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CIRCUIT COURT OF
COOK COUNTY, ILLINOIS
CHANCERY DIVISION
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EXHIBIT 6

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

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MEDICAL BENEFITS
FOR
CITY OF CHICAGO
ANNUITANTS AND ELIGIBLE DEPENDENTS

IMPORTANT!
Read immediately, dated materials

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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.

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SCHEDULE OF BENEFITS

Here's a quick look at the coverage provided by the City of Chicago Annuitant Medical Benefits Plan. Note 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, provided you notify a Benefit Adviser
- reduced payment, if Notification, Mandatory Outpatient or Mandatory Second Opinion requirement is not 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 outpatien
- 50% payment if performed as an inpatient
- See pages 14-15.

Mandatory Second Opinion
- 15 surgical procedures covered 100% after you get second doctor's opinion
- 50% payment, if performed without second opinion
- See page 16.

EXPENSES PAID AT 100%

For all persons covered
- certain expenses are always covered 100%, such a 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 expens ($15,000 for family) then 100% of covered expens 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 prescript
- See page 22.

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ABOUT THE CITY OF CHICAGO ANNUITANT MEDICAL BENEFITS PLAN

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

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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.)

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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.

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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.*

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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:

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- Court orders if you are obligated to provide coverage for other children,
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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.

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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

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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.

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APPLIES TO MEDICARE ELIGIBLE

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.

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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.*

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HOSPITAL BENEFITS

IF YOU OR YOUR DEPENDENTS ARE NOT ELIGIBLE FOR MEDICARE

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

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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

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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.*

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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.**

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SPECIAL MANDATORY PLAN PROVISIONS

IF YOU OR YOUR DEPENDENTS ARE NOT ELIGIBLE FOR MEDICARE

- Mandatory Outpatient Surgery
- Mandatory Second Opinion

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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 ELICIBLE

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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.

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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

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EXPENSES PAID AT 100%

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

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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.*

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MAJOR MEDICAL BENEFITS

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

- How Major Medical Works
- Maximum Major Medical Benefits

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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.

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MAIL ORDER RESCRIPTIONS

FOR YOU OR YOUR DEPENDENTS REGARDLESS OF MEDICARE ELIGIBILITY

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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.*

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WHAT IS
NOT COVERED

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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

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CLAIMS PROCESSING AND COORDINATION OF BENEFITS

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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.

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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

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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.

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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.

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MAINTENANCE OR MAIL ORDER PRESCRIPTIONS—Prescribed medications used on a 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.

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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.

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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

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