EXHIBIT 3
Korshak: Municipal Emp. Fund's Counterclaims

12/16

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - CHANCERY DIVISION

CITY OF CHICAGO, A Municipal Corporation, Plaintiff vs MARSHALL KORSHAK, ETAL., Defendants MUNICIPAL EMPLOYEES' ANNUITY AND BENEFIT FUND OF THE CITY OF CHICAGO, ETAL., Counterplaintiffs vs CITY OF CHICAGO, A Municipal Corporation, Counterdefendant	)	No. 87 CH 10134

NOTICE OF FILING

TO: See Attached Service List.

Please take Notice that on December 16, 1987 pursuant to Order of Court we caused to be filed Verified Counterclaim For Injunction And Other Relief, and Petition For Preliminary Injunction.

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The Attorneys for the Fund

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STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

CERTIFICATE OF SERVICE

The undersigned, being duly sworn on oath, states that I have served a copy of the foregoing Verified Counterclaim For Injunction And Other Relief, and Petition For Preliminary Injunction, pursuant to Supreme Court Rule 220, to the attorneys address herein named, mailed with proper postage pre-paid, on this 16th day of December, 1987, before the hour of 5:00 p.m..

Georgia Danhelka

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this Certificate Of Service are true and correct.

Georgia Danhelka

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726-0504

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - CHANCERY DIVISION

CITY OF CHICAGO, a Municipal Corporation,

Plaintiff,

vs.

MARSHALL KORSHAK, et al,

Defendants.

MUNICIPAL EMPLOYEES' ANNUITY AND BENEFIT FUND OF THE CITY OF CHICAGO, et al,

Counterplaintiffs,

vs.

CITY OF CHICAGO, a Municipal Corporation,

Counterdefendant.

No. 87 CH 10134

FILED
DEC 16 PM 1:14

VERIFIED COUNTERCLAIM FOR INJUNCTION AND OTHER RELIEF

Counterplaintiffs, MUNICIPAL EMPLOYEES' ANNUITY AND BENEFIT FUND OF THE CITY OF CHICAGO, WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, AND THOMAS G. SULLIVAN, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE MUNICIPAL EMPLOYEES' ANNUITY AND BENEFIT FUND OF THE CITY OF CHICAGO, complain of the Counterdefendant, the CITY OF CHICAGO, a Municipal Corporation, as follows:

Preliminary

1. Counterplaintiffs, MUNICIPAL EMPLOYEES ANNUITY AND BENEFIT FUND OF THE CITY OF CHICAGO ("the Fund") was established in accordance with Section 8-192 of the Municipal Employees, Officers and Official Annuity And Benefit Fund, Ill. Rev. Stat. Ch. 108½, Sec.8-192.

2. The Fund maintains its principal place of business in Chicago, Cook County, Illinois.

3. Counterplaintiffs, WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, AND THOMAS G. SULLIVAN, are each members of the retirement board of the Fund.

4. Various retirees and certain spouses of deceased city employees receive a monthly annuity from the Fund and have medical insurance coverage under the City of Chicago Annuitant Medical Benefits Plan ("the City's Plan").

5. The Fund is engaged, inter alia, in the business of administering certain annuity and disability insurance programs for certain retired employees who are members of the Fund and their dependents.

6. Counterdefendant, the CITY OF CHICAGO ("the City") is a municipal corporation, organized in accordance with Section 1-1-1 of the Illinois Municipal Code, Ill. Rev. Stat. Ch. 24, Sec. 1-1-1.

7. Some or all of the acts complained of herein took place in Cook County, Illinois.

8. Beginning in and continuously since approximately 1964, many of the Fund's annuitants have participated, with active City of Chicago employees, in a group medical benefits program sponsored by the City. That program, since the mid-1970's, has been administered on a self-funded, "claims made" basis. There is no insurance policy issued by an insurance company to cover claims made by the annuitants. Rather, when a covered claim is submitted by a covered individual, whether an active employee or a covered annuitant,

the City simply reimburses the private carriers which administer the program as the City's agents, and which pay the claims made by the covered individuals.

9. Approximately 5,500 of the Funds' annuitants currently participate in the City-sponsored group medical benefits program. Those annuitants, together with their spouses and other dependents who also may be covered by the program, comprise a group of approximately 7,000 individuals. A true and accurate copy of the City of Chicago Annuitant Medical Benefits Plan ("the City's Plan"), which has been in effect since September 1, 1985, is attached hereto and incorporated herein as Exhibit A.

10. Since July 18, 1985, there has been in force and effect in the State of Illinois, a certain statute known as Section 8-164.1 of the Municipal Employees, Officers and Official Annuity and Benefit Fund Annuity Fund Act, Ill. Rev. Stat. Ch. 108-1/2, Sec. 8-164.1. That statute provides in relevant part:

> "Each employee annuitant in receipt of an annuity on the effective date of this Section and each employee who retires on annuity after the effective date of this Section, may participate in a group hospital care plan and a group medical and surgical plan approved by the Board if the employee annuitant is age 65 or over with at least 15 years of service. The Board, in conformity with its regulations, shall pay to the organization underwriting such plan the current monthly premiums up to the maximum amounts authorized in the following paragraph for such coverage.
>
> As of the effective date the Board is authorized to make payments up to $25 per month for employee annuitants age 65 years or over with at least 15 years of service.
>
> If the monthly premium for such coverage exceeds the $25 per month maximum authorization, the difference between

> the required monthly premiums for such coverage and such maximum may be deducted from the employee annuitant's annuity if the annuitant so elects; otherwise such coverage shall terminate.
>
> Amounts contributed by the city as authorized under Section 8-189 for the benefits set forth in this Section shall be credited to the reserve for group hospital care and group medical and surgical plan benefits and all such premiums shall be charged to it.

11. Between the mid-1960's and April of 1982, the monthly rates charged the annuitants by the City for their medical benefits coverage were periodically increased. Nonetheless, since the mid-1970's, when the City's Plan became self-funded, the City has been subsidizing a portion of the costs of the annuitants' medical benefits.

12. Effective April 1, 1982, the City established the following monthly rates for the Fund's annuitants' medical benefits coverage:

Under Age 65 - Single	$ 55.00
Under Age 65 - Family	150.00
Medicare Eligible - Single	21.00
Medicare Eligible - Two	42.00
One Over 65, One Under Age 65	76.00

13. Notwithstanding the provisions of Section 8-164.1 of the Municipal Employees, Officers and Official Annuity And Benefit Fund, and notwithstanding the fact that the actual cost of the coverage has increased dramatically since 1982, these rates for the Fund's annuitants' medical benefits coverage have remained unchangedto the present date. Since April of 1982 the City has subsized the cost of the Fund's annuitants' medical benefits to the extent that they exceed the rates established at that time.

14. Both the Fund and the City have at all times been aware that the rates in effect since the mid-1970's were substantially less than the actual costs incurred by the City in paying the Fund's annuitants' medical claims under the Plan (together with the costs of administering that Plan). In September of 1984, for example, the City prepared a report titled "City of Chicago Annuitant Medical Care Benefits" in which it demonstrated the large disparity between contributions from the Fund, and the similar funds for other retired City employees, and the actual costs being incurred by the City. A copy of that report is attached hereto as Exhibit B.

15. The 1984 "City of Chicago Annuitant Medical Care Benefits" report proposed that the rates paid by the annuitants be increased by 100% effective two months later, in November of 1984, and increased by another substantial percentage three months after that, in January of 1985.

16. Despite this and other periodic "proposals" from the City that the annuitants' health insurance rates be increased the Fund was never directed to begin making deductions for "single" annuitants or to increase the amounts being deducted from the annuitants' monthly checks for the cost of their dependents' health insurance.

17. In mid-October of 1987, the director of the Fund received a letter from the Corporation Counsel for the City advising the Fund that from 1980 to the present the City has paid health care costs for the annuitants of the City's four

pension funds in excess of the contributions made by the funds towards those costs. A copy of that letter is attached hereto as Exhibit C. That letter further advised the Fund that the payments made by the City were not the subject of any appropriation and were thus illegal and must be repaid. The letter also advised the Fund that the City had filed a complaint in the Circuit Court of Cook County, naming as defendants the trustees of the four funds, asking that $59 million be repaid (18.5 million from the retirement fund), plus interest, and that the funds contract for health benefits as required by statute. Finally, the Corporation Counsel advised the Fund that he had directed the City's Benefits Office to cease making health care payments to pension fund annuitants as soon as each of the respective pension funds enters contracts for health insurance but in no event no later than January 1, 1988.

18. The complaint referred to in the Corporation Counsel's letter was filed on October 19, 1987, and is styled City of Chicago v. Marshall Korshak et al., 87 CH 10134. A True and accurate copy of that complaint is attached hereto as Exhibit D.

COUNT I - TERM AND CONDITION OF EMPLOYMENT

1.-18. As paragraphs 1 through 18 of this Count I, Counter plaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of this Counter Complaint.

19. Since the mid-1960's the City has paid the full cost of medical insurance coverage for City employees. Since 1971, the City has paid the full cost of medical benefits for the active employees of the City and for their spouses and dependents.

20. For the past ten years it has been common knowledge among the active City employees that the annuitants participate in the City's Annuitant Medical Benefits Plan and that the City subsidizes a substantial portion of the cost of its annuitants' medical care benefits.

21. The active City employees for the past ten years, relied upon this retirement benefit in continuing their employment with the City.

22. The City's inclusion of the annuitants in its medical benefits program and its subsidization of a substantial portion of the cost of its annuitants' medical care benefits thus became a term and condition of employment for active employees of the City.

23. The City's announced intention to terminate medical care benefits for the Fund's annuitants as of December 31, 1987, is a breach of those terms and conditions of these employment contracts with the City.

24. It would be inequitable and unjust to permit the City to breach these established terms and conditions of employment.

25. The Fund and its annuitants will suffer substantial and irreparable harm if the City is not enjoined from terminating the medical care benefits it has provided to them for the past 20 years. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate their medical benefits coverage on December 31, 1987.

26. Counterplaintiffs have no adequate remedy at law.

COUNT II - IMPLIED CONTRACT

1.-18. As paragraphs 1 through 18 of this Count II, Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City's actions described above gave rise to an implied contract between the Fund, the annuitants and the City under which the City agreed to subsidize the cost of the annuitants' medical benefits coverage in excess of the rates established for the medical benefits coverage effective April 1, 1982.

20. The City's letter to the Fund dated October 19, 1987 and its filing of the complaint described in paragraphs 17 and 18 above constitute a breach of that implied contract.

21. The Fund and its annuitants will suffer substantial and irreparable damage if the City is not enjoined from terminating the implied contract under which it agreed to and has, for more than five years, subsidized the annuitants' health insurance costs in excess of the rates effective April 1, 1982. Termination of the contract on January 1, 1988 would expose the annuitants to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage.

22. It would be inequitable and unjust to permit the City to breach this implied contract.

23. Counterplaintiffs have no adequate remedy at law.

COUNT III - BREACH OF CONTRACT

1.-18. As paragraphs 1 through 18 of this Count III, Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City has undertaken to provide medical benefits coverage to the Fund's annuitants since the mid-1960's and has been in a contractual relationship with each annuitant who chose to participate in the City's medical benefits program during this twenty year period.

20. The Fund's annuitants are presently covered by the City's Plan attached hereto as Exhibit A.

21. The City's Plan, which by its terms was effective September 1, 1985, provides as follows regarding "Termination of Coverage:"

> Coverage for you and your eligible dependents will terminate the first of the month following
>
> - the month a deduction is not taken from your annuity, or
>
> - the month you reach the limiting age for City-paid benefits, if you have not arranged for deductions from your annuity check.
>
> In addition, coverage for you and your eligible dependents will terminate the earliest of
>
> - the date it is determined that you have knowlingly submitted false bills or bills for ineligible dependents for reimbursement under this Plan
>
> - the date the Plan is terminated, or
>
> - the date the Plan is terminated for the class of Annuitant of which you are a member.

22. The City's Plan does not itself contain any procedures or time frame regarding a notice of intent to terminate the Plan.

23. In the absence of an express term, a reasonable notice period must be implied.

24. The City's letter of October 19, 1987, informing the Fund that coverage would be terminated no later than December 21, 1987 is not, under the circumstances presented here, a reasonable period of notice of intent to terminate the Plan.

25. Upon receipt of the City's October, 1987 letter, the Fund contacted a number of private health insurance companies and requested quotations as to the cost of coverage for the approximately

7,000 individuals (the annuitants and their dependents) who are now covered by the City's Plan.

26. The Fund is awaiting those price quotations.

27. When the Fund has the price quotations and details of the coverage being offered by the private carriers, it will then have to determine whether to approve the plan, see Ill. Rev. Stat. Ch. 108-1/2 Sec. 8-164.1.

28. This process, involving the solicitation and evaluation of proposals from various private carriers, negotiating and executing contracts with one or more of them, and giving the annuitants reasonable notice of the terms and costs of the new coverage, will not and cannot be accomplished by the City's announced termination date of January 1, 1988.

29. The City has breached the Plan by failing to give sufficient notice of its intent to terminate the Plan.

30. It would be inequitable and unjust to permit the City to terminate the City's Plan on such short notice.

31. The Fund's annuitants will suffer substantial and irreparable harm if the City is permitted to terminate the City's Plan on such short notice. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate coverage effective January 1, 1988.

32. Counterplaintiffs have no adequate remedy at law.

COUNT IV - EQUITABLE ESTOPPEL

1.- 18. As paragraphs 1 through 18 of this Count IV Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City has engaged in a continuous pattern of affirmative acts over the past ten years by subsidizing a substantial portion of the cost of the annuitants' medical care benefits. Since April of 1982, the City has subsidized all costs in excess of the rates which went into effect at that time.

20. The City's actions have been taken with full knowledge of the actual amounts expended by it for the annuitants' medical care benefits.

21. The Fund and its annuitants have reasonably relied on the City's subsidization of those costs.

22. In reliance on this longstanding practice of the City, the Fund took no steps until after receipt of the City's letter of October 19, 1987, to locate a private health insurance carrier to provide medical insurance to the Fund's annuitants and the annuitants have not planned for the financial burden of having to pay the full cost of their own medical insurance.

23. It would be inequitable and unjust to permit the City to terminate this practice.

24. If the City is permitted to terminate the annuitants' medical care benefits on December 31, 1987, the Fund and its annuitants will suffer substantial and irreparable harm. The annuitants will be exposed to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage.

25. The City is estopped from terminating this long standing practice.

26. Counterplaintiffs have no adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, Counterplaintiffs pray for a judgment, order and decree against the counterdefendant as follows:

A. That the City of Chicago be restrained and enjoined, both temporarily and permanently, from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan.

B. That the City of Chicago be restrained and enjoined from ceasing its practice of subsidizing the cost of the Fund's annuitants' medical benefits to the extent that it exceeds the rates which went into effect in April of 1982.

C. That in the alternative, the City of Chicago be restrained and enjoined from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan until the Fund has had sufficient time to contract for similar medical benefits coverage with a private insurance carrier.

D. That this Court retain jurisdiction of this action to enforce its injunction order.

E. For such other and further relief as this Court may deem just and proper together with the costs of this action.

One of the Attorneys for Counterplaintiffs

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.

Executive Director

Frederick P. Heiss
William A. Marovitz
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EXHIBIT 3
Korshak: Firemen Fund's Counterclaims

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - CHANCERY DIVISION

CITY OF CHICAGO, a Municipal Corporation, Petitioner, vs. MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS, and JAMES McDONOUGH, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE POLICEMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; MICHAEL A. COHEN, NORMAN S. HOLLAND, ANN FOLEY, JAMES R. CONMEY, WALTER S. KOZUBOWSKI, RONALD D. PICUR, RONALD MALONEY, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE FIREMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, and EDWARD J. LAIRD, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE MUNICIPAL EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; ROGER E. McMAHON, RONALD D. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE LABORERS' & RETIREMENT BOARD EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000, Respondent.	)	No. 87 CH 10134

VERIFIED COUNTER-COMPLAINT
FOR INJUNCTION AND OTHER RELIEF

Counterplaintiffs, Michael A. Cohen, Norman S. Holland, Ann Foley, James R. Conmey, Walter S. Kozubowski, Ronald D. Picur, Ronald Maloney, and Cecil A. Partee, in their capacity as the Board Members of the Firemen's Annuity and Benefit Fund by their

attorneys, Martin J. Burns and Thomas J. Esler, as their counterclaim against the City of Chicago, counterdefendant, allege as follows:

Preliminary

1. The Retirement Board of the FIREMEN'S ANNUITY & BENEFIT FUND OF THE CITY OF CHICAGO ("the Fund") was established in accordance with Section 6-174 of the Firemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2, ¶6-174. The Fund maintains its principal place of business in Chicago, Cook County, Illinois.

2. Counterplaintiffs Michael A. Cohen, Norman S. Holland, Ann Foley, James R. Conmey, Walter S. Kozubowski, Ronald D. Picur, Ronald Maloney, and Cecil A. Partee are each Members of the Retirement Board of the Fund.

3. The Fund is engaged, inter alia, in administering certain annuity, disability and group health benefits for disabled and retired fire fighters and other employees of the City of Chicago's Fire Department ("Annuitants"), their spouses, and their dependents.

4. Counterdefendant, the CITY OF CHICAGO ("the City"), is a municipal corporation, organized in accordance with Section 1-1-1 of the Illinois Municipal Code, Ill. Rev. Stat. ch. 24, ¶1-1-1.

5. Some or all of the acts complained of herein took place in Cook County, Illinois.

6. Beginning in, and continuously since, approximately 1976, many of the Fund's annuitants and dependents have participated, with active City of Chicago Fire Fighters and other

employees of the City of Chicago's Fire Department, in a group medical benefits program sponsored by the City. That program has been administered by insurance companies, but is financed on a self-funded, "claims made" basis. No insurance policy is issued by an insurance company to cover health care costs incurred by the annuitants and their dependents. Rather, when a covered claim is approved and paid by the insurance companies which administer the program, the City reimburses them.

7. Approximately 4,000 of the Fund's annuitants, including surviving spouses, currently participate in the City-sponsored group medical benefits program. Those annuitants, together with their spouses and other dependents who also may be covered by the program, comprise a group of approximately 6,000 individuals.

8. Since January 12, 1983, there has been in force and effect in the State of Illinois, Section 6-164.2 of the Firemen's Annuity and Benefit Fund Act, Ill. Rev. Stat. ch. 108-1/2, ¶6-164.2. That statute provides, in relevant part:

* * *

> (b) The Board shall contract with one or more carriers to provide group health insurance for all annuitants.
>
> * * *
>
> (d) The Board shall pay the premiums for such health insurance for each annuitant with funds provided as follows:
>
> The basic monthly premium for each annuitant shall be contributed by the city from the tax levy prescribed in Section 6-165, up to a maximum of $55 per month if the annuitant is not qualified to receive medicare benefits, or up to a maximum of $21 per month if the

annuitant is qualified to receive medicare benefits.

If the basic monthly premium exceeds the maximum amount to be contributed by the city on his behalf, such excess shall be deducted by the Board from the annuitant's monthly annuity, unless the annuitant elects to terminate his coverage under this Section, which he may do at any time.

9. Since approximately 1965, active Fire Fighters, and certain Fund annuitants, and dependents have participated in a City-sponsored medical benefits program without any contribution required from them; other Fund annuitants and their dependents have been covered upon payment of a contribution which was not directly related to the total cost of the benefits provided to the group.

10. Effective April 1, 1982, the City established the following monthly rates for certain of the Fund's annuitants' medical benefits coverage:

Under Age 65 - Single	$ 55.00
Under Age 65 - Family of Two	110.00
Under Age 65 - Family of Three or more	150.00
Medicare Eligible - Single	21.00
Medicare Eligible - Two	42.00
One Over 65, One Under Age 65	76.00

11. Consistent with the aforesaid provisions of Section 6-164.2 of the Firemen's Annuity Fund Act, these rates for the Fund's annuitants' and dependents' medical benefits coverage have remained unchanged to the present date.

12. Also consistent with the provisions of Section 6-164.2 of the Firemen's Annuity Fund Act, the City of Chicago has

entered into labor agreements with Chicago Fire Fighters Union, Local 2 which provide:

(Article XII of the Labor Contract covering the period January 1, 1982 through December 31, 1983):

> Section 12.1 Hospitalization and Medical Coverage, Dental, Optical, Life Insurance Programs
>
> A. The Employer agrees to make available to eligible employees and their eligible dependents the hospitalization and medical program attached hereto as Appendix C, the dental plan attached hereto as Appendix D, and the optical plan attached hereto as Appendix E. The definition of eligible employees and eligible dependents is set forth in each respective program or plan. The Employer shall contribute the full cost of eligible employee and eligible dependent coverage.
>
> B. The Employer also agrees to make available to the following other persons the hospitalization and medical program, the dental plan, and the optical plan: employees who retire at age 63 (i.e., mandatory retirement) and their eligible dependents; widows and children of employees killed in the line of duty; former employees on pension disability (both duty and occupational) and their eligible dependents; widows and children of deceased employees who were formerly on pension disability. The Employer will contribute the full cost of coverage for any of the above enumerated persons who elect coverage under any plan or plans. However, coverage under a plan for such persons shall terminate when a person either reaches the age of 65 or ceases to be a dependent as defined in a plan, whichever occurs first.
>
> In addition to the foregoing, it is expressly understood that the coverage herein provided shall be subject to coordination of benefits on a non-duplicating basis; i.e., if any of the persons covered herein are also covered by another hospitalization, dental or optical plan, then said other plan shall be

considered the primary plan and the benefits payable under any plan provided herein shall be reduced by the amount paid by the other plan, but in no event shall the coordination of benefits allow for payment of more than 100% of allowable expenses.

C. Employees who retire before the age of 63 (i.e., early retirement) shall be allowed to remain in the hospitalization and medical program until reaching age 65, provided they pay the following premium costs:

(1) From January 1, 1982 to April 1, 1982: a maximum of $38.26 per month for single coverage and $114.68 for family coverage if they elect Blue Cross; or a maximum of $26.00 per month for single coverage and $68.00 per month for family coverage if they elect Bankers Life.

(2) Beginning April 1, 1982, the hospitalization and medical premiums shall be frozen for the term of this agreement at a maximum of $55.00 per month for single coverage; $110.00 per month for coverage of a family of two (2); $150.00 per month for coverage of a family of more than two (2).

(Article XII of the Labor Contract covering the period from January 1, 1984 through December 31, 1987):

Section 12.1 Hospitalization and Medical Coverage, Dental, Optical, Life Insurance Programs

A. The Employer agrees to make available to eligible employees and their eligible dependents the 'City of Chicago Medical Care Plan for Employees, which became effective October, 1984,' and the City dental plan and the City optical plan also provided to City employees. The definition of eligible employees and eligible dependents is set forth in each respective program or plan. However, for the Medical Care Plan only, eligible dependents are those dependents who are unmarried and less than 25 years of age regardless of an employee's date of hire. The Employer shall contribute the full cost

of eligible employee and eligible dependent coverage.

B. The Employer also agrees to make available to the following other persons the hospitalization and medical program, the dental plan, and the optical plan: widows and children of employees killed in the line of duty; former employees on pension disability (both duty and occupational) and their eligible dependents; widows and children of deceased employees who were formerly on pension disability. The Employer will contribute the full cost of coverage for any of the above enumerated persons who elect coverage under any plan or plans. However, coverage under a plan for such persons shall terminate when a person either reaches the age of 65 or ceases to be a dependent as defined in a plan, whichever occurs first.

In addition to the foregoing, it is expressly understood that the coverage herein provided shall be subject to coordination of benefits on a non-duplicating basis; i.e., if any of the persons covered herein are also covered by another hospitalization, dental or optical plan, then said other plan shall be considered the primary plan and the benefits payable under any plan provided herein shall be reduced by the amount paid by the other plan, but in no event shall the coordination of benefits allow for payment of more than 100% of allowable expenses.

C. Employees who retire pursuant to the pension statute shall be allowed to participate in the City of Chicago Annuitants Medical Benefit Plan until reaching age 65, provided they pay the then current contribution rate. The following are the current contribution rates:

1. A maximum of $55.00 per month for single coverage;

2. $110.00 per month for coverage of a family of two (2);

3. $150.00 per month for coverage of a family of more than two (2).

(Copies of the above Labor Contract Articles are attached hereto as Exhibits A and B.)

13. The City acknowledged and took credit for the fact that the required contributions were not necessarily equal to individual costs incurred for covered health care benefits. The City, as many employers in private industry, paid the excess, if any, between the contributions received from the Annuitant and the cost of the benefits provided to the Annuitant and/or dependents.

14. The Annuitants relied upon that practice in deciding whether, and when, to retire. The Annuitants rightfully expected that their medical benefit insurance coverage or its cost to them would remain unchanged, or that any changes would only occur in the same bargaining process that culminated in the labor agreements referred to in Paragraph 12.

15. By letter of October 19, 1987, the Trustees of the Fund were advised by the City's Corporation Counsel, that medical insurance coverage for Annuitants and dependents would cease no later than January 1, 1988.

COUNT I - TERM AND CONDITION OF EMPLOYMENT

1-15. As paragraphs 1 through 15 of this Count I, the counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 15 of this Counterclaim.

16. It has been common knowledge among active City of Chicago firemen and other employees that the Annuitants of the

Fund were protected by the City's Annuitant Medical Benefits Plan upon the payment of a reasonable contribution.

17. The Active City of Chicago firemen and other employees relied upon this retirement benefit in continuing their employment with the City.

18. Many Annuitants while actively employed relied upon this practice of the City.

19. The City's inclusion of the Annuitants and their dependents in its medical benefits program and its payment of any cost of the Annuitants' medical care benefits in excess of contributions received became a term and condition of employment for all employees of the Fire Department of the City who were actively employed during the time the aforesaid benefits and practice were in effect.

20. The City's announced intention to terminate medical care benefits for the Fund's annuitants as of December 31, 1987, is a breach of the terms and conditions of employment with the City.

21. It would be inequitable and unjust to permit the City to breach these established terms and conditions of employment.

22. The Fund, the current annuitants and the future annuitants will suffer substantial and irreparable harm if the City is not enjoined from terminating the medical care benefits it has provided to them. The annuitants will be exposed to the risk of financial catastrophe and a denial of medical service if

the City is permitted to terminate their medical benefits coverage on December 31, 1987.

23. Counterplaintiffs have no adequate remedy at law.

COUNT II - IMPLIED CONTRACT

1.-15. As paragraphs 1 through 15 of this Count II, counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 15 of this Counterclaim.

16. The City's actions described above gave rise to an implied contract between the Fund, the Annuitants and the City under which the City agreed to provide medical benefits coverage to the Annuitants.

17. The City's letter to the Fund, dated October 19, 1987, and its filing of the complaint in this cause, constitute a breach of that implied contract.

18. The Fund and its Annuitants will suffer substantial and irreparable damage if the City is not enjoined from terminating the implied contract under which it agreed to provide, and has provided, medical benefits coverage to the Annuitants and their dependents. Termination of the coverage on January 1, 1988 would expose the Annuitants to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage. Further, Annuitants and their dependents may be denied necessary medical service because many health care providers will not provide medical service without proof of medical insurance.

19. It would be inequitable and unjust to permit the City to breach this implied contract.

20. Counterplaintiffs have no adequate remedy at law.

COUNT III - BREACH OF CONTRACT

1.-15. As paragraphs 1 through 15 of this Count III, counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 15 of this Counterclaim.

16. The City has undertaken to provide medical benefits coverage to the Fund's Annuitants since the mid-1960's and has been in a contractual relationship with each Annuitant who chose to participate in the City's medical benefits program during this twenty year period.

17. The Fund's Annuitants are presently covered by the City's Plan pursuant to the labor agreement provision set forth in paragraph 12. Said labor agreement is effective until December 31, 1987, and thereafter until changed or amended by the parties.

18. The City of Chicago and Fire Fighters Local No. 2 are currently in negotiations as to the terms and conditions of employment to be effective after December 31, 1987. Article XII of the existing Labor Contract has not been changed or amended and will continue in effect beyond December 31, 1987 if no labor agreement is reached and ratified by that date.

19. The City's unilateral attempt to terminate the health care coverage of Annuitants and their dependents no later than December 31, 1987 constitutes a clear violation of Article XII of the present Labor Contract.

20. If the City is permitted to terminate the annuitants' medical care benefits on December 31, 1987, the Fund and the Annuitants will suffer substantial and irreparable harm. The Annuitants will be exposed to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage. Furthermore, the Annuitants may be denied medical services because many health care providers will not provide services without proof of medical insurance.

21. The counterplaintiffs have no adequate remedy at law.

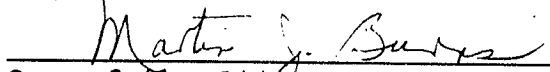
PRAYER FOR RELIEF

WHEREFORE, counterplaintiffs pray for a judgment, order and decree against the City as follows:

A. That the City of Chicago be restrained and enjoined, both temporarily and permanently, from terminating coverage of the Fund's Annuitants and their dependents under the City of Chicago Annuitant Medical Benefits Plan;

B. That this Court retain jurisdiction of this action to enforce its injunction order;

C. For such other and further relief as this Court may deem just and proper together with the costs of this section.



One of the Attorneys for Plaintiffs

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as foresaid that he verily believes the same to be true.

NORMAN S. HOLLAND

JACOBS, BURNS, SUGARMAN & ORLOVE
201 North Wells Street, Suite 1900
Chicago, Illinois 60606
(312) 372-1646
Attorney's ID No. 01725

Pursuant to Section 2-611 of the Illinois Code of Civil Procedure, the undersigned certifies that he has read the above Countercomplaint For Injunction and other relief; that to the best of his knowledge, information and belief formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in cost of litigation.

MARTIN J. BURNS

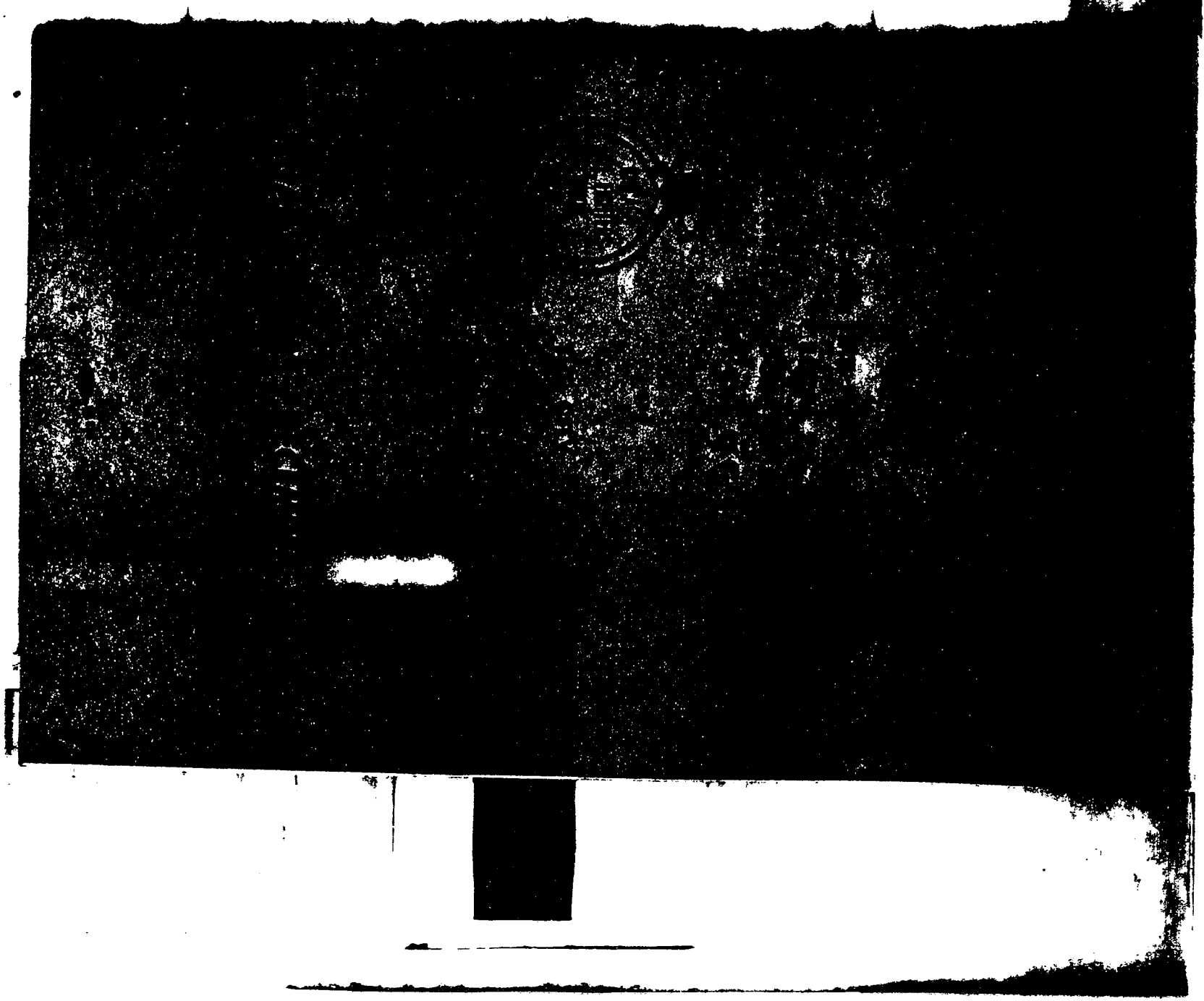


EXHIBIT "A"

ARTICLE XII
SAFETY, HEALTH & WELFARE

Section 12.1 Hospitalization and Medical Coverage, Dental, Optical, Life Insurance Programs

A. The Employer agrees to make available to eligible employees and their eligible dependents the hospitalization and medical program attached hereto as Appendix C, the dental plan attached hereto as Appendix D, and the optical plan attached hereto as Appendix E. The definition of eligible employees and eligible dependents is set forth in each respective program or plan. The Employer shall contribute the full cost of eligible employee and eligible dependent coverage.

B. The Employer also agrees to make available to the following other persons the hospitalization and medical program, the dental plan, and the optical plan: employees who retire at age 63 (i.e., mandatory retirement) and their eligible dependents; widows and children of employees killed in the line of duty; former employees on pension disability (both duty and occupational) and their eligible dependents; widows and children of deceased employees who were formerly on pension disability. The Employer will contribute the full cost of coverage for any of the above enumerated persons who elect coverage under any plan or plans. However, coverage under a plan for such persons shall terminate when a person either reaches the age of 65 or ceases to be a dependent as defined in a plan, whichever occurs first.

In addition to the foregoing, it is expressly understood that the coverage herein provided shall be subject to coordination of benefits on a non-duplicating basis; i.e., if any of the persons covered herein are also covered by another hospitalization, dental or optical plan, then said other plan shall be considered the primary plan and the benefits payable under any plan provided herein shall be reduced by the amount paid by the other plan, but in no event shall the coordination of benefits allow for payment of more than 100% of allowable expenses.

C. Employees who retire before the age of 63 (i.e., early retirement) shall be allowed to remain in the hospitalization and medical program until reaching age 65, provided they pay the following premium costs:

(1) From January 1, 1982 to April 1, 1982: a maximum of $38.26 per month for single coverage and $114.68 for family coverage if they elect Blue Cross; or a maximum of $26.00 per month for single coverage and $68.00 per month for family coverage if they elect Bankers Life.

(2) Beginning April 1, 1982, the hospitalization and medical premiums shall be frozen for the term of this agreement at a maximum of $55.00 per month for single coverage; $110.00 per month for coverage of a family of two (2); $150.00 per month for coverage of a family of more than two (2).

LABOR CONTRACT

between

CHICAGO FIRE FIGHTERS UNION,
LOCAL 2,
INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS,
AFL-CIO, CLC

and

THE CITY
OF
CHICAGO, ILLINOIS

JANUARY 1, 1984 - DECEMBER 31, 1987

EXHIBIT "B"

ARTICLE XII
SAFETY, HEALTH & WELFARE

Section 12.1 Hospitalization and Medical Coverage, Dental, Optical, Life Insurance Programs

A. The Employer agrees to make available to eligible employees and their eligible dependents the "City of Chicago Medical Care Plan for Employees, which became effective October, 1984," and the City dental plan and the City optical plan also provided to City employees. The definition of eligible employees and eligible dependents is set forth in each respective program or plan. However, for the Medical Care Plan only, eligible dependents are those dependents who are unmarried and less than 25 years of age regardless of an employee's date of hire. The Employer shall contribute the full cost of eligible employee and eligible dependent coverage.

B. The Employer also agrees to make available to the following other persons the hospitalization and medical program, the dental plan, and the optical plan: widows and children of employees killed in the line of duty; former employees on pension disability (both duty and occupational) and their eligible dependents; widows and children of deceased employees who were formerly on pension disability. The Employer will contribute the full cost of coverage for any of the above enumerated persons who elect coverage under any plan or plans. However, coverage under a plan for such persons shall terminate when a person either reaches the age of 65 or ceases to be a dependent as defined in a plan, whichever occurs first.

In addition to the foregoing, it is expressly understood that the coverage herein provided shall be subject to coordination of benefits on a non-duplicating basis; i.e., if any of the persons covered herein are also covered by another hospitalization, dental or optical plan, then said other plan shall be considered the primary plan and the benefits payable under any plan provided herein shall be reduced by the amount paid by the other plan, but in no event shall the coordination of benefits allow for payment of more than 100% of allowable expenses.

C. Employees who retire pursuant to the pension statute shall be allowed to participate in the City of Chicago Annuitants Medical Benefit Plan until reaching age 65, provided they pay the then current contribution rate. The following are the current contribution rates:

1. A maximum of $55.00 per month for single coverage;
2. $110.00 per month for coverage of a family of two (2);
3. $150.00 per month for coverage of a family of more than two (2).

EXHIBIT 3
Korshak: Laborers Fund's Counterclaims

12/16

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - CHANCERY DIVISION

CITY OF CHICAGO, a Municipal Corporation,

Plaintiff,

vs.

MARSHALL KORSHAK, et al,

Defendants,

THE LABORERS' AND RETIREMENT BOARD EMPLOYEES' AND BENEFIT FUND OF CHICAGO, et al,

Counterplaintiffs,

vs.

CITY OF CHICAGO, a Municipal Corporation,

Counterdefendant.

No. 87 CH 10134

VERIFIED COUNTERCLAIM FOR INJUNCTION AND OTHER RELIEF

Counterplaintiffs, THE LABORERS' AND RETIREMENT BOARD EMPLOYEES' AND BENEFIT FUND OF CHICAGO, ROGER E. McMAHON, RONALD D. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE LABORERS' AND RETIREMENT BOARD EMPLOYEES AND BENEFIT FUND OF CHICAGO, complain of the Counterdefendant, the CITY OF CHICAGO, a Municipal Corporation, as follows:

Preliminary

1. Counterplaintiffs, THE LABORERS' AND RETIREMENT BOARD EMPLOYEES' AND BENEFIT FUND OF CHICAGO ("the Fund") was established in accordance with Section 11-181 of The Laborers' and Retirement

Board Employees' and Benefit Fund of Chicago, Ill. Rev. Stat. Ch. 108½, Sec. 11-181.

2. The Fund maintains its principal place of business in Chicago, Cook County, Illinis.

3. Counterplaintiffs, ROGER E. McMAHON, RONALD R. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, are each members of the retirement board of the Fund.

4. Various retirees and certain spounses of deceased city employees receive a monthly annuity from the Fund and have medical insurance coverage under the City of Chiago Annuitant Medical Benefits Plan ("the City's Plan").

5. The Fund is engaged, inter alia, in the business of administering certain annuity and disability insurance programs for certain retired employees who are members of the Fund and their dependents.

6. Counterdefendant, the CITY OF CHICAGO ("the City") is a municipal corporation, organized in accordance with Section 1-1-1 of the Illinois Municipal Code, Ill. Rev. Stat. Ch 24, Sec.1-1-1.

7. Some or all of the acts complained of herein took place in Cook County, Illinois.

8. Beginning in and continuously since approximately 1964, many of the Fund's annuitants have participated, with active City of Chicago employees, in a group medical benefits program sponsored by the City. That program, since the mid-1970's has been administered on a self-funded, "claims made" basis. There is no insurance policy issued by an insurance company to cover claims made by the annuitants. Rather, when a covered claim is submitted by a covered individual, whether an active employee or a covered annuitant,

the City simply reimburses the private carriers which administer the program as the City's agents, and which pay the claims made by the covered individuals.

9. Approximately 2,100 of the Funds' annuitants currently participate in the City-sponsored group medical benefits program. Those annuitants, together with their spouses and other dependents who also may be covered by the program, comprise a group of approximately 3,000 individuals. A true and accurate copy of the City of Chicago Annuitant Medical Benefits Plan ("the City's Plan"), which has been in effect since September 1, 1985, is attached hereto and incorporated herein as Exhibit A.

10. Since August 16, 1985, there has been in force and effect in the State of Illinois, a certain statute known as Section 11-160.1 of the Laborers' And Retirement Board Employees' Annuity And Benefit Fund Act, Ill. Rev. Stat. Ch. 108-1/2, Sec. 11-160.1. That state provides in relevant part:

> "Each employee annuitant in receipt of an annuity on the effective date of this Section and each employee who retires on annuity after the effective date of this Section, may participate in a group hospital care plan and a group medical and surgical plan approved by the Board if the employee annuitant is age 65 or over with a least 15 years of service. The Board, in conformity with its regulations, shall pay to the organization underwriting such plan the current monthly premiums up to the maximum amounts authorized in the following paragraph for such coverage.
>
> As of the effective date the Board is authorized to make payments up to $25 per month for employee annuitants age 65 years or over with at least 15 years of service.
>
> If the monthly premium for such coverage exceeds the $25 per month maximum authorization, the difference between

the required monthly premiums for such coverage and such maximum may be deducted from the employee annuitant's annuity if the annuitant so elects; otherwise such coverage shall terminate.

Amounts contributed by the City as authorized under Section 8-189 for the benefits set forth in this Section shall be credited to the reserve for group hospital care and group medical and surgical plan benefits and all such premiums shall be charged to it.

11. Between the mid-1960's and April of 1982, the monthly rates charged the annuitants by the City for their medical benefits coverage were periodically increased. Nonetheless, since the mid-1970's, when the City's Plan became self-funded, the City has been subsidizing a portion of the costs of the annuitants' medical benefits.

12. Effective April 1, 1982, the City established the following monthly rates for the Fund's annuitants' medical benefits coverage:

Under Age 65 - Single	$ 55.00
Under Age 65 - Family	150.00
Medicare Eligible - Single	21.00
Medicare Eligible - Two	42.00
One Over 65, One Under Age 65	76.00

13. Notwithstanding the provisions of Section 1-160.1 of the (Laborers' and Retirement Board Employees' Annuity and Benefit Fund), and notwithstanding the fact that the actual cost of the coverage has increased dramatically since 1982, these rates for the Fund's annuitants' medical benefits coverage have remained unchanged to the present date. Since April of 1982 the City has subsidized the cost of the Fund's annuitants' medical benefits to the extent that they exceed the rates established at that time.

14. Both the Fund and the City have at all times been aware that the rates in effect since the mid-1970's were substantially less than the actual costs incurred by the City in paying the Fund's annuitants' medical claims under the Plan (together with the costs of administering that Plan). In September of 1984, for example, the City prepared a report titled "City of Chicago Annuitant Medical Care Benefits" in which it demonstrated the large disparity between contributions from the Fund, and the similar funds for other retired City employees, and the actual costs being incurred by the City. A copy of that report is attached hereto as Exhibit B.

15. The 1984 "City of Chicago Annuitant Medical Care Benefits" report proposed that the rates paid by the annuitants be increased by 100% effective two months later, in November of 1984, and increased by another substantial percentage three months after that, in January of 1985.

16. Despite this and other periodic "proposals" from the City that the annuitants' health insurance rates be increased the Fund was never directed to begin making deductions for "single" annuitants or to increase the amounts being deducted from the annuitants' monthly checks for the cost of their dependents' health insurance.

17. In mid-October of 1987, the director of the Fund received a letter from the Corporation Counsel for the City advising the Fund that from 1980 to the present the City has paid health care costs for the annuitants of the City's four

pension funds in excess of the contributions made by the funds towards those costs. A copy of that letter is attached hereto as Exhibit C. That letter further advised the Fund that the payments made by the City were not the subject of any appropriation and were thus illegal and must be repaid. The letter also advised the Fund that the City had filed a complaint in the Circuit Court of Cook County, naming as defendants the trustees of the four funds, asking that $59 million be repaid (18.5 million from the retirement fund), plus interest, and that the funds contract for health benefits as required by statute. Finally, the Corporation Counsel advised the Fund that he had directed the City's Benefits Office to cease making health care payments to pension fund annuitants as soon as each of the respective pension funds enters contracts for health insurance but in no event no later than January 1, 1988.

18. The complaint referred to in the Corporation Counsel's letter was filed on October 19, 1987, and is styled City of Chicago v. Marshall Korshak et al., 87 CH 10134. A True and accurate copy of that complaint is attached hereto as Exhibit D.

COUNT I - TERM AND CONDITION OF EMPLOYMENT

1.-18. As paragraphs 1 through 18 of this Count I, Counter plaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of this Counter Complaint.

19. Since the mid-1960's the City has paid the full cost of medical insurance coverage for City employees. Since 1971, the City has paid the full cost of medical benefits for the active employees of the City and for their spouses and dependents.

20. For the past ten years it has been common knowledge among the active City employees that the annuitants participate in the City's Annuitant Medical Benefits Plan and that the City subsidizes a substantial portion of the cost of its annuitants' medical care benefits.

21. The active City employees for the past ten years, relied upon this retirement benefit in continuing their employment with the City.

22. The City's inclusion of the annuitants in its medical benefits program and its subsidization of a substantial portion of the cost of its annuitants' medical care benefits thus became a term and condition of employment for active employees of the City.

23. The City's announced intention to terminate medical care benefits for the Fund's annuitants as of December 31, 1987, is a breach of those terms and conditions of these employment contracts with the City.

24. It would be inequitable and unjust to permit the City to breach these established terms and conditions of employment.

25. The Fund and its annuitants will suffer substantial and irreparable harm if the City is not enjoined from terminating the medical care benefits it has provided to them for the past 20 years. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate their medical benefits coverage on December 31, 1987.

26. Counterplaintiffs have no adequate remedy at law.

COUNT II - IMPLIED CONTRACT

1.-18. As paragraphs 1 through 18 of this Count II, Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City's actions described above gave rise to an implied contract between the Fund, the annuitants and the City under which the City agreed to subsidize the cost of the annuitants' medical benefits coverage in excess of the rates established for the medical benefits coverage effective April 1, 1982.

20. The City's letter to the Fund dated October 19, 1987 and its filing of the complaint described in paragraphs 17 and 18 above constitute a breach of that implied contract.

21. The Fund and its annuitants will suffer substantial and irreparable damage if the City is not enjoined from terminating the implied contract under which it agreed to and has, for more than five years, subsidized the annuitants' health insurance costs in excess of the rates effective April 1, 1982. Termination of the contract on January 1, 1988 would expose the annuitants to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage.

22. It would be inequitable and unjust to permit the City to breach this implied contract.

23. Counterplaintiffs have no adequate remedy at law.

COUNT III - BREACH OF CONTRACT

1.-18. As paragraphs 1 through 18 of this Count III, Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City has undertaken to provide medical benefits coverage to the Fund's annuitants since the mid-1960's and has been in a contractual relationship with each annuitant who chose to participate in the City's medical benefits program during this twenty year period.

20. The Fund's annuitants are presently covered by the City's Plan attached hereto as Exhibit A.

21. The City's Plan, which by its terms was effective September 1, 1985, provides as follows regarding "Termination of Coverage:"

> Coverage for you and your eligible dependents will terminate the first of the month following
>
> - the month a deduction is not taken from your annuity, or
>
> - the month you reach the limiting age for City-paid benefits, if you have not arranged for deductions from your annuity check.
>
> In addition, coverage for you and your eligible dependents will terminate the earliest of
>
> - the date it is determined that you have knowlingly submitted false bills or bills for ineligible dependents for reimbursement under this Plan
>
> - the date the Plan is terminated, or
>
> - the date the Plan is terminated for the class of Annuitant of which you are a member.

22. The City's Plan does not itself contain any procedures or time frame regarding a notice of intent to terminate the Plan.

23. In the absence of an express term, a reasonable notice period must be implied.

24. The City's letter of October 19, 1987, informing the Fund that coverage would be terminated no later than December 21, 1987 is not, under the circumstances presented here, a reasonable period of notice of intent to terminate the Plan.

25. Upon receipt of the City's October, 1987 letter, the Fund contacted a number of private health insurance companies and requested quotations as to the cost of coverage for the approximately

3,000 individuals (the annuitants and their dependents) who are now covered by the City's Plan.

26. The Fund is awaiting those price quotations.

27. When the Fund has the price quotations and details of the coverage being offered by the private carriers, it will then have to determine whether to approve the plan, see Ill. Rev. Stat. Ch. 108-1/2 Sec. 11-160.1.

28. This process, involving the solicitation and evaluation of proposals from various private carriers, negotiating and executing contracts with one or more of them, and giving the annuitants reasonable notice of the terms and costs of the new coverage, will not and cannot be accomplished by the City's announced termination date of January 1, 1988.

29. The City has breached the Plan by failing to give sufficient notice of its intent to terminate the Plan.

30. It would be inequitable and unjust to permit the City to terminate the City's Plan on such short notice.

31. The Fund's annuitants will suffer substantial and irreparable harm if the City is permitted to terminate the City's Plan on such short notice. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate coverage effective January 1, 1988.

32. Counterplaintiffs have no adequate remedy at law.

COUNT IV - EQUITABLE ESTOPPEL

1.- 18. As paragraphs 1 through 18 of this Count IV Counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 18 of Count I.

19. The City has engaged in a continuous pattern of affirmative acts over the past ten years by subsidizing a substantial portion of the cost of the annuitants' medical care benefits. Since April of 1982, the City has subsidized all costs in excess of the rates which went into effect at that time.

20. The City's actions have been taken with full knowledge of the actual amounts expended by it for the annuitants' medical care benefits.

21. The Fund and its annuitants have reasonably relied on the City's subsidization of those costs.

22. In reliance on this longstanding practice of the City, the Fund took no steps until after receipt of the City's letter of October 19, 1987, to locate a private health insurance carrier to provide medical insurance to the Fund's annuitants and the annuitants have not planned for the financial burden of having to pay the full cost of their own medical insurance.

23. It would be inequitable and unjust to permit the City to terminate this practice.

24. If the City is permitted to terminate the annuitants' medical care benefits on December 31, 1987, the Fund and its annuitants will suffer substantial and irreparable harm. The annuitants will be exposed to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage.

25. The City is estopped from terminating this long standing practice.

26. Counterplaintiffs have no adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, Counterplaintiffs pray for a judgment, order and decree against the counterdefendant as follows:

A. That the City of Chicago be restrained and enjoined, both temporarily and permanently, from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan.

B. That the City of Chicago be restrained and enjoined from ceasing its practice of subsidizing the cost of the Fund's annuitants' medical benefits to the extent that it exceeds the rates which went into effect in April of 1982.

C. That in the alternative, the City of Chicago be restrained and enjoined from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan until the Fund has had sufficient time to contract for similar medical benefits coverage with a private insurance carrier.

D. That this Court retain jurisdiction of this action to enforce its injunction order.

E. For such other and further relief as this Court may deem just and proper together with the costs of this action.

One of the Attorneys for Counterplaintiffs

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.

Executive Director

Frederick P. Heiss
William A. Marovitz
Attorneys for Counterplaintiffs
188 West Randolph St., Suite 1226
Chicago, Illinois 60602
726-0504
Attorney's No. 01405

Your City of Chicago
Annuitant Medical Benefits Plan

...a brief review of
eligibility, coverages
and how the Plan works

Harold Washington,
Mayor

IMPORTANT!
READ IMMEDIATELY
DATED MATERIALS

Exhibit A

MEDICAL BENEFITS
FOR
CITY OF CHICAGO
ANNUITANTS AND ELIGIBLE DEPENDENTS

IMPORTANT!
Read immediately, dated materials

ABOUT THIS BOOKLET

This booklet describes the hospital and medical expense coverage provided by the City of Chicago Annuitant Medical Benefits Plan.

You will notice the booklet is divided into sections that describe the way the City Plan works

- if you or your covered dependents are eligible for Medicare, or
- if you or your covered dependents are **not** eligible for Medicare.

Other sections apply to everyone covered by the City Plan—Medicare eligible and non-Medicare eligible.

There are two important things to keep in mind when reading this material. *First,* the way the City Plan pays benefits is based on premium deductions. You must also be enrolled in Medicare A & B to pay the lower Annuitant premium. If you are eligible for Medicare but not enrolled, or if you are enrolled but do not submit a claim to Medicare, the City Plan will still pay benefits as if Medicare were also paying part of the bills. So, it is important to sign up for Medicare when you become eligible. And, submit your claims to Medicare first.

Second, it is also important to understand that the way the City Plan pays benefits is determined individually—for each person covered by the plan based on his or her Medicare eligibility. For example, if you are eligible for Medicare, the City Plan will coordinate its benefit payments for your medical expenses with Medicare's payments. But, if your spouse or another covered dependent is **not** covered by Medicare, full benefits are payable from the City Plan. So, the Plan may work differently for members of the same family. Your dependents' coverage does not depend on the way the Plan pays benefits for you.

The "Table of Contents", which follows, will give you an idea which sections apply according to Medicare eligibility. Sections not specified apply to everyone covered by the City of Chicago Annuitant Medical Benefits Plan.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Here's a quick look at the coverage provided by the City of Chicago Annuitant Medical Benefits Plan. Not that some benefits are different based on either your or your dependent's Medicare eligibility.

HOSPITAL BENEFITS

Inpatient	
If you are eligible for Medicare	• limited to Medicare deductibles and co-payments • See pages 6-8.
If you are not eligible for Medicare	• 100% payment of Medically Necessary days, provide you notify a Benefit Adviser • reduced payment, if Notification, Mandatory Outp tient or Mandatory Second Opinion requirement is n met • See pages 10-12.
Outpatient	
For all persons covered	• 80% payment of covered expenses • See page 12. • 100% payment of certain expenses • See page 18.

SPECIAL MANDATORY PROVISIONS: Only If You Are Not Eligible for Medicare

Mandatory Outpatient Surgical Procedures	• 32 surgical procedures covered 100% as an outpati • 50% payment if performed as an inpatient • See pages 14-15.
Mandatory Second Opinion	• 15 surgical procedures covered 100% after you ge second doctor's opinion • 50% payment, if performed without second opinior • See page 16.

EXPENSES PAID AT 100%

For all persons covered	• certain expenses are always covered 100%, such outpatient testing and emergency treatment • See page 18.

MAJOR MEDICAL BENEFITS

For all persons covered	• $100 deductible • two $100 deductibles per family • 80% payment of next $7,500 of covered expe ($15,000 for family) then 100% of covered expe for balance of plan year • $1,000,000 lifetime max • See page 20.

MAIL ORDER PRESCRIPTIONS

For all persons covered	• pays all but $3.00 of cost for each covered prescr • See page 22.

ABOUT THE CITY OF CHICAGO ANNUITANT MEDICAL BENEFITS PLAN

- Eligibility
- Effective Date of Coverage
- Termination of Coverage
- Getting Coverage for You and Your Dependents

ABOUT THE CITY OF CHICAGO ANNUITANT MEDICAL BENEFITS PLAN

The City of Chicago Annuitant Medical Benefits Plan is available to you, an Annuitant of the City, whether or not you are eligible for Medicare benefits.

This booklet briefly reviews the Plan. *Please read it carefully.* If you have questions, call or visit the City Benefits Management Office, 7th Floor, Kraft Building, 510 N. Peshtigo Court, Chicago, Illinois 60611, (312) 744-0777.

ELIGIBILITY

You will be eligible for coverage if you are:

- An Annuitant of the City of Chicago. "Annuitant" means a former employee who is receiving an age and service annuity from one of four retirement funds,
- The spouse of a deceased Annuitant if you are receiving spousal annuity payments, or
- A dependent of a deceased Annuitant if you are receiving annuity payments.

Your eligible dependents are:

- Your spouse, unless your spouse is a City employee eligible to participate in the Medical Care Plan, or a retired City employee eligible to participate in this Plan as an Annuitant
- Your unmarried children under age 25, if you are retired before January 1, 1986
- Your unmarried children under age 19, if you are retired on or after January 1, 1986
- If you are retired on or after January 1, 1986, your children between the ages of 19 and 22 who are enrolled in an accredited community college, college or university as a full-time undergraduate student in good standing provided all other eligibility requirements are met.
- Your unmarried children of any age incapable of self-support due to mental retardation or physical handicap and dependent on you for support and maintenance if satisfactory proof of incapacity is received and all other eligibility requirements are met.
- Children for whom you have been appointed legal guardian if other eligibility requirements are met.

"Children" include: natural children, stepchildren, children placed in your home for adoption and legally adopted children. A child of an eligible Annuitant shall not be eligible if a divorce decree or other valid judgement imposes upon a person other than the eligible Annuitant or his/her spouse the responsibility to provide medical care for such children.

A dependent of an eligible Annuitant can be covered by the Plan as a dependent of only one City employee or Annuitant. If a dependent is also eligible for coverage as a City employee, or Annuitant, he or she will not be eligible as a dependent. *The only dependents you may include on your coverage are those who would have been eligible for coverage on the date of retirement of the Annuitant.* (This requirement is waived for Annuitants enrolled for coverage prior to January 1, 1986.)

EFFECTIVE DATE OF COVERAGE

Special Rule for Annuitants and Dependents Covered by the City on August 31, 1985

If you and your eligible dependents are currently receiving City Retiree Health Care Benefits, provided you re-enroll, you will be covered under the provisions of this revised City Plan starting September 1, 1985, with one exception. If you or your covered dependent is hospitalized on September 1, 1985, you will be covered under the old Plan rules until you leave the hospital, provided you re-enroll and submit documentation. Also, if you submitted documentation while an active City employee, the requirement to submit proof of dependency is waived.

The General Rule for Annuitants and Dependents First Eligible for Annuitant Benefits September 1, 1985 or Later

Your coverage will be effective on the first day of the month following your enrollment in the Plan. Remember you *must* submit a completed enrollment form before coverage will begin.

The effective date of coverage for a dependent who is confined in a hospital on the day coverage would otherwise be effective will be deferred until the day following the date the dependent is discharged from the hospital. Coverage for your eligible dependents will be effective on the first day of the month following receipt in the Benefits Management Office of satisfactory proof of dependency (if you are enrolled for benefits at that time). This requirement is waived if documentation was submitted for the dependent while the Annuitant was an active City employee.

If you do not elect to enroll yourself or your dependents when you are first eligible for benefits as an Annuitant, you will be required to submit proof of good health on a form acceptable to the Benefits Management Office. Coverage will then be effective on the first day of the month following receipt of satisfactory proof of good health. In the event you are unable to submit satisfactory proof of good health, coverage will be denied.

An Annuitant retiring September 1, 1985, or later, but prior to age 65 who elects not to enroll on his or her original retirement date may do so without proof of good health during a 30 day period beginning with the Annuitant's 65th birthday.

TERMINATION OF COVERAGE

Coverage for you and your eligible dependents will terminate the first of the month following

- the month a deduction is **not** taken from your annuity, or
- the month you reach the limiting age for City-paid benefits, if you have not arranged for deductions from your annuity check.

In addition, coverage for you and your eligible dependents will terminate the earliest of

- the date it is determined that you have knowingly submitted false bills or bills for ineligible dependents for reimbursement under this Plan
- the date the Plan is terminated, or
- the date the Plan is terminated for the class of Annuitant of which you are a member.

GETTING COVERAGE FOR YOU AND YOUR DEPENDENTS

You must fill out an enrollment form. You must also give the City proof of dependency. Dependency may be proved by the following documents:

- Marriage certificates,
- Birth certificates for all children you claim as dependents,
- Divorce decrees if the Annuitant and his/her spouse are not the two parents shown on a child's birth certificate,
- Adoption papers for legally adopted children,
- Court orders if you are obligated to provide coverage for other children,
- Proof of mental or physical incapacity on a form provided annually by Benefits Management Office if such incapacity is the basis for continued eligibility, and
- The statement of academic standing for children enrolled in an accredited community college, college or university if enrollment in good academic standing is the basis for continued eligibility.

Additional documentation may be required by the Benefits Management Office.

All certificates, court orders and divorce decrees must be *certified*—you cannot send photocopies. If you supply the City Benefits Management Office with a self-addressed envelope including adequate postage along with your enrollment documents, your documents will be returned to you.

If you need information about where to get certified copies or have any difficulty providing proof of dependency call the City Benefits Management Office.

Remember: *If you submitted re-enrollment documentation while an active City employee, the requirement to submit documentation at this time is waived.*

GETTING COVERAGE FOR YOU AND YOUR DEPENDENTS

You must fill out an enrollment form. You must also give the City proof of dependency. Dependency may be proved by the following documents:

- Marriage certificates,
- Birth certificates for all children you claim as dependents,
- Divorce decrees if the Annuitant and his/her spouse are not the two parents shown on a child's birth certificate,
- Adoption papers for legally adopted children,
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- Proof of mental or physical incapacity on a form provided annually by Benefits Management Office if such incapacity is the basis for continued eligibility, and
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If you need information about where to get certified copies or have any difficulty providing proof of dependency call the City Benefits Management Office.

Remember: *If you submitted re-enrollment documentation while an active City employee, the requirement to submit documentation at this time is waived.*

HOSPITAL BENEFITS

IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR MEDICARE

- How Medicare Part A and the City Plan Work Together
- A Summary of What Medicare Part A and the City Plan Will Pay

Remember: *Each person, Annuitant or dependent is covered by the Plan based on his or her own Medicare or non-Medicare eligibility.*

HOSPITAL BENEFITS

HOW MEDICARE PART A AND THE CITY PLAN WORK TOGETHER

THE FOLLOWING SECTION APPLIES ONLY TO THOSE ANNUITANTS OR DEPENDENTS COVERED BY MEDICARE. IT DESCRIBES HOW THE CITY PLAN WILL COVER YOUR MEDICARE DEDUCTIBLES AND CO-PAYMENTS FOR HOSPITAL BILLS.

If you are 65 years old or older and you are receiving monthly Social Security (or Railroad Retirement) benefits, you are also eligible for hospital insurance (Part A) benefits at no charge under the federal government's Medicare program.

If an Annuitant or a dependent is eligible for Medicare, Medicare is the primary payer of all covered hospital expenses. City Plan benefits are limited to the part of the bills that Medicare does not pay—the Medicare deductibles and co-payments.

The deductibles and co-payments are the only items that the hospital can bill to you. The hospital must accept Medicare payment as payment in full for other eligible expenses.

HOSPITAL BENEFITS

HOW MEDICARE PART A AND THE CITY PLAN WORK TOGETHER

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If you are 65 years old or older and you are receiving monthly Social Security (or Railroad Retirement) benefits, you are also eligible for hospital insurance (Part A) benefits at no charge under the federal government's Medicare program.

If an Annuitant or a dependent is eligible for Medicare, Medicare is the primary payer of all covered hospital expenses. City Plan benefits are limited to the part of the bills that Medicare does not pay—the Medicare deductibles and co-payments.

The deductibles and co-payments are the only items that the hospital can bill to you. The hospital must accept Medicare payment as payment in full for other eligible expenses.

APPLIES TO MEDICARE ELIGIBLE

HOSPITAL OUTPATIENT CHARGES PAID AT 100%

Hospital outpatient charges for Medicare eligible annuitants or Medicare eligible dependents are eligible for reimbursement under the City Plan.

The amount reimbursed will be coordinated with the amount paid under Medicare Part B.

The following expenses incurred in the emergency room or outpatient department of a hospital will be *paid in full* if services are Medically Necessary:

- Diagnostic x-rays and laboratory tests,
- Tests required before admission to a hospital,
- Chemotherapy, x-rays, radon and radioisotope treatments for the treatment of cancer,
- Emergency treatment within 72 hours of Accidental Injury, and
- Emergency treatment within 24 hours of the onset of a Sudden and Serious Illness.

These expenses are described in more detail on page 18 of this booklet.

Other expenses incurred in the emergency room or outpatient department will be paid at 80%.

All hospital bills for both inpatient and outpatient service are paid under the hospital portion of this plan. *No hospital charges are eligible for reimbursement under Major Medical.*

HOSPITAL BENEFITS

IF YOU OR YOUR DEPENDENTS ARE NOT ELIGIBLE FOR MEDICARE

- Hospital Cost Management—Notify Your Benefit Adviser
- What the Plan Covers

Remember: *Each person, Annuitant or dependent is covered under the Plan according to his or her own Medicare or non-Medicare eligibility.*

HOSPITAL BENEFITS

HOSPITAL COST MANAGEMENT—NOTIFY YOUR BENEFIT ADVISER

THE FOLLOWING SECTION APPLIES ONLY TO THOSE NOT COVERED BY MEDICARE AND DESCRIBES HOW THE CITY PLAN WILL HELP THEM MANAGE THEIR HOSPITAL STAYS.

HOSPITAL BENEFITS

HOSPITAL COST MANAGEMENT—NOTIFY YOUR BENEFIT ADVISER

An important feature of the City Plan is Hospital Notification. You should notify an Employee Benefit Adviser at the City Benefits Management Office within 48 hours after you or an eligible dependent are hospitalized. The Plan pays different levels of benefits depending on whether you contact your Adviser or not. If you do notify an Adviser, you will be eligible for the full benefits provided by the Plan. If you do not contact your Adviser, you must pay the first days' hospital room and board charges and 20% of all other eligible hospital charges.

Notifying your Adviser **before** you are hospitalized can also help you avoid unnecessary hospitalization. As the number of outpatient treatment facilities grows, and the number of outpatient treatments expand, the use of inpatient hospital facilities will become less necessary. Notifying your Employee Benefit Adviser prior to hospitalization can help you find the best setting for your medical care, but remember, if you don't notify your Adviser before you are hospitalized, you **must** notify your Adviser within 48 hours after being hospitalized to receive full benefits.

REMEMBER, TO RECEIVE FULL BENEFITS FROM THE PLAN YOU MUST NOTIFY AN EMPLOYEE BENEFIT ADVISER IN THE BENEFITS MANAGEMENT OFFICE WHEN YOU OR AN ELIGIBLE DEPENDENT ARE HOSPITALIZED. THE TELEPHONE NUMBER FOR THE EMPLOYEE BENEFIT ADVISER IS 312-744-1571.

You must contact the Benefits Management Office within 48 hours of **admission** to the hospital. A call to your Benefit Adviser will protect your benefits. Let the Adviser know who is hospitalized, the name of the hospital, the reason for the hospitalization, and the name of the admitting Physician.

If you call outside of normal working hours, you may leave the required information as a recorded message. An Adviser will return your call the next business day.

Collect calls will not be accepted.

An Employee Benefit Adviser can meet with you (or a spouse) or talk to you on the telephone. Your Adviser will work with you and your personal Physician.

You must contact an Employee Benefit Adviser within 48 hours of entering a hospital. This is very important because the plan pays only a portion of your cost if you do not contact the Adviser. And remember, this plan provision applies only if you are **not** covered by Medicare.

IMPORTANT:** REMEMBER THE PHONE NUMBER FOR NOTIFICATION IS **(312) 744-1571.

APPLIES TO NON-MEDICARE ELIGIBLE

WHAT THE PLAN COVERS

*GENERALLY, THE PLAN PAYS **DIFFERENT** LEVELS OF BENEFITS, DEPENDING ON WHETHER:*

- *YOU USE THE SERVICES OF AN EMPLOYEE BENEFIT ADVISER*

OR

- *YOU **DO NOT** USE THE SERVICES OF AN EMPLOYEE BENEFIT ADVISER.*

Covered inpatient hospital charges include such items as: unlimited days of semiprivate room and board for each *needed* confinement, drug and other necessary expenses.

The Plan pays 100% of covered hospital room, board and miscellaneous charges *if* you use the services of an Employee Benefit Adviser.

If you do **not** use the services of an Employee Benefit Adviser, you must pay:

- The *first day's* hospital room and board charges *and* 20% of *all* other hospital charges.

Even if you call an Adviser, the Plan pays **no** benefits for:

- Inpatient, diagnostic or pre-surgical testing not Medically Necessary,
- Friday and/or Saturday inpatient hospital expenses preceding Monday discharge if weekend days are not Medically Necessary,
- Friday and/or Saturday inpatient hospital expenses if confinement occurs on a weekend and weekend days are not Medically Necessary,
- Any hospital days not Medically Necessary, or
- Other expenses not Medically Necessary.

The Plan pays 50% of eligible charges if you do **not** follow the procedures for the Mandatory Outpatient Provision or the Mandatory Second Opinion Provision.

*IT IS IMPORTANT TO NOTE THAT EVEN IF YOUR DOCTOR PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS **MEDICALLY NECESSARY**, OUR CLAIMS ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES OR SUPPLIES IF IT DECIDES THEY WERE NOT **MEDICALLY NECESSARY**. A COMPLETE DEFINITION OF **MEDICALLY NECESSARY** APPEARS IN THE "DEFINITIONS" SECTION, SEE PAGES 29 AND 30.*

HOSPITAL OUTPATIENT CHARGES

The following expenses incurred in the emergency room or outpatient department of a hospital will be *paid in full* if services are Medically Necessary:

- Diagnostic x-rays and laboratory tests,
- Tests required before admission to a hospital,
- Chemotherapy, x-rays, radon and radioisotope treatments for the treatment of cancer,
- Emergency treatment within 72 hours of Accidental Injury, and
- Emergency treatment within 24 hours of the onset of a Sudden and Serious Illness.

These expenses are described in more detail on page 18 of this booklet.

Other expenses incurred in the emergency room or outpatient department will be paid at 80%.

All hospital bills for both inpatient and outpatient services are paid under the hospital portion of this plan. **No hospital bills are eligible for reimbursement under Major Medical.**

APPLIES TO NON-MEDICARE ELIGIBLE

SPECIAL MANDATORY PLAN PROVISIONS

IF YOU OR YOUR DEPENDENTS ARE NOT ELIGIBLE FOR MEDICARE

- Mandatory Outpatient Surgery
- Mandatory Second Opinion

MANDATORY OUTPATIENT SURGERY

THE FOLLOWING DESCRIBES TWO PROVISIONS FOR NON-MEDICARE ANNUITANTS AND NON-MEDICARE DEPENDENTS: ***MANDATORY OUTPATIENT SURGERY*** *AND* ***MANDATORY SECOND OPINION.***

Certain surgical procedures done on an outpatient basis will be covered 100% by the City Plan. If you and your Physician feel that for medical reasons inpatient care is necessary for a Mandatory Outpatient Procedure, your Benefit Adviser will provide you with a waiver request form. The form must be completed by your Physician and forwarded with your claim forms.

Completion of the form does not guarantee that a waiver will be granted. If, in the opinion of our claims administrator, inpatient care was not Medically Necessary, you will be responsible for 50% of the hospital bill and Physician's covered charges.

It is important to understand these Plan provisions to ensure that you receive the most appropriate care and treatment and the most appropriate benefit payment.

Call your Benefits Management Office; a Benefit Adviser can answer any questions you may have about the Mandatory Outpatient Provision.

The list of surgical procedures that must be done on an outpatient basis to be covered 100% by the City Plan follows. If any of these Mandatory Outpatient Procedures are performed as an inpatient, you will be responsible for 50% of the reasonable and customary charges for the hospital and Physician.

IMPORTANT: *REMEMBER THE PHONE NUMBER TO TALK WITH A BENEFIT ADVISER ABOUT MANDATORY OUTPATIENT SURGERY IS* ***(312) 744-1571.***

APPLIES TO NON-MEDICARE ELIGIBLE

LIST OF MANDATORY OUTPATIENT SURGICAL PROCEDURES

1. Abdominal Paracentesis (withdrawal of fluid from abdomen)
* 2. Arthrography/Arthroscopy
* 3. Augmentation Mammoplasty
* 4. Bunionectomy
5. Carpal Tunnel Release
* 6. Cataract
7. Circumcision (other than newborn)
* 8. Dilatation And Curettage (D & C)
9. Dorsal Slit
10. Extraocular Muscle Repair
*11. Excisions:
    Baker's Cyst
    Exostosis
    Pterygium
12. Eye Muscle Recession and/or Resection
13. Gastroscopy
14. Hammertoes with Tenostomy & Resection of Bone
*15. Herniorrhaphy and/or Hydrocelectomy
*16. Mammoplasty
17. Meatotomy
18. Myringotomy
19. Nasal Polypectomy
20. Nose, Closed Reduction
21. Orchiectomy
22. Orchiopexy (child to age 14)
23. Diagnostic Testing which requires the individual to sign a surgical permit or release, for example:
    Biopsy (i.e., Breast, Prostate, Muscle, Lung, Skin, etc.)
    Bronchoscopy
    Cystocopy
    Culdoscopy
    Laparoscopy
    Laryngoscopy
    Otoscopy
    Proctosigmoidoscopy
    Sigmoidoscopy
24. Phalangectomy (amputation of fingers/toes)
25. Removal of Hardware (pinnings)
26. Revision of Amputated Digit
27. Skin Graft
*28. Submucous Resection/Septoplasty
*29. Tonsillectomy and/or Adenoidectomy
30. Tenotomy of Hand or Foot
31. Thoracentesis
32. Varicocelectomy

**Second opinion must be obtained before these procedures will be approved for payment. See the Mandatory Second Opinion Provision.*

Call the Benefits Management Office and speak with a Benefit Adviser if you are planning to have any of these surgical procedures, or if you have any questions concerning the Mandatory Outpatient Surgery provision.

Note that some Mandatory Outpatient Surgery Procedures are marked with an asterisk (*). These procedures also require a second doctor's opinion before they are eligible for 100% coverage under the City Plan, as explained in the next section.

APPLIES TO NON-MEDICARE ELIGIBLE

MANDATORY SECOND OPINION

The following surgical procedures require a second doctor's opinion before they are eligible for 100% hospital coverage under the City Plan.

- Gall Bladder Surgery
- Hernia Repairs
- Joint Surgery
- Hysterectomy
- Nose Surgery
- Back Surgery
- Breast Surgery
- Heart Surgery, including Pacemaker Insertion
- Cataract Surgery
- Foot Surgery
- Dilatation & Curettage (D&C)
- Prostate Surgery
- Hemorrhoid Surgery
- Varicose Vein Surgery
- Tonsillectomy and/or Adenoidectomy

To get a second doctor's opinion, call the Benefits Management Office and speak with a Benefit Adviser. The Benefit Adviser will provide you with the names of qualified Physicians in your area who will give you a second opinion. The Benefit Adviser will also provide you with a special form to take to the second opinion doctor's office. The second opinion will be paid at 100% if arranged through the Benefit Adviser. **A second opinion not arranged through the Benefit Adviser does not fulfill the Mandatory Second Opinion Provision requirement!** If a procedure on the mandatory list is performed without a second opinion, the City Plan will pay only 50% of the charges for the hospital and physician.

When facing a decision as important as surgery, it is helpful to have as much information as possible to help you decide whether surgery is the right treatment for your problem. Many times a second opinion can show you a non-surgical method of treatment, or, it can prove to you that surgery is the only solution. Either way, it is to your best advantage to have as many facts at hand as possible when confronted by something as important as a decision about surgery.

Your City Plan has been designed to cover a second doctor's opinion at 100% for Mandatory Procedures. Call your Benefit Adviser for more information about the Mandatory Second Opinion Provision.

Remember: *To be eligible for 100% coverage, the second opinion must be arranged through an Employee Benefit Adviser.*

***IMPORTANT:** REMEMBER THE PHONE NUMBER TO TALK WITH A BENEFIT ADVISER ABOUT A MANDATORY SECOND OPINION IS (312) 744-1571.*

APPLIES TO NON-MEDICARE ELIGIBLE

EXPENSES PAID AT 100%

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

Remember: *This Plan provision covers all eligible Annuitants and their eligible dependents.*

EXPENSES PAID AT 100%

Some expenses are 100% paid regardless of where they are incurred. They include:

- Diagnostic testing—May be conducted in a doctor's office, a laboratory, or in the outpatient department of a hospital. Eligible tests include electrocardiograms (ECG), electroencephalograms (EEG), and upper and lower gastrointestinal (UGI, LGI) examinations, among others. Interpretation of these tests will be paid under Major Medical.
- Tests required before admission to a hospital—Certain tests generally required prior to hospital admission are paid for when ordered by a Physician. They may be conducted in a doctor's office, a laboratory or in the outpatient department of a hospital. Interpretation of these tests will be paid under Major Medical.
- Home Health Care—Care provided at the recommendation of a Physician in the patient's home but only as an alternative to in-hospital care. Care that is principally custodial in nature is not eligible for payment as home health care. To be eligible, Home Health Care must be arranged through an Employee Benefit Adviser.
- Hospice Care—A program of care delivered in the Hospice Unit of a hospital or in the patient's home, for individuals with terminal diseases and a life expectancy of less than 6 months. The aim of hospice care is to provide care to meet the special needs of the patient and his/her family during the final stages of a terminal disease.
- Skilled Nursing Facility—A legally operated institution or part of an institution which
  - —is under supervision of a licensed Physician or Registered Nurse
  - —provides 24 hour a day skilled nursing care on an inpatient basis
  - —has available at all times the services of a licensed Physician for necessary medical care and treatment
  - —maintains daily medical records on all patients
  - —does not include any institution or part of an institution that is used primarily for educational care, custodial care, for the care and treatment of drug addiction or alcoholism.
- Chemotherapy, x-ray, radon and radioisotope treatments for the treatment of cancer.
- Emergency treatment within 72 hours of Accidental Injury.
- Emergency treatment within 24 hours of the onset of a Sudden and Serious Illness.

Note: *Home Health Care, Hospice Care and/or Skilled Nursing Facility arrangements for Medicare eligible Annuitants or Medicare Eligible dependents will be coordinated with Medicare.*

MAJOR MEDICAL BENEFITS

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

- How Major Medical Works
- Maximum Major Medical Benefits

Remember: *The Major Medical part of the Plan covers all eligible Annuitants and their eligible dependents.*

HOW MAJOR MEDICAL WORKS

THE FOLLOWING APPLIES TO ALL PLAN PARTICIPANTS, WHETHER ELIGIBLE FOR MEDICARE OR NOT.

Major Medical Coverage works on a shared basis: you and the City Plan pay certain portions of your non-hospital bills (or, certain portions of your non-hospital bills not paid by Medicare). It works this way:

- You pay the *first* $100 of covered expenses each year for you and each of your dependents. This is called the *Annual Deductible.* No *family* must pay more than *two* deductibles in a Calendar Year (January 1–December 31). Expenses incurred in the last 3 months of a calendar year towards satisfaction of a deductible may be used to help satisfy the deductible in the next Calendar Year if the deductible is not satisfied in the year those expenses are incurred.
- The City Plan then pays *80%* of the *next* $7,500 ($15,000 for a family) in covered expenses.

If covered expenses go *over* these limits, Major Medical coverage then pays 100% of covered expenses above these limits for the rest of the Calendar year (January 1–December 31).

Covered expenses include such items as:

- Doctor and surgeon fees both in and out of the hospital,
- Prescriptions at a local drug store,
- Anesthesia,
- Local ambulance service,
- Rental of durable medical equipment needed temporarily,
- Private duty nurses who are not family members,
- Ambulance services, and
- Shock treatments.

Major Medical coverage pays 50% (*instead of 80%*) of outpatient charges for alcoholism, drug abuse or psychiatric treatment. If an in-hospital stay is needed, it is covered under the Hospital Coverage.

MAXIMUM MAJOR MEDICAL BENEFITS

The City Medical Benefits Plan will pay up to $1,000,000 in eligible expenses for you and each of your enrolled dependents. This is a lifetime maximum and applies as long as you continue to be an eligible Annuitant. Expenses you and your dependents accumulated toward the major medical maximum under plans in effect prior to September 1, 1985, as well as expenses incurred during all periods of employment with the City will be included in arriving at the maximum benefit.

MAIL ORDER PRESCRIPTIONS

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

Remember: *This Plan provision covers all eligible Annuitants and their eligible dependents.*

MAIL ORDER PRESCRIPTIONS

If you or an eligible dependent takes medication on a long-term basis (called "maintenance" prescriptions) for the treatment of a chronic condition such as high blood pressure, you may find the Mail Order Prescription feature in the City Plan useful.

Here's how the Mail Order Prescription plan works:

1) Obtain a written prescription from your Physician for the maintenance medications you and/or your dependents use. Be sure the Physician approves of your use of the Mail Order plan to obtain the medications.

2) Pick up instructions, including an order form, in the Benefits Management Office, or call the Benefits Office and have them mail the information.

3) Complete the order form, enclose the prescription form along with **a check, money order or credit card number** for your share of the cost. Your cost is $3 for **each** prescription ordered. For example, if you are ordering three prescriptions, you would need to send $9 ($3 × 3 prescriptions).

All orders will be filled within one week of the time the order is received. Your prescriptions will be mailed to you with instructions for ordering refills.

If you obtain a prescription through the Mail Order Plan you cannot submit a claim for reimbursement under the Major Medical part of the City Plan.

IMPORTANT: *THE MAIL ORDER PRESCRIPTIONS FEATURE OF THE CITY PLAN SHOULD NOT BE USED FOR MEDICATIONS THAT MUST BE TAKEN IMMEDIATELY. CHECK WITH YOUR PHYSICIAN BEFORE USING THE CITY PLAN'S MAIL ORDER PRESCRIPTION BENEFIT.*

WHAT IS
NOT COVERED

SERVICES NOT COVERED

Services not covered by the City of Chicago Annuitant Medical Benefits Plan include:

- Inpatient diagnostic or pre-surgical testing not Medically Necessary
- Unnecessary weekend hospital stays
- Hospital days not Medically Necessary
- In-hospital Physician visits for any day for which the Plan does not make a room and board payment for a hospital day because the day was not Medically Necessary
- The first day of hospital room and board charges and 20% of other hospital charges if the patient is required to contact an Employee Benefit Adviser but does not or any other hospital charges not paid in full under Hospitalization Coverage (Non-Medicare eligible Annuitants and Non-Medicare eligible dependents only)
- Hospital or other charges paid at a reduced rate due to failure to follow the procedure for Mandatory Outpatient or Mandatory Second Opinion Provisions. (Non-Medicare eligible Annuitants and Non-Medicare eligible dependents only)
- Medical services or supplies covered by or received from other private or government plans such as Workers' Compensation, or from a mutual benefit association, labor union or a similar group
- Charges for failure to keep an appointment or to file claims in specified time periods
- Glasses required as a result of cataract surgery
- Medical services or supplies for any custodial care
- Routine physical examinations and other services not necessary for the treatment of an injury, illness or mental or nervous condition
- Treatment of bodily injury arising from or in the course of any employment
- Services or supplies for which Annuitant or eligible dependent is not required to pay
- Services provided by a state hospital or institution
- Any operation on or treatment of the teeth or supporting tissues of the teeth except (i) removal of tumors, (ii) treatment of malerrupted impacted wisdom teeth, (iii) treatment of accidental injury to sound natural teeth (including replacement) due to an accident while covered under this Plan and (iv) hospital charges for oral surgery while a registered bed patient if Medically Necessary
- Medications, services or surgical procedures considered experimental by generally accepted medical standards
- Treatment programs principally for weight reduction regardless of reason for participation in program
- Personal convenience items or special medical equipment
- Cosmetic surgery—except for congenital deformities of a dependent child or for conditions due to accidental injuries, scars, tumors or diseases
- Whole blood or blood derivatives, when replaces (such as donations or blood banks)
- Inpatient and outpatient occupational therapy and speech therapy—unless promoting restoration or correction of a physical impairment as an inpatient only
- Services received while in the military service of any country
- Eyeglasses or contact lenses and exams for refractive errors of the eye
- Hearing aids or exams
- Purchase of durable medical equipment
- Treatment of injury, illness or mental or nervous condition occasioned by war, declared or undeclared, or in connection with intentionally self-inflicted injury or illness while sane or insane
- Treatment of foot conditions and prescriptions of supportive foot devices such as: cutting, trimming or paring of corns and callouses, routine foot care, etc
- Immunization injections
- Registered clinical social workers unless care is ordered or prescribed by a Physician and then only for treatment of a mental or nervous condition and payable under the psychiatric provisions of the plan

CLAIMS PROCESSING AND OORDINATION OF BENEFITS

CLAIMS PROCESSING

There are four easy rules to remember if you have a medical claim for you or a dependent.

1) If you are eligible for Medicare, submit the bills to Medicare first.

2) If expenses appear on a hospital bill, the bill will be sent to Blue Cross for payment. Normally the hospital will bill Blue Cross directly. If you are not eligible for Medicare, and you receive a bill, send the bill to Blue Cross for processing. If eligible for Medicare, the hospital will bill Medicare. After Medicare pays, send a completed claim form, the bill and a copy of what Medicare has paid to Blue Cross. The City's contract number with Blue Cross is **16600**.

3) All other eligible medical expenses should be sent to Bankers Life & Casualty for processing. Complete a claim form and send the bill and claim form to Bankers for processing. If eligible for Medicare, submit the bill to Medicare first, then, after Medicare pays, submit a complete claim form, the bill and a copy of what Medicare has paid to Bankers Life. The City's contract number with Bankers is **421-1**.

4) Always include your full name and Social Security Number with all claims.

Upon enrollment, a supply of claim forms will be sent to you for your use. You can also pick up forms in the Benefits Management Office.

IMPORTANT: *DO NOT SEND YOUR BILLS OR CLAIMS TO THE BENEFITS MANAGEMENT OFFICE. THAT WILL ONLY DELAY PROCESSING AS THE BENEFITS MANAGEMENT OFFICE WILL RETURN THE CLAIM TO YOU WITH INSTRUCTIONS FOR CORRECT PROCESSING.*

COORDINATION OF BENEFITS

If you or an eligible dependent are covered under this plan and any other plan, the benefits otherwise payable under this Plan may be reduced so that benefits payable under this Plan and all other plans will not exceed the total amount of allowable expenses. Plans that will be combined for this purpose include:

(a) any group or blanket insurance plan or any other plan covering individuals or members as a group;

(b) any group hospital or medical service prepayment plan; and

(c) any coverage under government programs (including Medicare) or any coverage required by statute, including any motor vehicle no-fault coverage required by statute.

Plans such as individual Medicare supplement policies will not be combined.

Benefits payable under this plan may also be reduced by the amount of any payments you receive as the result of legal action or settlement.

IF YOU ARE PAYING THE CITY PLAN CONTRIBUTION RATE FOR ANNUITANTS ELIGIBLE FOR MEDICARE PART A AND B, PAYMENT WILL BE COORDINATED AS THOUGH A MEDICARE PAYMENT HAD BEEN MADE EVEN IF YOU ARE NOT ENROLLED FOR MEDICARE OR DO NOT SUBMIT YOUR BILLS TO MEDICARE.

ADDITIONAL INFORMATION

- How You Can Help Control the Cost of Our Plan
- Definitions
- Determining What is Medically Necessary
- Appeal Procedures
- If You Need More Information

HOW YOU CAN HELP CONTROL THE COST OF OUR PLAN

The City of Chicago Annuitant Medical Benefits Plan has been designed to control costs by encouraging out-of-hospital care when it is possible and—most important—when it is safe for a patient to receive care outside a hospital or in the outpatient department of a hospital. The Employee Benefit Adviser will help you understand these options so you can discuss them with your personal Physician. If you or a dependent will be hospitalized, your Adviser will stay in touch during the hospitalization and make it easier for you to leave the hospital a day or two early if your physician approves an early discharge. By understanding and using Plan provisions wisely and talking to an Employee Benefit Adviser when you have questions, you can help control the cost of the City of Chicago Annuitant Medical Benefits Plan.

Become a wise consumer of medical care for you and your dependents. Discuss medical care and your alternatives with your Physician. Ask questions if you don't understand. Your Physician manages your health care and you can help by being sure your Physician understands the way the City Plan works.

Another important way you can help control the cost of our Plan is to carefully review your bills from hospitals, physicians and other medical providers. If you find an error on a bill and get the bill corrected you will receive a portion of the money you save the Plan. Just bring the original bill and the corrected bill to the Benefits Management Office. You will receive a check for 25% of the money you save the Plan if the money recovered by the City is at least $10. Payment for an error resulting from the misplacement of a decimal shall be limited to $250.

If you believe an Annuitant is presenting bills for services that have not been received or for a dependent who is not eligible, please notify the Benefits Management Office in writing. You will receive 25% of all funds actually recovered by the City.

DEFINITIONS

These important definitions may help you understand the City plan better—

ACCIDENTAL INJURY—Injury necessitating that emergency services be rendered by a licensed Physician.

CHEMOTHERAPY/RADIATION THERAPY—Generally accepted cancer treatment.

CUSTODIAL CARE—Care provided at a nursing facility or at home when the patient's condition is such that further progress is not expected and no medical treatment is being provided.

EMPLOYEE BENEFIT ADVISER—An Employee Benefit Adviser works in the Benefits Management Office. An Adviser will help you understand your options when you or a family member will be hospitalized and work with your Physician so that you may be able to return home from the hospital more quickly.

EMERGENCY HOSPITAL CONFINEMENT—Any hospital inpatient admission for which a patient has 24 hours or less advance notice.

MAINTENANCE OR MAIL ORDER PRESCRIPTIONS—Prescribed medications used on continual basis for the treatment of chronic health conditions.

MEDICALLY NECESSARY—A specific medical health care or hospital service that is required, in the reasonable medical judgement of the Plan, for the treatment or management of a medical symptom or condition and that the service or care provided is the most economical care or service which can safely be provided. See page 30 for examples of health care services that may not be considered Medically Necessary.

PHYSICIAN—A legally qualified practitioner of the healing arts acting within the scope of his/her license.

SUDDEN AND SERIOUS ILLNESS—Any condition or symptom which becomes so acute in nature and which is of such severity that it does, in fact, constitute an extremely hazardous medical condition which would result in jeopardy to the patient's life or cause serious harm to the patient's health if not treated immediately.

NOTIFICATION—An Annuitant or eligible dependent contacts an Employee Benefit Adviser within 48 hours of admission to a hospital. Notification **must** occur to receive full plan benefits. (NON-MEDICARE ELIGIBLE ONLY)

MANDATORY OUTPATIENT SURGERY PROVISION—A plan provision requiring certain surgical procedures to be performed in an outpatient setting rather than as an inpatient. (NON-MEDICARE ELIGIBLE ONLY)

MANDATORY SECOND OPINION PROVISION—A plan provision requiring certain surgical procedures to have a second opinion before a decision whether or not to have surgery is made. (NON-MEDICARE ELIGIBLE ONLY)

DETERMINING WHAT IS "MEDICALLY NECESSARY"

Your City Plan does not pay for the cost of hospitalization or any other health care services and supplies that our claims administrator in its reasonable judgement decides were not Medically Necessary as explained below.

Hospitalization is not Medically Necessary when, in the reasonable medical judgement of our claims administrator, the medical services provided did not require an acute hospital inpatient (overnight) setting, but could have been provided in a Physician's office, the outpatient department of a hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are **not** Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or hospital outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., hospital outpatient department or Physician's office.
- Continued inpatient hospital care, when the patient's medical symptoms and condition no longer require a continued stay in a hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing custodial care, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or doctor or because care in the home is not available or is unsuitable.
- The use of skilled or private nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

Remember that our claims administrator makes the decision whether hospitalization or other health care services or supplies are not Medically Necessary, and therefore are not eligible for payment under the terms of your contract. In most instances, this decision is made by our claims administrator after you have been hospitalized or have received other health care services or supplies, and after a claim for payment has been submitted.

The fact that your doctor may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that our claim administrator will pay the cost of the hospitalization services or supplies.

REMEMBER, EVEN IF YOUR DOCTOR PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, OUR CLAIMS ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES OR SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

APPEAL PROCEDURES

If the Benefits Manager or his/her designee determines that an Annuitant and/or his/her dependents are ineligible to participate in the Plan, or that a claim is not covered, the Benefits Manager or his/her designee shall notify the Annuitant. Notice will be given in writing within 5 business days after the denial of eligibility or denial of a claim and will include the reason for denial and a statement of the Annuitant's right to appeal the denial to the Benefits Committee.

If an Annuitant disagrees with the Benefits Manager's denial of eligibility of the Annuitant and/or his/her dependents, or denial of a claim submitted by the Annuitant, the Annuitant may appeal such denial to the Benefits Committee. The appeal must be in writing and addressed to the Benefits Committee (c/o Benefits Management Office, 510 N. Peshtigo Court, Chicago, IL 60611). It must be delivered or postmarked no later than 10 calendar days after the notice of the denial. The appeal should include a brief statement of the reason the Annuitant believes the denial is wrong.

The Benefits Committee will notify the Annuitant of its decision on the appeal within 60 calendar days after receipt of the appeal.

IF YOU NEED MORE INFORMATION

This booklet contains an overview of the City of Chicago Annuitant Medical Benefits Plan. The services described in the booklet illustrate the way the plan works. You may review a copy of the detailed plan document in the Benefits Management Office during normal work hours or in the Municipal Reference Library of the City of Chicago.

If you need more information call the Benefits Management Office, (312) 744-0777.

Your City of Chicago
Annuitant Medical Benefits Plan

...a brief review of
eligibility, coverages
and how the Plan works

Harold Washington,
Mayor

IMPORTANT!
READ IMMEDIATELY
DATED MATERIALS

CITY OF CHICAGO

ANNUITANT MEDICAL CARE BENEFITS

September 10, 1984

EXHIBIT B

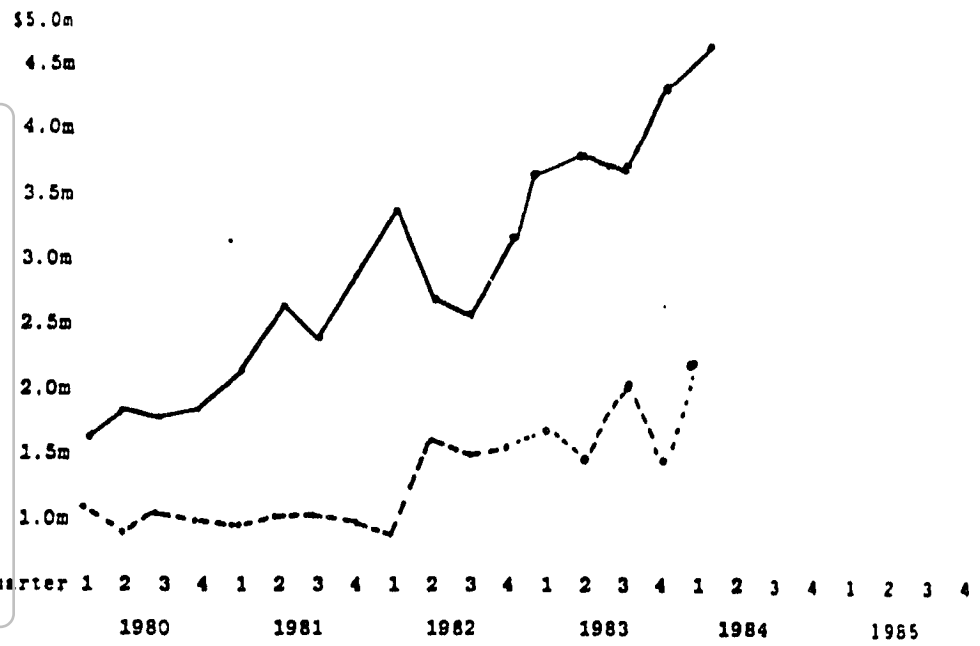
DISCUSSION TOPICS

- Cost of Annuitant Medical Benefits
- What Must be Done to Manage Costs in the Future
- How Retirement Funds and City of Chicago can Work Together to Manage Costs

COST OF ANNUITANT MEDICAL BENEFITS

HISTORIC

RETIREE MEDICAL CARE COSTS
CITY OF CHICAGO

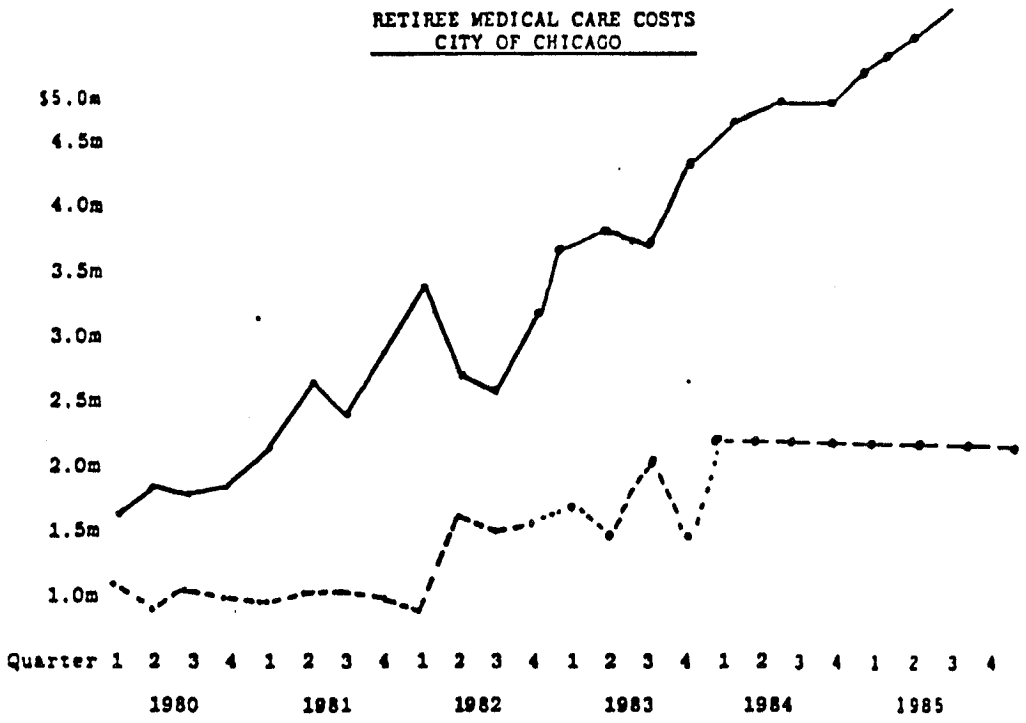


Solid line represents claims paic
plus administrative expenses for
retirees based on Bankers and Blu
Cross statistics.

Dotted line represents payments f
retirement boards.

COST OF ANNUITANT MEDICAL BENEFITS

PROJECTED



Solid line represents claims plus administrative expenses retirees based on Bankers and Cross statistics.

Dotted line represents paymen retirement boards.

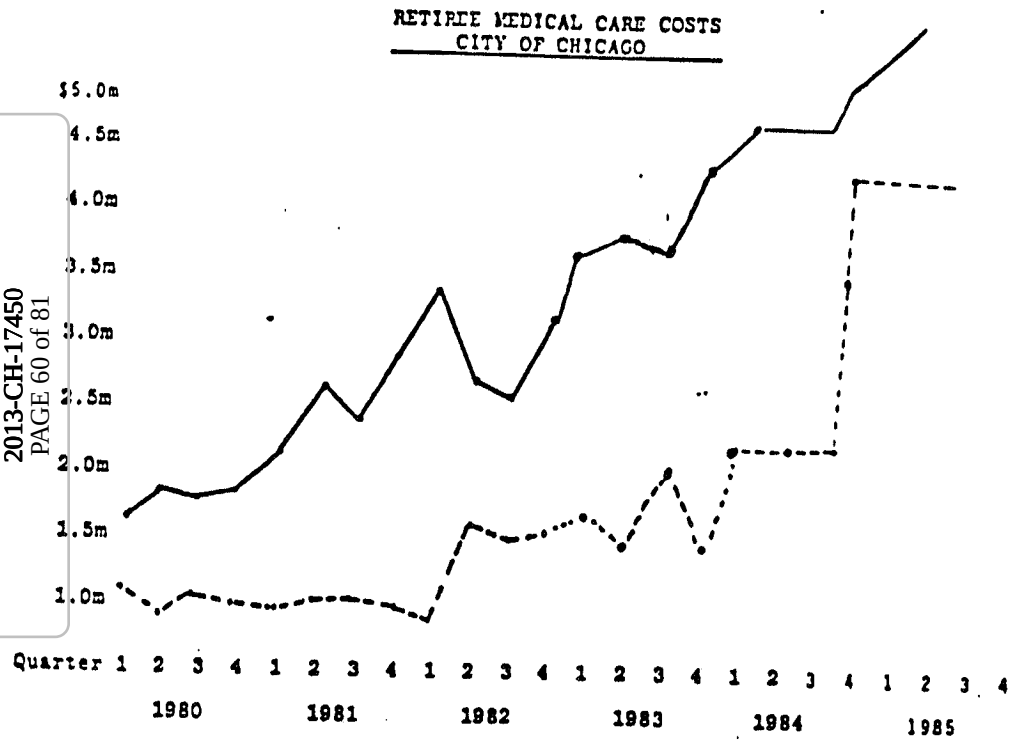
WHAT MUST BE DONE

- Double Contribution Rates November 1, 1984
- Revise Structure January 1, 1985 For Effective Management of Future Benefit Costs

DOUBLE CONTRIBUTION RATES NOVEMBER 1, 1984

Description	Monthly Cost Old Rate	Monthly Cost New Rate
Medicare Retirees		
Retiree Only	$ 21.00	$ 42.00
Retiree & Spouse	42.00	84.00
One on Medicare/ One Without Medicare	76.00	152.00
Early Retirees		
Retiree Only	55.00	110.00
Retiree & Spouse	110.00	220.00
Family	150.00	300.00
Miscellaneous		
2 Medicare, 1 Child	97.00	194.00
3 Medicare	63.00	126.00
2 Early Retiree, 1 Medicare	131.00	262.00

IMPACT OF INCREASED CONTRIBUTIONS



Solid line represents claims paid plus administrative expenses for retirees based on Bankers and Blue Cross statistics.

Dotted line represents payments fr retirement boards.

REVISE STRUCTURE JANUARY 1, 1985 FOR EFFECTIVE MANAGEMENT OF BENEFIT COSTS

- o Control Dependent Eligibility
- o Manage In-Hospital Stays
- o Encourage Use of Out-Patient Facilities
- o Increase Contributions

CONTROL DEPENDENT ELIGIBILITY

- o Re-enroll All Current Annuitants
- o Require Proof of Dependency
- o Obtain Information on Other Coverage for Dependents
- o Maintain Computerized Eligibility Records in Benefits Management Office

MANAGE IN-HOSPITAL STAYS

- Pre-notification required for any hospital stay unless patient has less than 24 hours notice
- Discussions Prior to Hospitalization of Alternatives to Proposed Treatment Plan
- Follow-up by Benefits Management Office to Facilitate Early Discharge from Hospital

ENCOURAGE USE OF OUTPATIENT FACILITIES

o Plan pays 100% of cost of

- outpatient surgery
- preadmission testing
- diagnostic testing

o Plan pays less than 100% of cost of inpatient surgery

o Plan pays nothing for inpatient charges for the following

- diagnostic testing
- pre surgery testing
- First Friday and Saturday of hospital stay if admitted on same Friday or Saturday
- Saturday and Sunday if discharge on Monday

o "Medical Necessity" tests apply to all confinements

o "Medical Necessity" decision may reverse any "no payment" situation

INCREASE CONTRIBUTIONS

Description	Current	11/84	1/85 est.
Medicare Retirees			
Retiree Only	$ 21.00	$ 42.00	$ 61.00
Retiree & Spouse	42.00	84.00	122.00
One on Medicare/ One Without Medicare	76.00	152.00	221.00
Early Retirees			
Retiree Only	55.00	110.00	160.00
Retiree & Spouse	110.00	220.00	320.00
Family	150.00	300.00	435.00
Miscellaneous			
2 Medicare, 1 Child	97.00	194.00	281.00
3 Medicare	63.00	126.00	183.00
2 Early Retiree, 1 Medicare	131.00	262.00	380.00

WHAT REVISIONS MEAN TO RETIREMENT FUNDS

- Must reenroll all current annuitants and obtain necessary documentation and information on other coverage.
- Must coordinate payments, eligibility lists and new enrollees with City's Benefits Management Office.
- Must communicate new plan and procedures to annuitants.

WHAT BENEFITS MANAGEMENT OFFICE WILL DO

- o Develop an enrollment package
- o Hold annuitant meetings to explain plan and answer questions
- o Educate annuitants on alternatives to City Plan

DEVELOP AN ENROLLMENT PACKAGE

- o Introductory letter
- o Enrollment forms and instructions for completion
- o Highlights of new plan benefits
- o Comparison of HMO alternatives
- o Cost comparisons
- o Rationale for changes
- o List of common questions and answers
- o Schedule of annuitant meetings

HOLD ANNUITANT MEETINGS

- Slide-tape presentation of new plan provisions and how to use them
- Discussion of alternatives to City Plan
- Slide-tape presentation explaining what an HMO is and how HMO coverage differs from City Plan
- Presentation of how to use Medicare
- Question and answer period

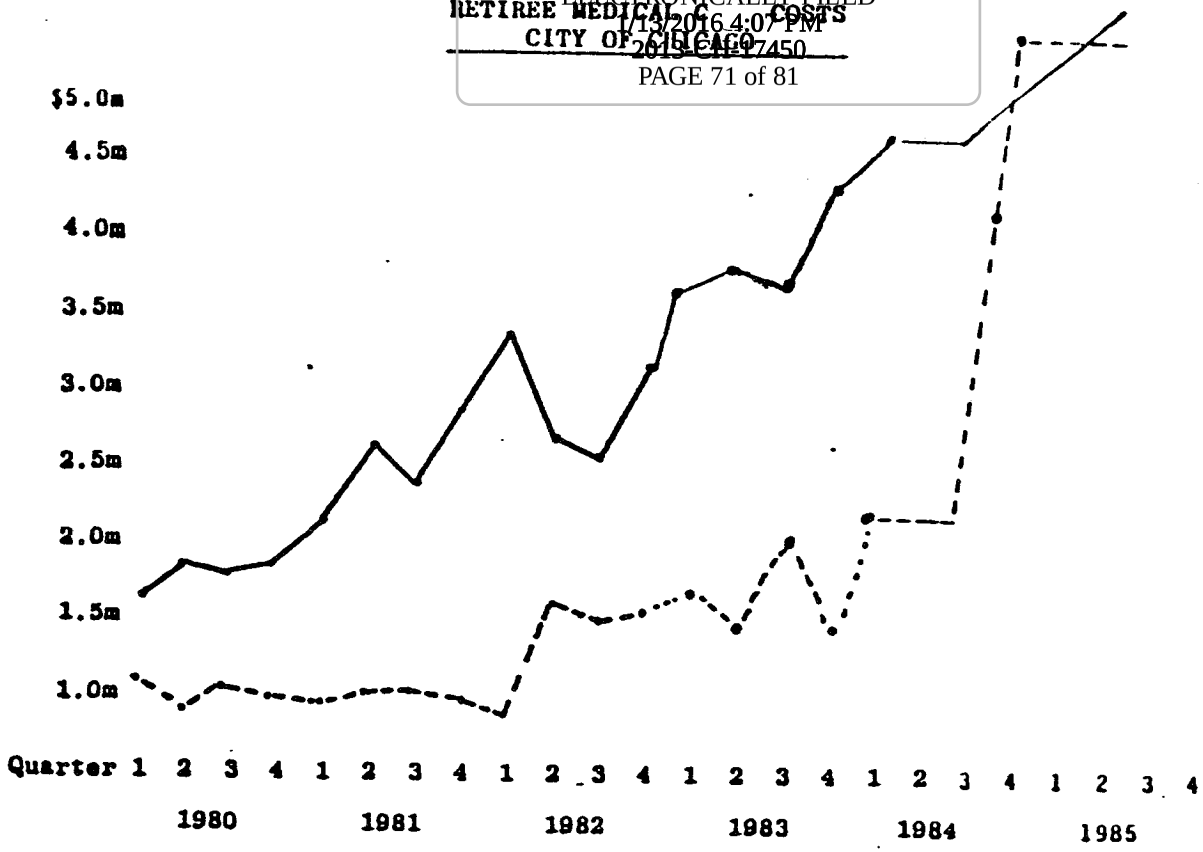
EDUCATE ANNUITANTS

- Booklet describing plan provisions

- Quarterly newsletter
  - -lifestyle tips
  - -alternatives
  - -how to use plan
  - -how to use Medicare

- Telephone contact

RETIREE MEDICAL COSTS
CITY OF CHICAGO



Solid line represents claims paid plus administrative expenses for retirees based on Bankers and Blu Cross statistics.

Dotted line represents payments f retirement boards.

City of Chicago
Harold Washington, Mayor

Department of Law
Judson H. Miner
Corporation Counsel

City Hall, Room 511
121 North LaSalle Street
Chicago, Illinois 60602
(312) 744-6900

October 19, 1987

Richard J. Jones
3927 W. 81st Place
Chicago, Illinois 60629

Re: Lawsuit re annuitants health benefits

Dear Mr. Jones:

From 1980 to the present, the City of Chicago has paid health care costs for the annuitants of the City's four pension funds in excess of the contributions made by the funds towards those costs. The payments have been made by the City without any appropriation, and thus they are illegal and must be repaid. Furthermore, each of the four funds is under a statutory obligation to contract for group health insurance for its annuitants. Each fund has failed to do so.

Enclosed, is a copy of a complaint which the City has today filed in the Circuit Court of Cook County against the members of the boards of each of the four funds, asking that: (1) the approximately $59 million dollars which the City illegally spent on annuitants health benefits be repaid, with interest, and (2) that the funds contract for health benefits as required by law.

I have taken this action because of the clear legal obligation on the part of the City to recover funds spent illegally, without prior appropriation. In order that this situation not be further aggravated I have also directed the City's Benefits office to cease making health care payments to pension fund annuitants as soon as each of the respective pension funds contracts for health insurance, but in no event later than January 1, 1988. The City will continue health care payments during the interim period so that annuitants health costs are paid while the boards have time to obtain lawful insurance coverage. However, the City will also seek return of payments made in the interim period, as they too will be made without lawful appropriation. In order to protect your annuitants I urge you to secure health insurance coverage for them immediately.

As the chief legal officer of the City of Chicago I

EXHIBIT C

am also, by statute, the designated attorney and legal advisor for each of the four pension boards. In practice, each of the boards has long employed one or more private attorneys to handle their legal matters. These attorneys have always been paid by the boards and have reported directly to them. Nonetheless, because of the conflicting financial interests of the boards and the City, I hereby notify you that I will have no involvement in this matter as attorney or legal advisor to the boards.

We have not yet placed the complaint for formal service. Please notify Assistant Corporation Counsel Amy Beckett (744-0746) whether you will accept service of process by this letter and the enclosed complaint, or whether you would prefer to be served by the Sheriff of Cook County.

Lastly, it is my sincere hope that we can avoid costly and unnecessary litigation by a negotiated resolution of this matter. I would like to meet with each board to discuss our claims as soon as possible. Please have your attorney contact Deputy Corporation Counsel Matthew J. Piers (744-0438) to schedule a meeting.

Sincerely,

JUDSON H. MINER
Corporation Counsel

cc: Members and attorneys of Police, Fire, Laborers and Municipal Employees retirement boards.
Matthew J. Piers
Joel Stein
Amy Beckett

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - CHANCERY DIVISION

(#90909)
CITY OF CHICAGO, a Municipal Corporation,

Petitioner,

vs.

No. 87CH10134

MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A. PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS, and JAMES McDONOUGH, IN THEIR CAPACITY AS THE BOARD MEMBERS OF OF THE POLICEMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; MICHAEL A. COHEN, NORMAN S. HOLLAND, ANN FOLEY, JAMES R. CONMEY, WALTER S. KOZUBOWSKI, RONALD D. PICUR, RONALD MALONEY, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE FIREMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, and EDWARD J. LAIRD, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE MUNICIPAL EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; ROGER E. McMAHON, RONALD D. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE LABORERS' & RETIREMENT BOARD EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000,

Respondents.

COMPLAINT FOR MANDAMUS, RESTITUTION, AND OTHER RELIEF

EXHIBIT D

COUNT I

Preliminary Statement

1. Count I of this action seeks a writ of mandamus to compel defendants, the board members of the Policemen's Annuity and Benefit Fund for cities over 500,000 and the board members of the Firemen's Annuity and Benefit Fund for cities over 500,000 to comply with their respective statutory obligations to enter into contracts with insurance carriers to provide group health insurance for their funds' annuitants.

Count I also seeks a writ of mandamus to compel the board members of the Municipal Employees' Annuity and Benefit Fund for cities over 500,000 and the board members of the Laborers' and Retirement Board Employees' Annuity and Pension Fund for cities over 500,000 (Laborers' Board) to comply with their respective statutory obligations to approve a group hospital care plan and a group medical and surgical plan for their respective funds' participating annuitants.

Parties

2. Petitioner, City of Chicago, is a municipal corporation, organized in accordance with Ill. Rev. Stat. ch. 24, §1-1-1.

3. Respondents Marshall Korshak, Russell Ewert, Odell Hicks, Thomas D. Allison, Fred W. Settles, Cecil A. Partee, Chester Jaskolka, Ronald R. Norris and James McDonough constitute the retirement board of the Policemen's Annuity and Benefit Fund established in accordance with Ill. Rev. Stat. ch. 108-1/2, §5-178 and

are responsible for, inter alia, administration of Article 5 of the Illinois Pension Code.

4. Respondents Michael A. Cohen, Norman S. Holland, Ann Foley, James R. Conmey, Walter S. Kozubowski, Ronald Maloney, Cecil A. Partee, and Ronald D. Picur constitute the retirement board of the Firemen's Annuity and Benefit Fund (Firemen's Board) established in accordance with Ill. Rev. Stat. ch. 108-1/2, §6-174 and are responsible for, inter alia, administration of Article 6 of the Illinois Pension Code.

5. Respondents William J. McMahon, Ronald D. Picur, Cecil A. Partee, Wayne N. Marshall, and Edward J. Laird constitute the retirement board of the Municipal Employees' Annuity and Benefit Fund (Municipal Board) established in accordance with Ill. Rev. Stat. ch. 108-1/2, §8-192 and are responsible for, inter alia, administration of Article 8 of the Illinois Pension Code.

6. Respondents Roger E. McMahon, Ronald D. Picur, Carmen Iacullo and Cecil A. Partee constitute the retirement board of the Laborers and Retirement Board of the Employees' Annuity and Benefit Fund (Laborers' Board) established in accordance with Ill. Rev. Stat. ch. 108-1/2, §11-181, and are responsible for, inter alia, administration of Article 11 of the Illinois Pension Code.

7. Respondent board members are sued in their official capacities as members of their respective retirement boards.

Factual Allegations

8. Section 5-167.5 of the Policemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2 §5-167.5, and Section 6-164.2 of the

Firemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2 §6-164.2 are identical and provide that: 1) "The Board shall contract with one or more [insurance] carriers to provide group health insurance for all annuitants; 2) an insurance carrier is defined as "an insurance company, or a corporation organized under the Nonprofit Hospital Service Plan Act, the Medical Service Plan Act or the Voluntary Health Services Plan Act, which is authorized to do group health insurance business in Illinois"; 3) the board shall pay the premiums for health insurance for each annuitant so that the basic monthly premium for each annuitant will be contributed: a) from the City's tax levy on behalf of the fund up to a maximum of $55.00 per month for annuitants not qualified to receive Medicare benefits and $21.00 per month for those who are qualified; and b) where the basic monthly premium exceeds the maximum to be contributed by the City on each annuitant's behalf, such excess shall be deducted by the board from the annuitant's monthly annuity.

9. The statutory provisions of the Policemen's Annuity Fund and Firemen's Annuity Fund concerning group health insurance were effective as of January 12, 1983.

10. Upon information and belief, from January 1983 to the present, neither the Policemen's Board nor the Firemen's Board has contracted with an insurance carrier to provide group health insurance for annuitants.

11. Section 8-164.1 of the Municipal Employees' Pension Statute, Ill. Rev. Stat. ch. 108-1/2, §8-164.1, and section 11-

160.1 of the Laborers' Pension Statute, Ill. Rev. Stat. ch. 108-1/2, §11-160.1 are identical and provide that: 1) each annuitant who is over 65 years of age and had at least fifteen years of municipal employment may participate in a group hospital care plan and a group medical and surgical plan (a plan) approved by the board (emphasis added); 2) the board is authorized to make health insurance payments from the City's tax levy up to $25.00 per month per annuitant; and 3) if the monthly premium exceeds the $25.00 statutory authorization: a) the excess may be deducted from the annuitant's annuity at the annuitant's election, or else b) the coverage shall terminate.

12. The statutory provisions of the Municipal Employees' Fund and the Laborers' Fund concerning group health insurance were effective as of July 18, 1985, and August 16, 1985, respectively.

13. Upon information and belief, from July 1985 to the present, neither the Municipals Employees' Board nor the Laborers' Board has approved a plan in which their annuitants may participate.

14. Until the filing of this complaint, the annuitants of all four funds receive health insurance through the City, which is a self-insurer.

Cause of Action

15. Respondents failed to carry out the statutory duties set forth in paragraphs 8 through 14.

16. Respondents are without discretion to refuse or otherwise fail to carry out the statutory duties enumerated in the sections of the Pension Code set forth in paragraphs 8 through 14.

17. The City is entitled to the respondents' execution of their statutory duties as members of their respective Pension Boards as a matter of law.

WHEREFORE, the petitioner prays that the Court:

A. Issue a writ of mandamus compelling the Police Board and Fire Board immediately to enter into contracts with insurance carriers to provide health insurance for their annuitants, and compelling the Municipal Employees' Board and Laborers' Board to approve a plan in which their respective annuitants may participate;

B. Issue a writ of mandamus compelling respondents Police, Fire, Municipal Employees' and Laborers' Boards to pay the excess monthly health insurance premium above the City's statutory tax levy contribution with monies deducted from each annuitant's annuity, and further requiring respondents Laborers' and Municipal Employees' Boards to terminate coverage for all annuitants who elect coverage and decline to pay the excess premiums out of their annuities.

COUNT II

Preliminary Statement

1. In Count II of this action, the City seeks to recover funds wrongfully expended by the City without a statutorily

required appropriation on behalf of annuitants of the four funds from 1980 to the present.

Parties

2-6. The City realleges paragraphs 2 through 6 of Count I and incorporates them by reference.

Factual Allegations

7. From 1980 through the present, the City has paid the health insurance coverage for annuitants of the Policemen's, Firemen's, Municipal Employees' and, Laborers' Annuity and Pension Funds and their dependents by allowing these annuitants and their dependents to use the City's own Health Care Plan.

8. The City is a self-insurer of its Health Care Plan.

9. The excess costs for health insurance paid by the City on behalf of annuitants of the four funds for the period 1980 through June 1987 are: Policemen's Fund - $27 million; Firemen's Fund- $9.3 million; Municipal Employees' Fund - $18.5 million; and Laborers' Fund - $4.0 million, for a total of $58.8 million. (All figures rounded to the nearest one hundred thousand dollars.)

10. The City has, from 1980 through June 1987, provided approximately $58.8 million on behalf of the pension funds for their annuitants over and above the premiums paid by those funds for the annuitants' health insurance costs.

11. The City spent this money for the funds and for the benefit of their annuitants and dependents from 1980 through June 1987 without an appropriation by the corporate authority as

required by ch. 24, section 8-1-1, of the Illinois Revised Statutes, and as required by the yearly Appropriation Ordinances of the City.

Cause of Action

12. The City has wrongfully expended public funds for the benefit of the four pension funds without statutory authority to do so.

13. The City is entitled to recover these funds.

WHEREFORE, the City prays for judgment as follows:

A. Ordering all four Boards to make restitution to the City in the full amount of the subsidies provided their respective funds from 1980 through 1987, plus interest and costs.

JUDSON H. MINER
Corporation Counsel
City of Chicago

By: _____
MATTHEW J. PIERS
Deputy Corporation Counsel

DATED: October 19, 1987

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Chief Assistant Corporation Counsel
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Assistant Corporation Counsel
Affirmative Litigation Division
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180 North LaSalle Street
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Chicago IL 60601

EXHIBIT 3
Korshak: Police Fund's Counterclaims

Attorney No. 23414

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

THE CITY OF CHICAGO, a municipal corporation, Plaintiff-Counterdefendant, vs. MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A. PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS and JAMES McDONOUGH, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE POLICEMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; MICHAEL A. COHEN, NORMAN S. HOLLAND, ANN FOLEY, JAMES R. CONMEY, WALTER S. KOZUBOWSKI, RONALD D. PICUR, RONALD MALONEY, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE FIREMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, and EDWARD J. LAIRD, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE MUNICIPAL EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; ROGER E. McMAHON, RONALD D. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE LABORERS' & RETIREMENT BOARD EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000, Defendant-Counterplaintiffs.	No. 87 CH 10134

VERIFIED COUNTERCLAIM FOR INJUNCTION AND OTHER RELIEF

Defendants-counterplaintiffs, MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A. PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS and JAMES McDONOUGH, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE POLICEMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000, complain

of the plaintiff-counterdefendant, the CITY OF CHICAGO, a municipal corporation, as follows:

Preliminary

1. The POLICEMEN'S ANNUITY & BENEFIT FUND OF THE CITY OF CHICAGO ("the Fund") was established in accordance with Section 5-178 of the Policemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2, ¶ 5-178. The Fund maintains its principal place of business in Chicago, Cook County, Illinois.

2. Counterplaintiffs Marshall Korshak, Russell Ewert, Odell Hicks, Thomas D. Allison, Fred W. Settles, Cecil A. Partee, Chester Jaskolka, Ronald R. Norris and James McDonough are each Members of the retirement board of the Fund.

3. The Fund is engaged, inter alia, in the business of administering certain annuity and disability insurance programs for retired employees of the City of Chicago's Police Department and their dependents.

4. Counterdefendant the CITY OF CHICAGO ("the City") is a municipal corporation, organized in accordance with Section 1-1-1 of the Illinois Municipal Code, Ill. Rev. Stat. ch. 24, ¶ 1-1-1.

5. Some or all of the acts complained of herein took place in Cook County, Illinois.

6. Beginning in and continuously since approximately 1964, many of the Fund's annuitants have participated, with active City of Chicago employees, in a group medical benefits program sponsored by the City. That program, since the mid-1970's, has been administered on a self-funded, "claims made" basis. There is no insurance policy issued by an insurance

company to cover claims made by the annuitants. Rather, when a covered claim is submitted by a covered individual, whether an active employee or a covered annuitant, the City simply reimburses the private carriers which administer the program as the City's agents, and which pay the claims made by the covered individuals.

7. Approximately 5,200 of the Fund's annuitants currently participate in the City-sponsored group medical benefits program. Those annuitants, together with their spouses and other dependents who also may be covered by the program, comprise a group of approximately 10,000 individuals. A true and accurate copy of the City of Chicago Annuitant Medical Benefits Plan ("the City's Plan"), which has been in effect since September 1, 1985, is attached hereto and incorporated herein as Exhibit A.

8. Since January 12, 1983, there has been in force and effect in the State of Illinois, a certain statute known as Section 5-167.5 of the Policemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2, ¶ 5-167.5. That statute provides, in relevant part:

* * *

> (b) The Board shall contract with one or more carriers to provide group health insurance for all annuitants.
>
> * * *
>
> (d) The Board shall pay the premiums for such health insurance for each annuitant with funds provided as follows:
>
> The basic monthly premium for each annuitant shall be contributed by the city from the tax levy prescribed in Section 5-168, up to a maximum of $55 per month if the annuitant is not qualified to receive medicare benefits, or up to a maximum of $21 per month if the annuitant is qualified to receive medicare benefits.

If the basic monthly premium exceeds the maximum amount to be contributed by the city on his behalf, such excess shall be deducted by the Board from the annuitant's monthly annuity, unless the annuitant elects to terminate his coverage under this Section, which he may do at any time.

9. Between the mid-1960's and April of 1982, the monthly rates charged the annuitants by the City for their medical benefits coverage were periodically increased. Nonetheless, since the mid-1970's, when the City's Plan became self-funded, the City has been paying a portion of the costs of the annuitants' medical benefits.

10. Effective April 1, 1982, the City established the following monthly rates for the Fund's annuitants' medical benefits coverage:

Under Age 65 - Single	$ 55.00
Under Age 65 - Family of Two	110.00
Under Age 65 - Family of Three or more	150.00
Medicare Eligible - Single	21.00
Medicare Eligible - Two	42.00
One Over 65, One Under Age 65	76.00

11. Notwithstanding the provisions of Section 5-167.5 of the Policemen's Annuity Fund Act, and notwithstanding the fact that the actual cost of the coverage has increased dramatically since 1982, these rates for the Fund's annuitants' medical benefits coverage have remained unchanged to the present date. Since April of 1982 the City has paid the cost of the Fund's annuitants' medical benefits to the extent that they exceed the rates established at that time.

12. Both the Fund and the City have at all times been aware that the rates in effect since the mid-1970's were substantially less than the actual costs incurred by the City in paying the Fund's annuitants' medical claims under the Plan (together with the costs of administering that Plan).

In September of 1984, for example, the City prepared a report titled "City of Chicago Annuitant Medical Care Benefits" in which it demonstrated the large disparity between contributions from the Fund, and the similar funds for other retired City employees, and the actual costs being incurred by the City. A copy of that report is attached hereto as Exhibit B.

13. The 1984 "City of Chicago Annuitant Medical Care Benefits" report proposed that the rates paid by the annuitants be increased by 100% effective two months later, in November of 1984, and increased by another substantial percentage three months after that, in January of 1985.

14. Despite this and other periodic "proposals" from the City that the annuitants' health insurance rates be increased, the Fund was never directed to begin making deductions for retired employees with individual coverage or to increase the amounts being deducted from the annuitants' monthly checks for the cost of their dependents' health insurance.

15. In mid-October of 1987, the director of the Fund received a letter from the Corporation Counsel for the City advising the Fund that from 1980 to the present the City has paid health care costs for the annuitants of the City's four pension funds in excess of the contributions made by the funds towards those costs. A copy of that letter is attached hereto as Exhibit C. That letter further advised the Fund that the payments made by the City were not the subject of any appropriation and were thus illegal and must be repaid. The letter also advised the Fund that the City had filed a complaint in the Circuit Court of Cook County, naming as defendants the trustees of the four funds, asking that $59 million be repaid ($27 million

from the policemen's fund), plus interest, and that the funds contract for health benefits as required by statute. Finally, the Corporation Counsel advised the Fund that he had directed the City's Benefits Office to cease making health care payments to pension fund annuitants as soon as each of the respective pension funds enters contracts for health insurance but in no event no later than January 1, 1988.

16. The complaint referred to in the Corporation Counsel's letter was filed on October 19, 1987, and is styled City of Chicago v. Marshall Korshak et al., 87 CH 10134. A true and accurate copy of that complaint is attached hereto as Exhibit D.

COUNT I - TERM AND CONDITION OF EMPLOYMENT

1.-16. As paragraphs 1 through 16 of this Count I, counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 16 of this Counterclaim.

17. Since the mid-1960's the City has paid the full cost of medical insurance coverage for the active employees of the City's Police Department. Since 1971, the City has paid the full cost of medical benefits for the active employees of the City's Police Department and for their spouses and dependents.

18. For the past ten years it has been common knowledge among the active City of Chicago policemen that the annuitants participate in the City's Annuitant Medical Benefits Plan and that the City pays a substantial portion of the cost of its annuitants' medical care benefits.

19. The active City of Chicago policemen, for the past ten years, relied upon this retirement benefit in continuing their employment with the City.

20. The City's inclusion of the annuitants in its medical benefits program and its payment of a substantial portion of the cost of its annuitants' medical care benefits thus became a term and condition of employment for active employees of the Police Department of the City.

21. The City's announced intention to terminate medical care benefits for the Fund's annuitants as of December 31, 1987, is a breach of those terms and conditions of these employment contracts with the City.

22. It would be inequitable and unjust to permit the City to breach these established terms and conditions of employment.

23. The Fund and its annuitants will suffer substantial and irreparable harm if the City is not enjoined from terminating the medical care benefits it has provided to them for the past 20 years. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate their medical benefits coverage on December 31, 1987.

24. Plaintiffs have no adequate remedy at law.

COUNT II - IMPLIED CONTRACT

1.-16. As paragraphs 1 through 16 of this Count II, counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 16 of Count I.

17. The City's actions described above gave rise to an implied contract between the Fund, the annuitants and the City under which the City

agreed to include the annuitants in the Plan's coverage and to pay the cost of the annuitants' medical benefits coverage to the extent that it exceeds the rates established for the medical benefits coverage effective April 1, 1982.

18. The City's letter to the Fund dated October 19, 1987 and its filing of the complaint described in paragraphs 15 and 16 above, constitute a breach of that implied contract.

19. The Fund and its annuitants will suffer substantial and irreparable damage if the City is not enjoined from terminating the implied contract under which it agreed to and has, for more than five years, paid the costs of the annuitants' health insurance in excess of the rates effective April 1, 1982. Termination of the contract on January 1, 1988 would expose the annuitants to the risk of a financial catastrophe if they incur substantial medical expenses with no insurance coverage.

20. It would be inequitable and unjust to permit the City to breach this implied contract.

21. Counterplaintiffs have no adequate remedy at law.

COUNT III - BREACH OF CONTRACT

1.-16. As paragraphs 1 through 16 of this Count III, counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 16 of Count I.

17. The City has undertaken to provide medical benefits coverage to the Fund's annuitants since the mid-1960's and has been in a contractual

relationship with each annuitant who chose to participate in the City's medical benefits program during this twenty year period.

18. The Fund's annuitants are presently covered by the City's Plan attached hereto as Exhibit A.

19. The City's Plan, which by its terms was effective September 1, 1985, provides as follows regarding "Termination of Coverage:"

> Coverage for you and your eligible dependents will terminate the first of the month following
>
> - the month a deduction is not taken from your annuity, or
>
> - the month you reach the limiting age for City-paid benefits, if you have not arranged for deductions from your annuity check.
>
> In addition, coverage for you and your eligible dependents will terminate the earliest of
>
> - the date it is determined that you have knowingly submitted false bills or bills for ineligible dependents for reimbursement under this Plan
>
> - the date the Plan is terminated, or
>
> - the date the Plan is terminated for the class of Annuitant of which you are a member.

20. The City's Plan does not itself contain any procedures or time frame regarding a notice of intent to terminate the Plan.

21. In the absence of an express term, a reasonable notice period must be implied.

22. The City's letter of October 19, 1987, informing the Fund that coverage would be terminated no later than December 31, 1987 is not, under

the circumstances presented here, a reasonable period of notice of intent to terminate the Plan.

23. Upon receipt of the City's October, 1987 letter, the Fund contacted a number of private health insurance companies and requested quotations as to the cost of coverage for the approximately 10,000 individuals (the annuitants and their dependents) who are now covered by the City's Plan.

24. The Fund is awaiting those price quotations.

25. When the Fund has the price quotations and details of the coverage being offered by the private carriers, it will then have to determine which proposal is in the best interest of the Fund and its annuitants, taking into account, inter alia, such criteria as administrative cost factors, service capabilities of the carrier, and the premiums charged. (See Ill. Rev. Stat. ch. 108-1/2, ¶5-167.5(c).) The Fund will then enter contracts with one or more carriers to provide group health insuance for all annuitants, pursuant to the terms of Section 5-167.5(b) of the Policemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2, ¶5-167.5(b).

26. Once the Fund enters into a contract(s) with a private carrier, the annuitants will have to be given notice of the terms and cost of the new policy and be given a reasonable time within which to decide whether to terminate their coverage through the Fund. See Ill. Rev. Stat. ch. 108-1/2, ¶5-167.5(d).

27. This process, involving the solicitation and evaluation of proposals from various private carriers, negotiating and executing contracts

with one or more of them, and giving the annuitants reasonable notice of the terms and costs of the new coverage, will not and cannot be accomplished by the City's announced termination date of January 1, 1988.

28. The City has breached the Plan by failing to give sufficient notice of its intent to terminate the Plan.

29. It would be inequitable and unjust to permit the City to terminate the City's Plan on such short notice.

30. The Fund's annuitants will suffer substantial and irreparable harm if the City is permitted to terminate the City's Plan on such short notice. The annuitants will be exposed to the risk of financial catastrophe if the City is permitted to terminate coverage effective January 1, 1988.

31. Counterplaintiffs have no adequate remedy at law.

COUNT IV-EQUITABLE ESTOPPEL

1. - 16. As paragraphs 1 through 16 of this Count IV counterplaintiffs reallege and incorporate as though fully set forth herein paragraphs 1 through 16 of Count I.

17. The City has engaged in a continuous pattern of affirmative acts over the past ten years by paying a substantial portion of the cost of the annuitants' medical care benefits. Since April of 1982, the City has paid all the costs in excess of the rates which went into effect at that time.

18. The City's actions have been taken with full knowledge of the actual amounts expended by it for the annuitants' medical care benefits.

19. The Fund and its annuitants have reasonably relied on the City's payment of those costs.

20. In reliance on this longstanding practice of the City, the Fund took no steps until after receipt of the City's letter of October 19, 1987, to locate a private health insurance carrier to provide medical insurance for the Fund's annuitants and the annuitants have not planned for the financial burden of having to pay the full cost of their own medical insurance.

21. It would be inequitable and unjust to permit the City to terminate this practice.

22. If the City is permitted to terminate the annuitants' medical care benefits on December 31, 1987, the Fund and its annuitants will suffer substantial and irreparable harm. The annuitants will be exposed to the risk of a financial catastrophe if they incure substantial medical expenses with no insurance coverage.

23. The City is estopped from terminating this long standing practice.

24. Counterplaintiffs have no adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, Counterplaintiffs pray for a judgment, order and decree against the counterdefendant as follows:

A. That the City of Chicago be restrained and enjoined, both temporarily and permanently, from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan;

B. That the City of Chicago be restrained and enjoined from ceasing its practice of paying the cost of the Fund's annuitants' medical benefits to the extent that it exceeds the rates which went into effect in April of 1982.

C. That in the alternative, the City of Chicago be restrained and enjoined from terminating coverage of the Fund's annuitants under the City of Chicago Annuitant Medical Benefits Plan until the Fund has had sufficient time to contract for similar medical benefits coverage with a private insurance carrier;

D. That this Court retain jurisdiction of this action to enforce its injunction order;

E. For such other and further relief as this Court may deem just and proper together with the costs of this action.

One of the Attorneys for Counter-plaintiffs

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VERIFICATION

JAMES B. WATERS, JR., Executive Director of the Policemen's Annuity & Benefit Fund of the City of Chicago, having been first duly sworn on oath, states that he has knowledge of all of the facts asserted in the VERIFIED COUNTERCLAIM FOR INJUNCTION AND OTHER RELIEF and that the facts alleged are true.

James B. Waters, Jr.
Executive Director of the
Policemen's Annuity & Benefit
Fund of the City of Chicago

SUBSCRIBED and SWORN to
before me this 14th day
of December, 1987.

Jeannie S. Sievers
Notary Public

12/15

Attorney No. 23414

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

THE CITY OF CHICAGO, a municipal corporation,

Plaintiff-Counterdefendant,

vs.

No. 87 CH 10134

MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A. PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS and JAMES McDONOUGH, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE POLICEMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; MICHAEL A. COHEN, NORMAN S. HOLLAND, ANN FOLEY, JAMES R. CONMEY, WALTER S. KOZUBOWSKI, RONALD D. PICUR, RONALD MALONEY, and CICIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE FIREMEN'S ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; WILLIAM J. McMAHON, RONALD D. PICUR, CECIL A. PARTEE, WAYNE N. MARSHALL, and EDWARD J. LAIRD, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE MUNICIPAL EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000; ROGER E. McMAHON, RONALD D. PICUR, CARMEN IACULLO, and CECIL A. PARTEE, IN THEIR CAPACITY AS THE BOARD MEMBERS OF THE LABORERS' & RETIREMENT BOARD EMPLOYEES' ANNUITY & BENEFIT FUND FOR CITIES OVER 500,000,

Defendant-Counterplaintiffs.

MOTION FOR PRELIMINARY INJUNCTION

Now come the counterplaintiffs, MARSHALL KORSHAK, RUSSELL EWERT, ODELL HICKS, THOMAS D. ALLISON, FRED W. SETTLES, CECIL A. PARTEE, CHESTER JASKOLKA, RONALD R. NORRIS and JAMES McDONOUGH, in their capacities as the Board Members of the Policemen's Annuity and Benefit Fund, by their counsel,

and move this Court for the entry of a preliminary injunction restraining the counterdefendant, the CITY OF CHICAGO, during the pendency of this case, from terminating the medical benefits coverage presently afforded under the City of Chicago Annuitant Medical Benefits Plan to the annuitants of the Policemen's Annuity & Benefit Fund of the City of Chicago ("the Fund") or from terminating its present payment of all the costs of such coverage in excess of the rates which have been in effect since April of 1982. In support of this motion, the Fund states as follows:

1. The allegations contained in the Verified Counterclaim are hereby incorporated in this motion as though fully set forth herein.

2. A plaintiff seeking a preliminary injunction must establish that it has a lawful right, certain and clearly ascertained, which is worthy of protection. Schwalm Electronics v. Electrical Products Corp., 14 Ill. App.3d 348, 302 N.E.2d 394 (1st Dist. 1973). The allegations of the Verified Counterclaim demonstrate the existence of such a right. The Fund in its own capacity, and the annuitants for whom it administers the annuitants' medical insurance program, have a clearly ascertained right to the continuation of the benefits provided to the annuitants under what is now known as the City of Chicago Annuitant Medical Benefits Plan ("the Plan"). That right derives from an express or implied contract. In addition, the City is estopped from terminating the long standing practice of providing medical benefits coverage to the Fund's annuitants as well as paying most of the cost of that coverage.

3. The plaintiff seeking a preliminary injunction must also demonstrate that it will suffer irreparable injury without the protection of

a preliminary injunction. "Irreparable injury" is established where there is no adequate remedy at law, because either money damages are inadequate compensation or the damages are incapable of quantification. Hutter v. Lake View Trust & Savings Bank, 54 Ill. App.3d 653, 370 N.E.2d 47 (1st Dist. 1977), cert. denied, 439 U.S. 1004 (1978). In other cases, courts have readily granted and subsequently upheld injunctions where loss of medical coverage threatened irreparable harm. Auto Workers Local 645 v. General Motors, 112 LRRM 3345 (C.D. Cal. 1982); United Steelworkers of America v. Fort Pitt Steel Casting, 598 F.2d 1273 (3d Cir. 1979). In Auto Workers, the District Court granted the injunction to preserve the status quo relating to health-care coverage stating that:

> The lack of health-care benefits will result in many cases in the inability to obtain needed medical treatment and, in some cases, in the termination of current necessary treatment for employees or their dependents now covered by health insurance. The harm likely to result from termination of health benefits will be irremediable. Id. at 3345.

In Fort Pitt Steel Casting, the Third Circuit upheld the District Court's finding that irreparable harm would occur if the employer ceased health insurance payments, noting that:

> ...the fact that payment of monies is involved does not automatically preclude a finding of irreparable injury. If the risk of "water pipes freezing" can constitute irreparable injury, see Celotex Corp. v. Oil Workers, 516 F.2d 242, 247 (3d Cir. 1975), then surely the possibility that a worker would be denied adquate medical care as a result of having no insurance would

constitute "substantial and irreparable injury." Id. at 1280.

The irreparable injury to the Fund and its annuitants here is plain. Replacing the coverage the annuitants presently have under the Plan is no simple matter and cannot be accomplished in the short amount of time within which the City is demanding that it be done (by January 1, 1988). Although the Fund has asked various private insurance carriers for quotations of premium levels which would give the annuitants the same coverage they now have, the private insurance companies have not yet responded. Once the quotations are in hand, the Trustees will have to select a carrier, pursuant to the terms of Section 5-167.5 of the Policemen's Annuity Fund Act, Ill. Rev. Stat. ch. 108-1/2, par. 5-167.5, and the annuitants will have to be given a reasonable period of time to decide whether to subscribe to this new group plan or whether to arrange for their own medical insurance. This cannot be accomplished by the City's January 1, 1988 deadline. The 5,200 retirees of the Fund who participate in the City's medical benefits program, together with their dependents (an estimated 8,400 individuals in all) will be without any medical insurance coverage on January 1, 1988, unless the City is enjoined from terminating the present coverage. The damages which would be suffered by the Fund and its retirees if the present coverage is terminated on January 1, 1988, are incapable of quantification.

4. The plaintiff seeking a preliminary injunction must also show that the injunction sought is designed to maintain the status quo. Bullard v. Bullard, 66 Ill. App.3d 132, 383 N.E.2d 684 (5th Dist. 1978). The status quo is defined as "the last actual, peaceable status preceding the pending

controversy." Sports Unlimited v. Scotch & Sirloin of Woodfield, 58 Ill. App.3d 579, 584, 374 N.E.2d 916, 920 (1st Dist. 1978). The Fund is seeking to maintain the status quo pending this Court's adjudication of the merits of the claims set forth in the Verified Complaint. The City is attempting to alter the status quo by terminating the annuitant's coverage under the Plan, coverage which has been provided to the retirees for the past 20 years.

5. The plaintiff must also show the inadequacy of a legal remedy. It is not necessary to show the total absence of a legal remedy; rather it must merely be shown that the requested equitable relief is in some respect superior to available legal relief. Bio-Medical Laboratories v. Trainor, 68 Ill.2d 540, 549, 370 N.E.2d 223, 227 (1977). As demonstrated in paragraph 3 above, an injunction to prevent the City's termination of the annuitants' medical benefits coverage is clearly a superior remedy than mere money damages.

6. The party seeking a preliminary injunction must demonstrate that it has a likelihood of success on the merits. LaSalle National Bank v. County of Cook, 57 Ill.2d 318, 312 N.E.2d 252 (1974); S&F Corp. v. American Express Co., 60 Ill. App.3d 824, 377 N.E.2d 73 (1st Dist. 1978). The Verified Counterclaim is in four counts. The four claims alleged are: (1) the City's announced intent to terminate coverage and to stop paying most of the cost of that coverage is a breach of a term and condition of the employment contract between the City and its employees; (2) the City's announced intent to terminate coverage is a breach of an implied agreement to continue that coverage and to continue to pay most of the costs thereof; (3)

the City should be estopped from terminating the annuitants' coverage and paying most of the cost thereof where its actions induced the detrimental reliance of the Fund and its annuitants; and, in the alternative, (4) the City's announced intent to terminate coverage by January 1, 1988 is a breach of the City of Chicago Annuitant Medical Benefits Plan because a "reasonable" notice of termination is required and has not been given.

Term and Condition of Employment

For the past 10 years it has been common knowledge among the active City of Chicago policemen that the annuitants participate in the City's Plan and that the City pays a substantial portion of the cost of the annuitants' medical care benefits. The active policemen, over the past ten years, relied upon the existence of this retirement benefit in continuing their employment with the City. The City's inclusion of the annuitants in its medical benefits program and its payment of a substantial portion of the cost of that program for the annuitants thus became a term and condition of employment for the active employees of the Police Department. The City's announced intention to terminate the annuitants' medical coverage and to terminate its payment of the cost thereof is a breach of the employment contract as to the annuitants, particularly those who left the active employ of the City over the past ten years. In a recent Illinois Supreme Court case, Duldulao v. St. Mary of Nazareth Hospital Center, 115 Ill.2d 482, 505 N.E.2d 314 (1987), the Court held that under certain circumstances an employee handbook or other policy statement may create enforceable contractual rights in favor of an employee. This holding was not expressly limited to written statements of

company policy. Under the circumstances presented here, it is clear that the City's long-standing practice of including annuitants in its medical benefits plan and the subsidization of a substantial portion of the costs thereof became a term and condition of employment which the City is now attempting to breach. It should not be permitted to do so.

Implied Contract

The City's actions in providing the annuitants with coverage over the past 20 years and in paying a substantial portion of the cost of that coverage over the past ten years, gave rise to an implied contract under which the City agreed to continue these practices. The City now claims it will cancel this contract effective January 1, 1988. This is a breach of the City's implied contract with the Fund and its annuitants. The City benefited this implied contract in that it assured the continuing services and good will of its active employees.

Breach of the City's Annuitant Medical Benefits Plan

Count III of the Verified Counterclaim alleges that the City's announcement, on October 19, 1987, that it would terminate the Plan as to the Fund's annuitants effective January 1, 1988, was a breach of the implied terms of that Plan. Although the Plan provides that coverage will terminate "the date the Plan is terminated," it does not contain any procedure or time frame regarding a notice of intent to terminate the Plan. In the absence of an express term, a reasonable notice period must be implied. Patton v. Farmers Mut. Fire Ins. Co., 125 S.W.2d 498 (Ct. App. Tenn., 1938); Chadbourne v. German-American Ins. Co., 32 F. 533 (S.D.N.Y. 1887). Under the

circumstances presented here, the City has not given reasonable notice of its intent to terminate the Plan. Implicit in the terms of the Plan is a reasonable notice period prior to termination. The City should be enjoined from terminating the Plan or its payment of the costs of the Plan as to the Fund's annuitants at least until a reasonable period of time has passed, sufficient for the Fund to obtain alternative coverage and to give the annuitants an opportunity to consider their options.

Estoppel

The City should be estopped from terminating the annuitants' coverage under the Plan and its subsidization of the cost of that coverage to the extent that it exceeds the rates established in 1982. Estoppel will lie against a municipality if, "under all of the circumstances, the affirmative acts of the public body have created a situation where it would be inequitable and unjust to permit it to deny what it has done or permitted to be done...." Stahelin v. Board of Education, 87 Ill. App.2d 28, 230 N.E.2d 465, 471 (2d Dist. 1967). The plaintiff must also show that it has detrimentally relied on the defendant's action. Haeflinger v. City of Wood Dale, 129 Ill. App.3d 674, 472 N.E.2d 1228 (2d Dist. 1984). The affirmative actions of the City here are two-fold. First, it has included the annuitantsin the medical benefits program it sponsors for its active employees for the past two decades. Second, since the mid-1970's it has paid a portion of the costs attributable to the retirees' medical coverage and, since April of 1982, it has paid he full amount of that cost to the extent that it exceeds the rates established in 1982. For an individual

retired employee, this has meant medical coverage at no cost since January of 1983. The Fund and its annuitants have relied to their detriment on these affirmative acts of the City. Until it received the City's letter in October of 1987, the Fund took no steps to locate a private carrier to write a policy for the annuitants' medical coverage. It is not possible for the Fund to contract with a private carrier and to give the annuitants a reasonable time to decide whether to subscribe to the new group policy or to contract for their own insurance, prior to January 1, 1988. In addition, a substantial portion of the annuitants left active employment with the City during the past ten years while the City was paying most of the cost of the annuitants' medical benefits. These individuals, in deciding to retire and whether to seek new employment, relied on the City's medical benefits plan and the minimal cost, if any, which the annuitants themselves were required to pay. Under these circumstances, it would be inequitable and unjust to permit the City to terminate either the annuitants' coverage or the payment of its costs.

7. The plaintiff must also show that the "balance of equities" favors the relief requested. In other words, the plaintiff should demonstrate that while failure to grant an injunction will result in immediate, certain, and great injury to the plaintiff, granting the injunction will cause only relatively minor loss or inconvenience to the party enjoined. Scott & Fetzer Co. v. Kahn, 74 Ill. App.3d 400, 393 N.E.2d 102 (4th Dist. 1979). The allegations of the Verified Complaint clearly demonstrate that the balance of the equities here favors the Fund and its

annuitants. The City has included the annuitants in its medical benefits plan for the past 20 years and, since April of 1982, has paid the full cost of the annuitants' benefits to the extent that it exceeds the rates put into effect in April of 1982. For an individual retired employee, this has meant medical insurance coverage at no cost since January of 1983. Now the City, for no apparent reason, has decided not only to quit paying for the annuitants' coverage but, in addition, to terminate their coverage under the Plan effective January 1, 1988 and to attempt to recoup the $26 million it paid for the annuitants' medical benefits since 1980. The balance of equities demonstrates that the injury to the Fund and its annuitants, if they are left with no coverage on January 1, 1988, far exceeds the injury the City will sustain if it is required to continue the coverage, at least for a reasonable period of time.

8. The movant must also show that granting the requested relief will not have an injurious effect on the general public. Biggs v. Health and Hospitals Governing Commission, 55 Ill. App.3d 501, 370 N.E.2d 1150 (1st Dist. 1977). The injunction sought by the counterplaintiffs will not have an injurious effect on the general public; to the contrary, it will have a positive effect. The Fund's annuitants have served the public as police officers and employees of the Chicago Police Department. These annuitants were parties to an express or implied agreement that the City would continue their medical benefits coverage under the City's program and that the City would continue to pay at least a substantial portion of the cost of those benefits. To permit the City to breach that agreement, particularly on the

impossibly short schedule it has announced, would have a negative impact on the morale of all the City's public servants and, consequently, a negative impact on the general public.

CONCLUSION

For the foregoing reasons, counterplaintiffs submit they have met all the prerequisites for injunctive relief, including the demonstration that they have a likelihood of prevailing on the merits, and ask this Court to enjoin the City from terminating the annuitants' coverage under its Plan and its payment of the costs of that coverage, pending hearing on the merits of the Complaint.

Repsectfully submitted,

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VERIFICATION

JAMES B. WATERS, JR., Executive Director of the Policemen's Annuity & Benefit Fund of the City of Chicago, having been first duly sworn on oath, states that he has knowledge of all of the facts asserted in the MOTION FOR PRELIMINARY INJUNCTION and that the facts alleged are true.

James B. Waters, Jr.
Executive Director of the
Policemen's Annuity & Benefit
Fund of the City of Chicago

SUBSCRIBED and SWORN to
before me this 14th day
of December, 1987.

Jeannie S. Sievers
Notary Public