complete SPD.

As you review this summary, it is important that you also review, Section 8, titled **Exclusions and Limitations.**

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPDs, the provisions of this SMM shall govern.

SECTION 3 - HOW THE PLAN WORKS

1. **For the Choice Plus Plan, The Eligible Expenses language described under *Eligible Expenses* in Section 3, *How The Plan Works is* hereby replaced in its entirety with the following:**

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 a result of an Emergency or 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.
    - 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 or data resources of competitive fees in a geographic area are not available, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. 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.

SECTION 5 - PLAN HIGHLIGHTS

Schedule of Benefits

1. **For the Choice Plus Plan, the *Annual Deductible and Annual Out-of-Pocket Maximum* is replaced under the Covered Health Services table as follows:**

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible[3] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person) **Coupon:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible	 $300 $600	 $600 $1,200
Annual Out-of-Pocket Maximum[3] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person) **Coupon:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Maximum	 $1,500 $3,000	 $5,000 $10,000

2. **For the Choice Plan, the *Annual Out-of-Pocket Maximum* is replaced under the Covered Health Services table as follows:**

Plan Features	Network Amounts
Annual Out-of-Pocket Maximum ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person) **Coupon:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Maximum	 $1,500 $3,000

3. **For the Choice Plan, the *Clinical Trials is* replaced under the Covered Health Services table as follows:**

Clinical Trials	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.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

1. **For the Choice Plus Plan some of the Prior Authorization Requirements in *Section 6: Additional Coverage Details* are replaced with the following:**

Hospice Care

For Non-Network Benefits, you must notify the Claims Administrator five business days before an inpatient admission.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

For Non-Network Benefits, you must 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Lab, X-Ray and Diagnostics - Outpatient

For Non-Network Benefits for Genetic Testing and sleep studies, you must notify the Claims Administrator five business days before scheduled services are received.

Reconstructive Procedures

For Non-Network Benefits you must 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

For Non-Network Benefits, you must 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

2. **The Choice Plus Plan is amended to replace the description of *Hearing Aids* in its entirety with the following**:

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.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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.

3. **The Choice Plan is amended to replace the description of *Hearing Aids* in its entirety with the following**:

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.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you

purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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.

4. **The Choice Plus and Choice Plans are amended to add the following language after the "Outpatient Treatment" bullet under the Benefit description for *Mental Health Services*:**

Mental Health Services

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

5. **The Choice Plus and Choice Plans are amended to add the following language after the "Outpatient Treatment" bullet under the Benefit description for *Neurobiological Disorders - Autism Spectrum Disorder Services*:**

Neurobiological Disorders - Autism Spectrum Disorder Services

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

6. **The Choice Plus Plan is amended to remove the following requirement under the *Physician's Office Services - Sickness and Injury* Benefit description:**

Physician's Office Services - Sickness and Injury

For Non-Network Benefits you must notify the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA is performed.

7. **The Choice Plus and Choice Plans are amended to replace the 4th bullet under the *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment Benefit* description as follows:**

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.

8. **The Choice Plus Plan is amended to replace the *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* Benefit description as follows:**

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 for Skilled Nursing Facility is limited to 90 days per calendar year and Inpatient Rehabilitation Facility is limited to 150 days per calendar year.

For Non-Network Benefits, you must 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

9. **The Choice Plan is amended to replace the *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* Benefit description as follows:**

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 for Skilled Nursing Facility are limited to 90 days per calendar year.

Benefits for Inpatient Rehabilitation Facility are limited to 150 days per calendar year.

10. **The Choice Plus and Choice Plans are amended to add the following language after the "Outpatient Treatment" bullet under the Benefit description for *Substance Use Disorder Services*:**

Substance Use Disorder Services

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

1. **The Choice Plus and Choice Plan exclusion #3 under the *Devices, Appliances and Prosthetics* exclusion is replaced in its entirety with the following:**

1. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

2. **The Choice Plus and Choice Plan exclusion #9 under the *Devices, Appliances and Prosthetics* exclusion is replaced in its entirety with the following:**

2. Powered and non-powered exoskeleton devices.

3. **The Choice Plus and Choice Plan exclusion # 2 under the *Drugs* exclusion is replaced in its entirety with the following:**

2. Self-administered or self-infused. 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). This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

4. **The Choice Plus and Choice Plan exclusion # 1 under the *Physical Appearance* exclusion is replaced in its entirety with the following:**

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.
- Sclerotherapy treatment of 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.

5. **For the Choice Plus and Choice Plan, exclusion #17 is added under *Procedures and Treatments*:**

17. Intracellular micronutrient setting.

6. **The Choice Plus and Choice Plan exclusions under *Reproduction* are replaced in their entirety:**

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. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:

- ♦ Assistive reproductive technology.
- ♦ Artificial insemination.
- ♦ Intrauterine insemination.
- ♦ Obtaining and transferring embryo(s).

- Health care services including:

- ♦ Inpatient or outpatient prenatal care and/or preventive care.
- ♦ Screenings and/or diagnostic testing.
- ♦ Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:

- ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
- ♦ Surrogate insurance premiums.
- ♦ Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
- Donor sperm – The cost of procurement and storage of donor sperm.

4. In vitro fertilization regardless of the reason for treatment.

5. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

6. The reversal of voluntary sterilization.

7. Contraceptive supplies and services.

7. **The Choice Plus and Choice plan exclusion # 2 under the *Transplants* exclusion is replaced in its entirety with the following:**

2. Health services for transplants involving animal organs

SECTION 10- COORDINATION OF BENEFITS (COB)

1. **For the Choice Plus and Choice Plan, effective February 1, 2020 the *When This Plan is Secondary* provision is replaced in its entirety with the following:**

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 the Medicare approved amount.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible and Coinsurance and Copay requirements of the Plan.

2. **For the Choice Plus and Choice Plan effective February 1, 2020, the *When a Covered Person Qualifies for Medicar*e provision is replaced in its entirety with the following:**

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 and disabled Dependents under age 65 who are Medicare eligible but do not meet the Cook County Pension Fund's Health Plan eligibility requirements for Medicare eligible members.

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 reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) 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 (as opposed to a provider who does not accept assignment of Medicare benefits), 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, UnitedHealthcare will apply the participating provider primary rate for covered services as the allowable expense. For non-participating providers, the rate UnitedHealthcare will apply is the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the allowable expense for both this Coverage Plan and Medicare.

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 the Medicare approved amount.
- 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.

SECTION 13 - OTHER IMPORTANT INFORMATION

1. **For the Choice Plus and Choice Plan. *The Relationship with Providers* provision is replaced in its entirety with the following:**

UnitedHealthcare has agreements in place that govern the relationships between it and Cook County Pension Fund and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

2. **For the Choice Plus and Choice Plan, the *Incentives to Providers* provision is replaced in its entirety with the following:**

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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 5, *Plan Highlights*.

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.

SECTION 14 - GLOSSARY

1. **The Choice Plus and Choice Plan is amended to replace the defined terms, *Genetic Testing, Gestational Carrier, Shared Savings Program and Surrogate* in their entirety with the following.**

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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 any applicable deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. 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.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

2. **The Choice Plan is amended to remove the defined term Domestic Partner in its entirety:**

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.