

**INTEREST ARBITRATION  
OPINION AND AWARD**

In the matter of Interest  
Arbitration

Between

CITY OF NAPERVILLE, ILLINOIS

And

ILLINOIS FRATERNAL ORDER OF  
POLICE LABOR COUNCIL

FMCS # 100615-03721-A

2-MA-09-143

Hearing Held

October 27, 2010  
City Council Chambers  
Naperville, Illinois

Appearances

For the Union:

Tamara L. Cummings, General Counsel  
Illinois FOP Labor Council  
5600 South Wolf Road, Suite 120  
Western Springs, Illinois 60558

Becky S. Dragoo, Field Supervisor  
Illinois FOP Labor Council  
974 Clock Tower Drive  
Springfield, IL 62704

Arbitrator

Robert Perkovich

For the City:

Dwight Pancottine, Labor and  
Employment Attorney  
City of Naperville  
400 South Eagle Street  
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Naperville, Illinois 60540

James Baird, Partner  
Clark Baird Smith  
6133 North River Road, Suite 1120  
Rosemont, Illinois 60018

## CONSENT AWARD

This matter came before the Neutral Arbitrator on October 27, 2010 for the purpose of conducting a mediation/arbitration hearing. After having reviewed the evidence, the respective positions of the Union and Employer, proposed resolutions and the relevant statutory factors, the following Award is issued:

1) ARTICLE 16, HOURS OF WORK AND OVERTIME

Section 16.2, Normal Work Periods and Overtime Pay

The normal work day shall be eight hours per day. Officers assigned to the patrol division shall have a normal workday of twelve hours per day. ~~The parties agree for this contract that if this issue of twelve-hour work days for patrol officers is an issue in negotiation of a successor agreement and is submitted to the statutory impasse resolution procedure under 5 ILCS 315/14, it shall not be considered a status quo issue for purposes of the "burden of proof".~~ Employees may be required to report fifteen (15) minutes before the beginning of their scheduled shift for roll call. Any hours exceeding eight (8) in a day or forty (40) in a week will be paid at the rate of one-and-one-half (1-1/2) times their regular rate of pay. Patrol officers working on a twelve hour shift schedule shall be paid overtime for hours exceeding twelve hours in a shift or eighty hours in a two week pay period. Overtime pay will be in fifteen (15) minute increments.

Officers assigned to work eight (8) hour shifts will be allowed to take a paid thirty (30) minute lunch break each day subject to availability and service calls. Officers assigned to work twelve (12) hour shifts will be allowed to take a paid sixty (60) minute lunch break each day subject to availability and service calls.

2) ARTICLE 24, WAGES

Section 24.2, Wage Rate Schedule

Step	Current		5/1/2009 (3.3%)		5/1/2010 (3.0%)		5/1/2011 (3.0%)	
	Hourly	Yearly	Hourly	Yearly	Hourly	Yearly	Hourly	Yearly
1	27.1140	\$56,397.12	28.0088	\$58,258.22	28.8490	\$60,005.97	29.7145	\$61,806.15
2	29.2494	\$60,838.75	30.2146	\$62,846.43	31.1211	\$64,731.82	32.0547	\$66,673.78
3	31.3330	\$65,172.64	32.3670	\$67,323.34	33.3380	\$69,343.04	34.3381	\$71,423.33
4	33.2129	\$69,082.83	34.3089	\$71,362.57	35.3382	\$73,503.44	36.3983	\$75,708.55
5	34.8736	\$72,537.09	36.0244	\$74,930.81	37.1052	\$77,178.74	38.2183	\$79,494.10
6	36.2686	\$75,438.69	37.4655	\$77,928.16	38.5894	\$80,266.01	39.7471	\$82,673.99
7	37.3567	\$77,701.94	38.5895	\$80,266.10	39.7472	\$82,674.08	40.9396	\$85,154.31
8	38.1038	\$79,255.90	39.3612	\$81,871.35	40.5421	\$84,327.49	41.7583	\$86,857.31

**Wage increases shall be retroactive to May 1, 2009 and to May 1, 2010, for all hours worked or paid as if worked. All current employees as of the date of this award, and those who retired or received medical disability during the term of this agreement shall receive retro pay for the time period that they were employed. Retroactive pay checks shall be issued separately within forty-five (45) days of the issuance of this award.**

3) ARTICLE 15, MEDICAL, DENTAL AND LIFE INSURANCE

Section 15.5

Employees participating in the medical insurance and/or dental insurance programs shall ~~effective May 1, 2006,~~ pay a monthly premium contribution of ten (10) percent of the monthly premium, as determined by the City, applicable to the plan(s) chosen by the employee. Monthly premium amounts may be adjusted each year of the contract on May 1. The employee premium contribution in these subsequent years shall be ten (10) percent of the adjusted premium not to exceed an annual increase of ten (10) percent. **On November 1, 2011 the premium contribution shall be increased to 15% of the adjusted premium. The ten percent annual increase cap shall not**

**apply to the calculation increasing the premium contribution from ten to fifteen percent.** Medical and dental insurance premium contribution levels effective May 1, ~~2006, 2009~~ and the maximum contribution levels for ~~2007 and 2008-2010 and 2011~~ are appended to this Agreement as **APPENDIX D.**

Section 15.6

The Employer agrees to continue medical and dental benefits provided for in this Article as set forth on the plan summary sheets appended to this agreement as **APPENDIX E until December 31, 2010. Effective January 1, 2011, the Employer will provide the medical and dental benefits provided for in this Article as set forth on the plan summary sheets appended to this agreement as APPENDIX E(1)**, provided that nothing in this agreement shall restrict the right of the employer to change insurance carriers, plan administrators, networks, to self insure, to change the method or manner of self insurance, to implement a health insurance program with multiple plan options, to participate in programs to reduce health insurance costs, or to use health maintenance groups or other similar programs. If any change is proposed in either benefits or charges to the employees, except as hereinafter provided, under said medical and/or dental program, such change shall be subject to negotiations between the parties before any such change shall be effective as to the Union employees. If the parties fail to reach Agreement, then the dispute will be subject to resolution in accordance with the procedures of Section 315/14 of the Public Labor Relations Act.

4) ARTICLE 18, LEAVES OF ABSENCE

Section 18.1, Personal Leave

All full-time permanent employees shall be granted two (2) days leave for personal business during each year of this contract without loss of pay, or deduction of sick leave. Personal business is defined as any business that cannot be conducted at a time not in conflict with the employee's regular work day, an emergency over which he has no control which requires immediate attention and the observance of a religious obligation. Notice of such leave shall be given as far in advance as is possible, and may be taken as a portion of a day, but in no event less than two (2) hours. A personal business day may not be used while an employee is on sick leave and may not be used during the week immediately before or after an employee's scheduled vacation, nor in conjunction with a holiday except in unusual or emergency circumstances but may be taken at the expiration of sick leave. A personal business day, or any portion thereof, that is unused at the end of each annual anniversary of this Agreement shall be dropped from the employee's record. If any full-time permanent employee shall take any personal leave prior to completing six (6) months of employment with the City, and shall leave the City's employment

during said six (6) month period, said employee shall be obligated to repay any said leave payment to the City and the City shall deduct any such amount from any funds owed by the City to said employee.

**On January 1, 2011, all active bargaining unit employees on the payroll at that time shall be granted eight (8) hours of additional personal leave which must be used no later than December 31, 2011. This leave must be taken as time off consistent with current practice in granting personal leave and cannot be converted to a cash payment. This shall be a one-time eight (8) hour grant for calendar year 2011 only. This term shall expire on the termination date of this agreement but shall not be applicable to the 2012 calendar year.**

5) ARTICLE 29, DURATION

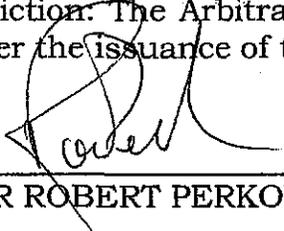
Section 29.1, Term of Agreement

This Agreement shall be effective ~~May 1, 2006~~, **May 1, 2009**, and shall remain in full force and effect until ~~April 30, 2009~~. **April 30, 2012**. It shall continue in effect from year to year thereafter unless notice of termination or demand to bargain is given in writing by certified mail by either party no earlier than one hundred fifty (150) days preceding expiration.

6) Tentative Agreements: All previously reached tentative agreements between the parties are hereby incorporated into this Award by reference and are identified as "Exhibit A".

7) All terms of the 2006-2009 collective bargaining agreement shall remain in effect except as changed or affected by the terms of this consent award.

8) Jurisdiction: The Arbitrator retains jurisdiction of this matter for ninety (90) days after the issuance of this Award.

Signed:   
ARBITRATOR ROBERT PERKOVICH

Date: October 29, 2010

**City of Naperville  
FOP - Police Officers  
Employee Premium Contribution Amounts**

	May 1, 2008	May 1, 2009 10%			May 1, 2010 10%		
		Premium Equivalent	City Contribution	Employee Contribution	Premium Equivalent	City Contribution	Employee Contribution
<b><u>Traditional PPO Plan</u></b>							
Single	\$44.30	\$439.46	\$395.50	\$43.96	\$498.58	\$450.24	\$48.34
Single + 1	\$91.44	\$907.13	\$816.41	\$90.72	\$1,029.17	\$929.39	\$99.78
Family	\$138.42	\$1,373.22	\$1,235.88	\$137.34	\$1,557.96	\$1,406.90	\$151.06
<b><u>Blue Advantage HMO</u></b>							
Single	\$39.22	\$445.92	\$402.78	\$43.14	\$425.97	\$383.37	\$42.60
Single + 1	\$75.80	\$861.91	\$778.55	\$83.36	\$823.34	\$741.00	\$82.34
Family	\$114.20	\$1,298.78	\$1,173.16	\$125.62	\$1,240.66	\$1,116.58	\$124.08
<b><u>Blue Edge PPO Plan</u></b>							
Single	\$33.02	\$327.59	\$294.83	\$32.76	\$371.66	\$335.62	\$36.04
Single + 1	\$68.16	\$676.23	\$608.61	\$67.62	\$767.21	\$692.82	\$74.38
Family	\$103.18	\$1,023.68	\$921.32	\$102.36	\$1,161.39	\$1,048.79	\$112.60
<b><u>Delta Dental</u></b>							
Single	\$2.42	\$24.64	\$22.18	\$2.46	\$25.31	\$22.77	\$2.54
Single + 1	\$4.86	\$49.26	\$44.32	\$4.94	\$50.60	\$45.54	\$5.06
Family	\$8.66	\$87.89	\$79.11	\$8.78	\$90.29	\$81.25	\$9.04

**City of Naperville**  
**FOP - Police Officers**  
**Employee Premium Contribution Amounts**

	May 1, 2011 10%		
	Premium Equivalent	City Contribution	Employee Contribution
<b><u>Traditional PPO Plan</u></b>			
Single	\$548.18	\$495.00	<b>\$53.18</b>
Single + 1	\$1,131.55	\$1,021.79	<b>\$109.76</b>
Family	\$1,712.94	\$1,546.78	<b>\$166.16</b>
<b><u>Blue Advantage HMO</u></b>			
Single	\$469.52	\$422.66	<b>\$46.86</b>
Single + 1	\$907.51	\$816.94	<b>\$90.57</b>
Family	\$1,367.49	\$1,231.00	<b>\$136.49</b>
<b><u>Blue Edge PPO Plan</u></b>			
Single	\$408.63	\$368.99	<b>\$39.64</b>
Single + 1	\$843.53	\$761.71	<b>\$81.82</b>
Family	\$1,276.92	\$1,153.06	<b>\$123.86</b>
<b><u>Delta Dental</u></b>			
Single	\$25.59	\$22.80	<b>\$2.79</b>
Single + 1	\$51.15	\$45.58	<b>\$5.57</b>
Family	\$91.26	\$81.32	<b>\$9.94</b>

	November 1, 2011 15%		
	Premium Equivalent	City Contribution	Employee Contribution
Single	\$548.18	\$465.95	<b>\$82.23</b>
Single + 1	\$1,131.55	\$961.82	<b>\$169.73</b>
Family	\$1,712.94	\$1,456.00	<b>\$256.94</b>
Single	\$469.52	\$399.09	<b>\$70.43</b>
Single + 1	\$907.51	\$771.38	<b>\$136.13</b>
Family	\$1,367.49	\$1,162.37	<b>\$205.12</b>
Single	\$408.63	\$347.34	<b>\$61.29</b>
Single + 1	\$843.53	\$717.00	<b>\$126.53</b>
Family	\$1,276.92	\$1,085.38	<b>\$191.54</b>
Single	\$25.59	\$21.75	<b>\$3.84</b>
Single + 1	\$51.15	\$43.48	<b>\$7.67</b>
Family	\$91.26	\$77.57	<b>\$13.69</b>



**BENEFIT HIGHLIGHTS**

**PPO Network**

**Mental Health & Chemical Dependency**

**Serious Mental Illness Treatment**

Subject to Overall Program Maximum

PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Inpatient:</b> \$15 Office visit copay \$25 Specialist copay 90% after deductible  <b>Outpatient:</b> \$15 Office visit copay \$25 Specialist copay 90% after deductible	<b>Inpatient:</b> 70% after deductible  <b>Outpatient:</b> 70% after deductible

**Other Mental Health & Chemical Dependency Treatment Services**

Subject to Overall Program Maximum

PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Inpatient:</b> \$15 Office visit copay \$25 Specialist copay 90% after deductible  <b>Outpatient:</b> \$15 Office visit copay \$25 Specialist copay 90% after deductible	<b>Inpatient:</b> 70% after deductible  <b>Outpatient:</b> 70% after deductible

**Additional Services**

**Muscle Manipulation Services\***

Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits.

- \$1,000 maximum per calendar year.

90% after deductible	70% after deductible
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**Therapy Services – Speech, Occupational and Physical\***

Coverage for services provided by a physician or therapist.

- \$5,000 maximum per therapy per calendar year

90% after deductible	70% after deductible
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**Temporomandibular Joint (TMJ) Dysfunction and Related Disorders\***

90% after deductible	70% after deductible
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**Other Covered Services**

- Private duty nursing\* - \$1,000 maximum per month
- Naprapathic services\* - \$1,000 maximum per calendar year
- Blood and blood components
- Ambulance services
- Medical supplies

80% after deductible

See paragraph below regarding Schedule of Maximum Allowances (SMA).

- Does not apply to any out-of-pocket limits

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotic, Prosthetic, Podiatrists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

**Discounts on Eye Exams, Prescription Lenses and Eyewear**

Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at [www.bcbstl.com/member](http://www.bcbstl.com/member) and click on the BlueExtras Discount Program link.

**Blue Care Connection (BCC)**

When members receive covered inpatient hospital services, coordinated home care, skilled nursing facility or private duty nursing from a participating provider in the state of Illinois, the member will be responsible for contacting the BCC pre-notification line. When using non-participating Illinois providers and out-of-state providers, members are required to contact the BCC pre-notification line 1 business day prior to any elective inpatient admission or within 2 business days after an emergency or maternity admission. Failure to pre-notify with the BCC when required will result in benefits being reduced by \$1,000.

**Schedule of Maximum Allowances (SMA)**

The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. Providers who do not participate in the PPO network are not obligated to accept the SMA as payment in full and may bill for the balance of their actual charge above and beyond the SMA. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

To Locate a Participating Provider: Visit our Web site at [www.bcbstl.com/providers](http://www.bcbstl.com/providers) and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.

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The HMOs of Blue Cross and Blue Shield of Illinois  
**BlueAdvantage HMO**

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300 East Randolph, Chicago, IL 60601 • Member Services: (800) 892-2803 • [www.bcbsil.com](http://www.bcbsil.com)

# 2010 Description of Coverage

City of Naperville  
January 1, 2010

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions, including external independent reviews.
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. **SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT**, for full benefit information please refer to your contract or certificate, or contact your health care plan at (800) 892-2803. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance or information, please contact the Illinois Department of Financial and Professional Regulation – Division of Insurance, Office of Consumer Health Insurance at (877) 527-9431 or in writing to either of the following addresses:

**320 West Washington Street  
Springfield, IL 62767-0001**

**100 West Randolph Street, Suite 15-100  
Chicago, IL 60601-3251**

You may also contact the department online at <http://www.idfpr.com>.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)



**BlueCross BlueShield  
of Illinois**

Basics		Description of Coverage		
<b>Your Doctor</b>		Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. A member's PCP and WPHCP must have a referral arrangement with each other. All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).		
<b>Annual Deductible</b>		none		
<b>Out-of-Pocket Maximum</b> (excludes drugs, vision, durable medical equipment and prosthetics)	Individual	\$1500/calendar year		
	Family	\$3000/calendar year		
<b>Lifetime Maximums</b>		none		
<b>Pre-existing Condition Limitations</b>		none		
In the Hospital		Description of Coverage	Health Care Plan Covers	You Pay
<b>Number of Days of Inpatient Care</b>		unlimited days	n/a	n/a
<b>Room &amp; Board Deductible</b>		private or semi-private room	100%*	\$100
<b>Surgeon's Fees</b>		covered	100%*	\$0
<b>Doctor's Visits</b>		covered	100%*	\$0
<b>Medications</b>		covered	100%*	\$0
<b>Other Miscellaneous Charges</b>		see exclusions	100%*	\$0
Emergency Care				
<b>Emergency Services</b> (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part)		Covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted.	100%	\$50
<b>Emergency Post-stabilization Services</b> covered if approved by PCP		primary care physician	100%*	\$15
		specialist	100%*	\$25

\* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

## EXHIBIT E-1

In the Doctor's Office	Description of Coverage	Health Care Plan Covers	You Pay
<b>Doctor's Office Visit</b> (copayment covers the visit and all covered services provided)	primary care physician	100%*	\$15
	specialist	100%*	\$25
<b>Routine Physical Exams</b>	covered	100%*	\$15
<b>Diagnostic Tests and X-rays</b>	covered	100%*	\$0
<b>Immunizations</b>	covered	100%*	\$0
<b>Allergy Treatment &amp; Testing</b>	covered	100%*	\$0
<b>Wellness Care</b>	covered	100%*	\$15
<b>Medical Services</b>			
<b>Outpatient Surgery</b>	hospital facility	100%*	\$75
	physician(s)	100%*	\$0
<b>Maternity Care</b>	Hospital Care	unlimited days	100%*
	Physician Care	copay, if any, for 1 <sup>st</sup> visit only	100%*
<b>Infertility Services</b>		based on your group policy	100%* if covered
<b>Non-Serious Mental Health</b>	Outpatient		100%*
	Inpatient		100%*
<b>Substance Abuse/ Chemical Dependency</b>	Outpatient		100%*
	Inpatient		100%*
<b>Serious Mental Health</b>	Outpatient		100%*
	Inpatient		100%*
<b>Outpatient Rehabilitation Services</b> (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*
<b>Outpatient Speech Therapy</b> (for Pervasive Developmental Disorder only)		20 visits/CY	100%*

\* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

EXHIBIT E-1

In the Doctor's Office		Description of Coverage	Health Care Plan Covers	You Pay
<b>Doctor's Office Visit</b> (copayment covers the visit and all covered services provided)		primary care physician	100%*	\$15
		specialist	100%*	\$25
<b>Routine Physical Exams</b>		covered	100%*	\$15
<b>Diagnostic Tests and X-rays</b>		covered	100%*	\$0
<b>Immunizations</b>		covered	100%*	\$0
<b>Allergy Treatment &amp; Testing</b>		covered	100%*	\$0
<b>Wellness Care</b>		covered	100%*	\$15
<b>Medical Services</b>				
<b>Outpatient Surgery</b>		hospital facility	100%*	\$75
		physician(s)	100%*	\$0
<b>Maternity Care</b>	Hospital Care	unlimited days	100%*	\$100
	Physician Care	copay, if any, for 1 <sup>st</sup> visit only	100%*	\$15
<b>Infertility Services</b>		based on your group policy	100%* if covered	\$25
<b>Non-Serious Mental Health</b>	Outpatient		100%*	\$25
	Inpatient		100%*	\$100
<b>Substance Abuse/ Chemical Dependency</b>	Outpatient		100%*	\$25
	Inpatient		100%*	\$100
<b>Serious Mental Health</b>	Outpatient		100%*	\$25
	Inpatient		100%*	\$100
<b>Outpatient Rehabilitation Services</b> (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*	\$0
<b>Outpatient Speech Therapy</b> (for Pervasive Developmental Disorder only)		20 visits/CY	100%*	\$0

\* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

Other Services	Description of Coverage	Health Care Plan Covers	You Pay	
<b>Durable Medical Equipment</b>	covered	100%*	\$0	
<b>Prosthetic Devices</b>	covered	100%*	\$0	
<b>Ambulance Service</b>	covered	100%*	\$0	
<b>Hospice</b>	covered	100%*	\$0	
<b>Coordinated Home Care</b> (excludes custodial care)	covered	100%*	\$0	
<b>Prescription Drug –</b> up to 34 day supply per script	Generic	based on your group policy	100%*	\$10
	Formulary Brand	based on your group policy	100%*	\$25
	Non-formulary Brand	based on your group policy	100%*	\$40
	Self-injectable	based on your group policy	100%*	\$50
<b>Prescription Drug –</b> up to 90 day supply per script visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call Member Services for information on the 90 day pharmacy network	Generic	based on your group policy	100%*	\$20
	Formulary Brand	based on your group policy	100%*	\$50
	Non-formulary Brand	based on your group policy	100%*	\$80
	Self-injectable	based on your group policy	100%*	\$50
<b>Dental Services</b>	see limitations, pages 6-7	100%*	\$15	
<b>Vision Care</b>	Exams	one every 12 months	100%*	\$15
	Eyewear	based on your group policy	0%	remainder after discount

\*HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

## Service Area

The HMO Illinois and BlueAdvantage HMO service areas include the Illinois counties of Boone, Christian, Cook, DeKalb, DuPage, Fulton, Greene, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, Lee, Livingston, Logan, Macoupin, Mason, McHenry, Menard, Monroe, Morgan, Ogle, Peoria, Sangamon, Stark, St. Clair, Stephenson, Tazewell, Whiteside, Williamson, Will, Winnebago and Lake county in Indiana. The HMO Illinois service area also includes Kenosha county in Wisconsin. *Please note: Some employer groups may have different service areas (see your employer for details) and the service area is subject to change.*

## Exclusions and Limitations

*To receive benefits, all care must be provided or coordinated by the member's Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP) or medical group/Independent Practice Association (IPA), except substance abuse/chemical dependency, vision care and hospital emergency care benefits, which are available at contracting providers without a PCP referral.*

Below is a summary list of exclusions and limitations. Your plan may have specific exclusions and limitations not included on this list – check *Your Health Care Benefit Program Certificate*.

### Exclusions

1. Services or supplies that are not specifically listed in *Your Health Care Benefit Program Certificate*.
2. Services or supplies that were not ordered by your primary care physician or Woman's Principal Health Care Provider, except as explained in the *Certificate*.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws.
5. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received; except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.
8. Custodial care services.
9. Long Term Care services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions, which are not specifically the result of mental illness.
12. Special education therapy, such as music therapy or recreational therapy.
13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
15. 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.
16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.
19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Marriage counseling.
23. Hypnotism.
24. Inpatient and Outpatient Private-Duty Nursing Service.
25. Routine foot care, except for persons diagnosed with diabetes.
26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the *Certificate*.
32. Hearing aids, except as stated in the *Certificate*.
33. Wigs (also referred to as cranial protheses).

### Limitations

In addition to the exclusions noted, the following limitations apply:

1. Benefits for oral surgery are limited to:
  - 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 the facial bone,
  - external incision and drainage of cellulitis,
  - incision of accessory sinuses, salivary glands or ducts, and
  - reduction of, dislocation of or excision of the temporomandibular joints.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
  - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility",
  - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or

- embryos from you, will be covered if you choose to use a surrogate,
- selected termination of an embryo in cases where the mother's life is not in danger,
  - cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
  - non-medical costs of an egg or sperm donor,
  - travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the plan,
  - infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
  - Infertility treatment rendered to your dependents under the age of 18.
7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.
8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.
9. Hospice benefits are only available for persons having a life expectancy of one year or less.
10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.
11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
- recreational sunglasses
  - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
  - additional charges for tinted, photo-sensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
  - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations
12. Durable Medical Equipment rental is covered up to the price of purchase.
13. Mental health and chemical dependency treatment benefits may be limited – see your *Certificate*.
14. Rehabilitation therapy benefits may be limited – see your *Certificate*.
15. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

### **Pre-certification and Utilization Review**

All benefits are provided or coordinated by your PCP or WPHCP. Therefore, certification by the member is not required. Utilization review is conducted by your medical group/IPA, not by the HMO. To ensure fair and consistent decisions regarding medical care, the HMOs of Blue Cross and Blue Shield of Illinois require medical groups/IPAs to use nationally recognized utilization review criteria.

### Primary Care Physician (PCP) Selection

Each member must join a contracting medical group/IPA and select a PCP affiliated with that medical group/IPA to provide and coordinate care. Each female member may also choose an OB/GYN to be her Woman's Principal Health Care Provider (WPHCP). A member's PCP and WPHCP must have a referral arrangement with each other. A member has access to her WPHCP as often as needed without a PCP referral. Members may change PCPs/WPHCPs – refer to the Member Handbook or *Certificate* for instructions and exceptions. Listings of contracting providers are available in the printed HMO directory or online at [www.bcbsil.com](http://www.bcbsil.com).

### Access to Specialty Care

If clinically appropriate, your PCP or WPHCP will refer you to a specialist, usually within the same medical group as your PCP. If the member's preferred network specialist does not have a referral arrangement with your PCP/WPHCP, you may choose a new PCP/WPHCP with whom the specialist has such an arrangement. You can ask your PCP for a standing referral for conditions that require ongoing care from a specialist physician. Standing referrals may be made for a specified number of visits or a time period up to one year. Specialist copays may differ, depending on plan design.

### Out-of-Area Coverage

When you are out of state, urgent care and hospital emergency room services are available through a network of contracting Blue Cross and Blue Shield providers. When you are out of state for a minimum of 90 consecutive days, guest membership may be arranged in participating communities throughout the U.S. with the Guest Membership Coordinator.

### Financial Responsibility

You are responsible for copayments at time of service, as shown in the Description of Coverage. You are also responsible for payment for care not provided or coordinated by your PCP or WPHCP, except where otherwise noted. You should contact your employer's benefit administrator to confirm the level of your contribution to the premium.

### Continuity of Treatment (Transition of Care)

If a physician you are currently obtaining services from leaves the HMO network, you have the right to request transition of care benefits. To qualify for transition of care services, you must currently be undergoing a course of evaluation and/or medical treatment or be in the second or third trimester of pregnancy. The ongoing evaluation and/or medical treatment concerns a condition or disease that requires repeated health care services under a physician's treatment plan, with the potential for changes in a therapeutic regimen.

Transitional services may be authorized for up to 90 days from the date the physician terminated from the network. Authorization of services depends on the physician's agreement to comply with contractual requirements and submit a detailed treatment plan, including reimbursement from the HMO at specified rates and adherence to the HMO's quality assurance requirements, policies and procedures. All care must be transitioned to your new HMO PCP in the medical group/IPA after the transition period has ended. Coverage will be provided only for benefits outlined in your *Certificate*.

**Existing members:** Submit a written Transition of Care request *within 30 days* of receiving notice of the termination of the physician or medical group/IPA.

**New members:** Submit a written Transition of Care request *within 15 days* after your eligibility effective date. When submitting the transition of care form prior to your effective date, please include a copy of the signed application and/or confirmation of enrollment with the HMO.

#### Submit the request to:

Blue Cross and Blue Shield of Illinois  
Customer Assistance Unit, Transition of Care  
300 East Randolph Street, 23rd Floor  
Chicago, IL 60601

Include the following information:

- Policyholder's name and work/home phone numbers
- Group and ID numbers

- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

You will be notified within 15 business days of the outcome of your Transition of Care request.

### Appeals Process

You can file an appeal by writing to the HMO or calling Member Services.

#### Non-urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

#### Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours – or no later than three calendar days – of the initial receipt of the clinical appeal request. You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your

PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

#### Non-clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out-of-area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within five business days of receiving your request. If your appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the Committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.



## City of Naperville

### Delta Dental PPO Plan Highlights

Group #8391

#### Introduction

The Delta Dental PPO program allows you to go to any in- or out-of-network general or specialty dentist at the time of treatment. City of Naperville dental enrollees have access to two managed care networks, Delta Dental PPO and Delta Dental Premier traditional fee-for-service. When you call your dentist's office to make an appointment, ask if your dentist participates in either Delta Dental PPO or Premier network. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist.** There are 121,000 Delta Dental PPO and 200,850 Delta Dental Premier dentist locations nationwide.

#### Choosing Your Dentist

Under your Dental Plan, you may go to any in- or out-of-network general or specialty dentist. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on pre-established, reduced fees; payment to Premier dentists is based on Delta's Maximum Plan Allowances (MPAs). In both networks, you only have to pay your coinsurance and deductible – *you are not responsible for charges exceeding the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.\**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is \$500 and the MPA is \$600. If your plan covers crowns at 50% and your dentist normally charges \$700, your out-of-pocket cost (excluding deductible) would be:

**Delta Dental PPO Dentist - \$250**  
(50% of the \$500 PPO fee allowance)

**Delta Dental Premier Dentist - \$300**  
(50% of the \$600 MPA)

**Out-of-Network Dentist - \$400**  
(50% of the \$600 MPA **plus** \$100 difference between the MPA and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your coinsurance and deductible; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta's MPAs as payment-in-full. If an out-of-network dentist's charge exceeds the MPA, you must pay the difference **plus** your coinsurance and deductible. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

*\*If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta, please call our customer service department at 1-800-323-1743.*

#### Non-Covered Services

There are some limitations on the expenses for which City of Naperville Dental Plan pays. For further information, refer to your certificate of coverage or call our customer service department.

#### Finding a Network Dentist

To verify your dentist's participation status, simply ask him/her if he/she is a Delta Dental PPO or Delta Dental Premier network dentist, call our automated phone system, contact our customer service department or visit our Web site.

Visit Delta Dental of Illinois' Web site at  
[www.deltadentalil.com](http://www.deltadentalil.com)

City of Naperville Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier networks. To locate a network dentist, click on Dentist Search in the Subscriber section.

You can search by:

- 1) City, state and ZIP code
- 2) Specialty
- 3) Dentist name (optional)

Summary of Benefits and Covered Services for City of Naperville

	<u>Delta Dental PPO Network</u>	<u>Delta Dental Premier Network</u>	<u>Out-of-Network</u>
<b>Calendar Year Maximum</b> <i>**Enrollees may carryover unused portions of their annual maximums to the new year's annual maximum. Maximum amounts eligible for carryover are subject to limitations.**</i>	\$1,500/person	\$1,000/person	\$1,000/person
<b>Calendar Year Deductible</b> (applies to basic & major)	\$50/person; \$150 /family	\$50/person; \$150/family	\$50/person; \$150/family
<b>Lifetime Orthodontia Maximum</b>	\$1,000/dependent	\$1,000/dependent	\$1,000 /dependent
<b>Preventive/Diagnostic</b>			
• oral evaluations (two per calendar year)	100% of reduced fee* deductible doesn't apply	80% of MPA** deductible doesn't apply	80% of MPA*** deductible doesn't apply
• X-rays (bitewings - two per calendar year; full mouth - once every three years)			
• prophylaxis (cleaning; two per calendar year)			
• fluoride treatment (once per calendar year for children under age 19)			
• space maintainers			
<b>Basic</b>			
• fillings	80% of reduced fee* deductible applies	80% of MPA** deductible applies	80% of MPA*** deductible applies
• sealants			
• oral surgery			
• periodontics			
• endodontics			
<b>Major</b>			
• crowns, jackets, cast restorations	50% of reduced fee* deductible applies	50% of MPA** deductible applies	50% of MPA*** deductible applies
• fixed/removable bridges			
• partial/full dentures			
• Implants related procedures (will alternate to benefit of crown or bridge based on consultant review)			
<b>Orthodontia</b>	50%	50%	50%

\*You will not be "balance billed" for charges exceeding Delta's allowed PPO fees.

\*\*You will not be "balance billed" for charges exceeding Delta's Maximum Plan Allowances (MPAs).

\*\*\*You are responsible for charges exceeding MPAs.

The preceding information is a brief summary of City of Naperville Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 1-800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

**City of Naperville**

**BENEFIT HIGHLIGHTS**

**PPO Network**

*This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.*

**Program Basics**

**PPO**  
(In-Network)

**Non-PPO**  
(Out-of-Network)

<b>Lifetime Benefit Maximum</b> Per individual		\$3,000,000
<b>Individual Coverage Deductible</b> Program deductible does not apply to services that have a copayment.	\$300	\$600
<b>Family Coverage Deductible</b> The family deductible maximum is equal to three individual deductibles.	3x individual	
<b>Individual Coverage Out-of-Pocket Expense (OPX) Limit</b> The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit: <ul style="list-style-type: none"> <li>• Reductions in benefits due to non-compliance with utilization management program requirements</li> <li>• Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)</li> <li>• Services that are asterisked below (*)</li> </ul>	\$1,500	\$5,100
<b>Family Coverage Out-of-Pocket Expense (OPX) Limit</b>	\$4,500	\$15,300

**Prescription Drug**

Retail & Mail Order: Maximum member copay per calendar year \$1000

<b>Prescription Drug Card (Retail)</b> 34 day supply	Generic Drugs: \$10 copay Brand Name: \$25 copay Non-Formulary Brand: \$40 copay
<b>Prescription Drug Card (Mail Order)</b> Prescription maintenance drugs provides up to a 90-day supply of maintenance drugs used on a continuous basis for treatment of chronic health conditions. Oral contraceptives are available through Mail Order only.	Generic Drugs: \$20 copay Brand Name: \$50 copay Non-Formulary Brand: \$80 copay

**Physician Services**

<b>Physician Office Visits</b> One copayment per person per day. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance. *Deductible and coinsurance apply in addition to copays.	\$15 Office visit copay \$25 Specialist copay 90% after deductible	70% after deductible
<b>Well Adult Care (age 16 and over)</b> Includes benefits for routine physical examinations, immunizations and routine diagnostic tests. 100% coverage for mammograms, PAP, Prostate, and Digital Rectal/Colorectal Cancer Screenings <ul style="list-style-type: none"> <li>• Unlimited benefits per calendar year. The Deductible does not apply for PPO claims</li> </ul>	90%	70% after deductible
<b>Well Child Care (to age 16)</b> Coverage for physical exams, immunizations and routine diagnostic tests. No Maximum of benefit <ul style="list-style-type: none"> <li>• Unlimited benefits per calendar year. The Deductible does not apply for PPO claims</li> </ul>	90%	70% after deductible.
<b>Maternity Services</b> All other maternity physician covered services are paid the same as Medical / Surgical Services.	90% after deductible \$25 Specialist copay for first visit.	70% after deductible
<b>Medical / Surgical Services</b> Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	90% after deductible	70% after deductible

**Hospital Services**

<b>Inpatient Hospital Services</b> Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.	90% after deductible	70% after deductible
<b>Outpatient Hospital Services</b> Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center.	90% after deductible	70% after deductible
<b>Outpatient Emergency Care (Accident or Illness)</b> The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.	90% after deductible	



## City of Naperville 1.1.10 CDHP PPO

## BENEFIT HIGHLIGHTS

## PPO Network

This provides only highlights of the benefit plans(s). After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

## Health Care Account (HCA)

## Contribution

Annual HCA Employer Contribution for Individual Coverage	\$500— every January 1 thereafter
Annual HCA Employer Contribution for Individual + 1 Coverage	\$750— every January 1 thereafter
Annual HCA Employer Contribution for Family Coverage	\$1,000— every January 1 thereafter
Maximum HCA Balance for Individual Coverage	\$1,000
Maximum HCA Balance for Individual + 1 Coverage	\$1,500
Maximum HCA Balance for Family Coverage	\$2,000

## Program Basics

PPO  
(In-Network)Non-PPO  
(Out-of-Network)

<b>Lifetime Benefit Maximum</b> Per individual	\$3,000,000	
<b>Individual Coverage Deductible*</b> The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$1,000 \$1,500 for Individual +1	
<b>Family Coverage Deductible*</b> Satisfied when the total of expenses applied to the deductible reaches the family deductible amount for all covered family members. No individual family member may meet any more than the individual deductible amount. The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$2,000	
<b>Individual Coverage Out-of-Pocket Expense (OPX) Limit</b> The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit: <ul style="list-style-type: none"> <li>• Reductions in benefits due to non-compliance with utilization management program requirements</li> <li>• Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)</li> <li>• Services that are asterisked below (*)</li> </ul>	\$3,000 \$4,500 for individual +1	\$6,000 \$9,000 for individual +1
<b>Family Coverage Out-of-Pocket Expense (OPX) Limit</b> Satisfied when the total expenses of all covered family members meet the Family Coverage OPX limit amount. Each family member may not meet more than the Individual Coverage OPX.	\$6,000	\$12,000
<b>Outpatient Prescription Drugs</b> Applies to all drugs at retail and mail.	80%	

## Physician Services

<b>Physician Office Visits</b> Includes coverage for office charge, diagnostic lab tests and x-ray services other than for routine care. For routine services, please refer to Well Adult Care and Well Child Care below.	80% after deductible	60% after deductible
<b>Well Adult Care (age 18 and over)</b> Includes unlimited benefits for routine physical examinations, immunizations and routine diagnostic tests.	100%	60% after deductible
<b>Well Child Care (to age 18)</b> Includes unlimited coverage for routine office visits included physical exams, immunizations and routine diagnostic tests.	100%	60% after deductible.
<b>Maternity Services</b> First prenatal visit (per pregnancy) and all other maternity physician covered services.	80% after deductible	60% after deductible
<b>Medical / Surgical Services</b> Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	80% after deductible	60% after deductible

## Hospital Services

<b>Hospital Admission Deductible</b> Per admission, per individual	\$0	\$300
<b>Inpatient Hospital Services</b> Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.	80% after deductible	60% after deductible



## City of Naperville 1.1.10 CDHP PPO

## BENEFIT HIGHLIGHTS

## PPO Network

This provides only highlights of the benefit plans(s). After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

## Health Care Account (HCA)

## Contribution

<b>Annual HCA Employer Contribution for Individual Coverage</b>	\$500— every January 1 thereafter
<b>Annual HCA Employer Contribution for Individual + 1 Coverage</b>	\$750— every January 1 thereafter
<b>Annual HCA Employer Contribution for Family Coverage</b>	\$1,000— every January 1 thereafter
<b>Maximum HCA Balance for Individual Coverage</b>	\$1,000
<b>Maximum HCA Balance for Individual + 1 Coverage</b>	\$1,500
<b>Maximum HCA Balance for Family Coverage</b>	\$2,000

## Program Basics

PPO  
(In-Network)Non-PPO  
(Out-of-Network)

<b>Lifetime Benefit Maximum</b> Per Individual	\$3,000,000	
<b>Individual Coverage Deductible*</b> The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$1,000 \$1,500 for Individual +1	
<b>Family Coverage Deductible*</b> Satisfied when the total of expenses applied to the deductible reaches the family deductible amount for all covered family members. No individual family member may meet any more than the individual deductible amount. The first services applied to the deductible each calendar year are paid from the HCA, provided there is any balance in the account. Remaining deductible is paid from the members' own funds.	\$2,000	
<b>Individual Coverage Out-of-Pocket Expense (OPX) Limit</b> The amount of money that any individual will have to pay toward <u>covered</u> health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit: <ul style="list-style-type: none"> <li>• Reductions in benefits due to non-compliance with utilization management program requirements</li> <li>• Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)</li> <li>• Services that are asterisked below (*)</li> </ul>	\$3,000 \$4,500 for Individual +1	\$6,000 \$9,000 for Individual +1
<b>Family Coverage Out-of-Pocket Expense (OPX) Limit</b> Satisfied when the total expenses of all covered family members meet the Family Coverage OPX limit amount. Each family member may not meet more than the Individual Coverage OPX.	\$6,000	\$12,000
<b>Outpatient Prescription Drugs</b> Applies to all drugs at retail and mail.	80%	

## Physician Services

## Physician Office Visits

Includes coverage for office charge, diagnostic lab tests and x-ray services other than for routine care. For routine services, please refer to Well Adult Care and Well Child Care below.

80% after deductible

60% after deductible

## Well Adult Care (age 16 and over)

Includes unlimited benefits for routine physical examinations, immunizations and routine diagnostic tests.

100%

60% after deductible

## Well Child Care (to age 16)

Includes unlimited coverage for routine office visits included physical exams, immunizations and routine diagnostic tests.

100%

60% after deductible.

## Maternity Services

First prenatal visit (per pregnancy) and all other maternity physician covered services.

80% after deductible

60% after deductible

## Medical / Surgical Services

Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.

80% after deductible

60% after deductible

## Hospital Services

## Hospital Admission Deductible

Per admission, per individual

\$0

\$300

## Inpatient Hospital Services

Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates.

80% after deductible

60% after deductible

**APPENDIX G**  
**DRT AGREEMENT**

Below is an addendum to the agreement between the Naperville Police Department and Naperville FOP Lodge #42 regarding the method of implementing DRT and filling in openings when a sick call occurs and the shifts fall below minimum staffing. This agreement is only in effect with the regard to twelve hour shifts.

**DRT SCHEDULING:**

DRT will automatically be linked to vacation, compensation time, personal time, holiday time (where the officer takes the day off), and training. It will not be linked to an individual sick day, unless the sick call is on the officers scheduled DRT day, DRT will not be rescheduled to move to a sick day. The exception is an FMLA sick day or an extended illness. DRT will only be given in four hour blocks. If the cancellation of an officer's DRT was due to a shortage on shift it will not be rescheduled and overtime will be paid to the officer whose DRT was cancelled. DRT already scheduled will not be re-arranged and rescheduled due to a shift shortage from an injury or extended illness etc. Canceling the DRT and paying overtime to the officers would fill these slots.

DRT will be scheduled by seniority on a three month basis, beginning in December 2006, February 2007, April 2007, and July 2007 and in subsequent years of this contract. The DRT selection will cover January through March, April through June, July through September, and October through December. There may be some overlap into the following month depending on when the start of the schedule year begins. All leave applications will be considered on a quarterly basis and will be accepted after each DRT selection is completed for the respective quarter. Leave applications will be turned into a supervisor from their shift or their watch commander if a shift supervisor is not available. The request will be dated and initialed by the supervisor and will be approved or denied within a 48 hour time period and returned to the officers follow-up folder. Leave applications received on the same date will be considered on a seniority basis. Leave applications received on different dates will be considered on a date received basis, first received first approved. The DRT schedule shall be set by the Watch Commander, shall continue to be bid by seniority and the City shall have the right to set the slots.

**SICK CALL, CALL IN PROCEDURE:**

Sick call on any shift:

1. If the call in is received 12 hours prior to the start of shift but less than 24 hours prior to the start of shift, the opposite company same shift will be called to fill the vacancy. If no one on the opposite company same shift will fill the vacancy then the members of the bargaining unit who are assigned as evidence technicians (investigations members), traffic officers, and tactical officers (all three units combined) would be called in seniority order to fill the vacancy. If no one takes the vacancy after the calling is completed, then reverse seniority of this entire group will be utilized and the junior officer will be forced to come into work.

2. If it is less than 12 hours prior to the start of shift, the available personnel on duty would be requested by seniority to hold over for four hours, and then procedure one would be followed. If this sick call results in the potential cancellation of drt on the shift, the officer whose drt is being cancelled would be asked if he/she would like to work the drt as overtime. If the officer does not want to work the overtime, then procedure one of the call in procedure would be utilized. If no one off duty accepts the 4 hours of drt overtime, then the officer's drt will be cancelled and he/she will be forced to "stay".
3. If the sick call, vacancy is known greater than 24 hours but less than five days then an email to the officers Naperville email address and a message to the on duty squad cars will be sent out asking for an officer to fill an opening that will occur, a minimum opportunity of four hours for officers to respond is required. This selection will be made strictly by seniority of those who respond.
4. Vacancies known greater than five days in advance will follow normal posting procedures.
5. Call in lists by seniority, company, shift, and specialty position will be maintained by the Watch Commander secretary.
6. No officer will be required to work more than 16 hours in a 24 period without receiving 8 hours of rest. Unless in a case of emergency, which must be documented by the on duty Watch Commander.

Agreed to by:

\_\_\_\_\_  
 Captain Gary J. Bolt  
 Patrol Division Commander  
 Naperville Police Department

Date: \_\_\_\_\_

\_\_\_\_\_  
 R. Joe Matshok / Vince Clark  
 President  
 Naperville F.O.P. Lodge #42

Date: \_\_\_\_\_

## APPENDIX I

### CITY OF NAPERVILLE AND F.O.P LODGE # 42 PHYSICAL FITNESS PROGRAM AGREEMENT

#### PURPOSE AND SCOPE:

The parties recognize the safety, health and productivity benefits that can be realized from promoting physical fitness of police officers. As a result, the parties have agreed to implement an incentive-based physical fitness program for the FOP Lodge #42 bargaining unit for the purpose of promoting and increasing the fitness and conditioning of the Naperville Police Department. This agreement shall be incorporated into the parties' collective bargaining agreement and shall replace the language currently found in article 25 of the agreement. Participation in this program is mandatory for all sworn officers in the Lodge #42 unit (hereinafter referred to as "Officers").

#### PARTICIPATION:

##### Eligibility

All officers are required to participate in this program. Officers who volunteer to participate in this test will be selected first. Then, officers will be selected to participate in reverse seniority order. Because the four exercises in the program involve strenuous physical exertion, all officers will first be required to obtain a written Medical Release (attached) from the Edward Hospital Corporate Health or from their personal physician. In addition, Health History and Physical Activity Readiness Questionnaires—PAR-Q (attached), must be filled out in advance and submitted to the examining physician prior to the any scheduled appointment. The signed release must be dated within 90 days of the actual fitness testing.

Officers who elect to obtain their medical releases from their personal physicians may do so at their own cost. On-duty officers may obtain their medical waivers from Edward Hospital Corporate Health or from their personal physician (if located within the City of Naperville) with proper supervisory notification and approval as outlined in Section 16.9, Changes in Normal Workweek and Workday of the parties' collective bargaining agreement. There will be every attempt to complete every aspect of this program during normal work hours. Officers will be compensated for all hours spent participating in this program in accordance with Article 24 of the collective bargaining agreement, except if they elect to use their own physician outside of Naperville.

The parties recognize that there may be officers who will not be able to obtain medical clearance to participate in the program. If an officer is medically precluded from participating in any program exercise, he shall submit to a complete physical examination

through the City or through his or her personal physician to determine what actions must take in order to participate. The officer's progress will be measured annually until he is medically cleared to participate in the program.

### **Frequency**

Officers shall be required to participate in the program on a biannual basis. The Chief of Police shall set a scheduling plan for the four exercises in consultation with FOP Lodge # 42 representatives. If an officer is unable to complete an exercise within the minimum standard (Bronze Standard), he will be required to retake that exercise every twelve months until he meets the minimum standard. It should be stressed that to attain goals, officers should not over-exert themselves but instead should seek to steadily improve their conditioning.

### **Fit for Duty Determinations**

The purpose of this program is to foster officer fitness and not to determine an officer's fitness for duty. As such, there will be no discipline associated with this program. The Chief of Police determines if an officer is physically fit for duty based solely on work-related duties and functions and not as a result of any of the physical fitness tests in this program. Likewise, FOP Lodge #42 continues to have a contractual right to challenge any fitness for duty determination made by the Chief of Police. Neither party's rights are abridged through their agreement to this physical fitness program.

### **Off Duty Workouts**

The City does not require officers to engage in workouts or other forms of physical exercise during their non-work time. As such, any workout or physical exercise engaged in by officers during non-work time in preparation for this program is voluntary and not covered under the Workers' Compensation statute.

### **Administration of the Program**

The Resource and Safety Management Section (R&SM) will be responsible for the administration and management of this program. Such responsibilities include recordkeeping of names, waivers, achievement time/number of each standard, monetary incentives, etc. In addition, R&SM will research and determine the most appropriate location to host this program based on cost, availability and scheduling.

### **STANDARDS AND INCENTIVES:**

All officers will participate in the four program exercises and will have an opportunity to earn incentives based upon goal attainment.

There will be three (3) levels of standards for each exercise - Bronze, Silver and Gold. The standards were chosen to make success within reach at the Bronze level for all officers who are willing to work for it, while the Silver and Gold levels will require extra effort and challenge, even for those who are currently fit. Monetary incentives will consist of a payment following the successful accomplishment of an exercise standard as follows: **Bronze Standard** - \$20 per exercise; **Silver Standard** - \$25 per exercise; and **Gold Standard** - \$40 per exercise.

**Standards**

<b><u>Test</u></b>	<b><u>Bronze Standard</u></b>	<b><u>Silver Standard</u></b>	<b><u>Gold Standard</u></b>
1.5 Mile Run	Time 16:28	Time 15.32	Time 14.36
1 Rep Max Bench Press or Minimum Push Up (1 minute Time limit)	64% of Body Weight or 25 Push-ups	73% of Body Weight or 27 Push-ups	82% of Body Weight or 29 Push-ups
Minimum Sit-Ups (1 minute time limit)	29 Sit-ups	32 Sit-ups	35 Sit-ups
Vertical Jump	16 Inches	17 Inches	18.5 Inches

**EFFECTIVE DATE**

This program takes effect on May 1, 2010.

City of Naperville

F.O.P Lodge #42

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Dated: April \_\_, 2010