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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

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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.

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

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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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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.

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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 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.*

APPLIES TO MEDICARE ELIGIBLE

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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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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

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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.***

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APPLIES TO NON-MEDICARE ELIGIBLE

LIST OF MANDATORY OUTPATIENT SURGICAL PROCEDURES

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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

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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.

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.

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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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CIRCUIT COURT OF
COOK COUNTY, ILLINOIS
CHANCERY DIVISION
CLERK DOROTHY BROWN

EXHIBIT 7

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Policemen's Annuity and Benefit Fund City of Chicago

YOUR SERVICE RETIREMENT BENEFITS

Effective January 1, 1986

221 NORTH LA SALLE STREET
ROOM 1626
TELEPHONE:
744-3891, 744-3893

638

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BOARD OF TRUSTEES
1986

MARSHALL KORSHAK - President
(Appointive Member)

FRED SETTLES - Vice President
(Elective Member)

JAMES McDONOUGH - Recording Secretary
(Elective Member)

CECIL A. PARTEE - Trustee
(City Treasurer and Ex-Officio Treasurer and Member)

CHESTER JASKOLKA - Trustee
(Elective Member)

RONALD R. NORRIS - Trustee
(Elective Member)

THOMAS D. ALLISON - Trustee
(Appointive Member)

RUSSELL EWERT - Trustee
(Appointive Member)

ODELL HICKS - Trustee
(Appointive Member)

RICHARD J. JONES - Executive Director

Policemen's Annuity
and
Benefit Fund
City of Chicago

221 North LaSalle Street, Room 1626
Chicago, Illinois 60601

STAFF MEMBERS

JAMES B. WATERS, JR. .... *Comptroller*
DR. C. LARKIN FLANAGAN .... *Physician*
DAVID KUGLER .... *Attorney*

D.F. CAMPBELL .... *Consulting Actuary*

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This booklet has been prepared by the Retirement Board under the direction of the Executive Director and staff members in order to present to the members of the Chicago Police Pension Fund, a summary of benefits to which they are entitled and the detailed requirements which must be met in order to become entitled to those benefits. It also describes the method of financing and operational procedures.

The Trustees of the Retirement Board sincerely hope that this booklet will enable the members to fully understand and appreciate their rights, benefits, and obligations and will familiarize themselves with its contents. If any member has any questions, he or she should contact the Retirement Board.

The Trustees of your Fund wish to express their grateful appreciation to the Mayor of the City of Chicago and to the members of the Legislature of the State of Illinois for their support in providing the benefits we now enjoy.

The Retirement Board of the
Policemen's Annuity and Benefit Fund
of the City of Chicago

Marshall Korshak, President

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Administration and Membership

Board of Trustees - Nine members constitute the Board. Four members are appointed by the Mayor of the City of Chicago; three are police officers, elected by the active members of the Police Department; one is a retired police officer, who is elected by the retirees; and the other member is the City Treasurer of the City of Chicago. Their duties include (1) Employing professional and clerical services, (2) Authorizing pension payments and other benefits, and (3) Investing funds.

Executive Director - responsible for the proper performance of the detail work of the Fund.

Attorney for the Fund - advises and interprets all legal matters confronting the trustees.

Financial Consultant - Advises the trustees regarding the performance and activities of the several money manager's retained by the fund.

Compulsory - Any person who successfully passes the Career Service Examination for the position of Police Officer with the Chicago Police Department and is then certified by the Department of Personnel to that position becomes a participant of the Fund.

Financing - Contributions
Members - City

City Contributions - The city shall levy a tax annually upon all taxable property thereon for the purpose of providing revenue for the Fund. Beginning with the year 1970 and each year thereafter, the city council shall levy a tax annually at a rate on the dollar of the assessed valuation of all taxable property that will produce when extended an amount not to exceed the total amount of contributions by the police officers to the Fund made in the calendar year two years before the year for which the applicable annual tax is levied, multiplied by 2.00 for the tax levy year 1982, and for each year thereafter.

Members (Police Officers) Contributions - 7 percent for Retirement age and service; 1½ percent for Spouse's Annuity; ½ percent for Automatic Increase.

Interest Income on Investments - is received in addition to the income received from City and members' contributions.

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Investments

Chapter 108½ of the Illinois Revised Statutes - Section 5-187. To invest money. To invest the monies of the fund in the types of investments, and subject to the restrictions, set forth in Section 22A-112 of this Act.

The limitations on investments prescribed in this Article shall be applicable at the time of purchase, and shall not require liquidation of any investment at any time. The Retirement Board may, however, sell any security held by it at any time it deems desirable.

Common and preferred stocks shall be carried at cost.

Bonds or any security purchased by the Board shall be registered in the name of the Fund, or may, at the discretion of the Board, be registered in the name of a nominee, established for the purpose of registering securities of the Fund by a national bank or trust company authorized to act as trustee in the State of Illinois. Tax anticipation warrants shall be clearly marked to evidence ownership by the Board. The Board may sell any of the securities belonging to the fund and borrow money upon such securities as collateral whenever in its judgment such action is necessary to meet the cash requirements of the Fund.

Annuities

Age and service requirements - If you are at least 50 years of age and have at least 10 years of service, you qualify for an annuity. However, in order to receive full benefits, you must be 50 years of age with 20 years of service.

Estimating your annuity - You can calculate the amount of annuity you will receive by following three basic steps:

1. Apply the formula necessary to determine your percentage.*
2. Average your annual pay grade salary. (Overtime pay should not be included)
3. Multiply your average monthly salary by your total percentage to determine your monthly annuity.

*In computing your annuity, the formula that gives you the greatest percentage (either 50/20 or 55/25) should be used.

1. **Formulas**

A. 50/20 forumula (Attaining age 50 in service before completing 20 years of service) If you attain age 50 in service before you complete 20 years of service, you get 50% of your average monthly salary on the date you complete 20 years of service. However, for each year or fraction thereof served in excess of 20 years an additional 2% is added. Any lost time must be added to your appointment date in order to arrive at a continuous service date. For example, if you were appointed on May 3, 1955 and lost a total of 15 days, you would complete 20 years of service on May 18, 1975.

Example: Born 8/10/24:
Date Appt'd.: 5/3/55
Anticipated retirement date: 5/16/86
Age at retirement: 61

Retired	1986- 5-16	
Appointed	1955- 5- 3	
Years of Service	31- 0-13	
Serv. Requirement	20- 0- 0	
Excess of 21 yrs. (11x 2 + 2 = 24%)	11- 0-13	= 24%
		+ 50%
on 5/16/86		74%

B. 50/20 formula (Completing 20 years of service before attaining age 50) If you complete 20 years of service before attaining age 50 in service you get 50% of your average monthly salary on the day after you attain age 50 in service. An additional 2% for each year or fraction in excess of 20 years of service is added.

Example: Born 4/26/25:
Date Appt'd.: 8/10/53
Anticipated retirement date: 8/16/86
Age at retirement: 61

Retired	1986- 8-16	
Appointed	1953- 8-10	
Years of Service	33- 0- 6	
Serv. Requirement	20- 0- 0	
Excess of 21 yrs. (13x 2 + 2 = 28%)	13- 0- 6	= 28%
		+ 50%
on 8/16/86		75% max

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C. 55/25 formula

Upon attainment of age 55, you get 2% for each year of service plus 1/6 of 1% for each complete month of service.

NOTE: This formula may apply to only a small fraction of officers. Most officers will get a greater percentage using the 50/20 formula.

Example: Born 8/10/24
Appt. 5/3/55 Retirement date 5/16/86

AGE	SERVICE
1986-5-16	1986-5-16
1924-8-10	1955-5- 3
61-9- 6	31-0-13

31 years and 0 mos. at 2% = 62%

However, by using the 50/20 formula you get 74%. (See the first example of the 50/20 formula; attaining age 50 before completing 20 years of service.)

2. **Determine average monthly salary** - Add your total annual pay grade salary (overtime should not be included) during the highest **48 consecutive months** of the last 10 years and divide by 48 to arrive at your average monthly salary.

3. Multiply your average monthly salary by your total percentage and the result will be the amount of your annuity per month.

Automatic annual increase - You will receive an automatic increase in your pension and the effective date of this increase will be determined by one of the following, whichever applies to you.

A. Your retirement annuity is increased by 1½% of your **original annuity** on the first day of the month following your 60th birthday if it occurs **after** the first anniversary of your retirement date. It is again increased by 1½% of the **original annuity** on Jan. 1st of each year thereafter up to a maximum of 20 increases.

B. Your retirement annuity is increased by 1½% of your **original annuity** on the first of the month following the first anniversary of your date of retirement if you are 60 years of age or over on the date of your retirement. It is again increased on Jan. 1st of each year thereafter up to a maximum of 20 increases.

C. Beginning Jan. 1, 1983 increases shall be 3% for policemen **born before Jan. 1, 1930,** and they shall not be subject to the 30% maximum increase.

On the following pages you will find tables showing the annuity to which a police officer will be entitled upon retirement expressed as a percentage (%) of average monthly salary for age of retirement 50 to 63 inclusive and for years of service from 20 to 39 inclusive.

Tables showing the annuity to which a police officer will be entitled upon retirement expressed as a minimum percentage (%) of average salary for age of retirement 50 to 63 inclusive and for years of service from 20 to 39 inclusive. The tables do not take into consideration additional percentages for working the day after the anniversary date.

YEARS OF SERVICE

AGE AT RETIRE-MENT	20	21	22	23	24	25	26	27	28	29	AGE AT RETIRE-MENT
50	50%	52	54	56	58	60	62	64	66	68	50
51	50	52	54	56	58	60	62	64	66	68	51
52	50	52	54	56	58	60	62	64	66	68	52
53	50	52	54	56	58	60	62	64	66	68	53
54	50	52	54	56	58	60	62	64	66	68	54
55	50	52	54	56	58	60	62	64	66	68	55
56	50	52	54	56	58	60	62	64	66	68	56
57	50	52	54	56	58	60	62	64	66	68	57
58	50	52	54	56	58	60	62	64	66	68	58
59	50	52	54	56	58	60	62	64	66	68	59
60	50	52	54	56	58	60	62	64	66	68	60
61	50	52	54	56	58	60	62	64	66	68	61
62	50	52	54	56	58	60	62	64	66	68	62
63	50	52	54	56	58	60	62	64	66	68	63

YEARS OF SERVICE (Continued)

AGE AT RETIRE-MENT	30	31	32	33	34	35	36	37	38	39	AGE AT RETIRE-MENT
50	70										50
51	70	72									51
52	70	72	74								52
53	70	72	74	75							53
54	70	72	74	75	75						54
55	70	72	74	75	75	75					55
56	70	72	74	75	75	75	75				56
57	70	72	74	75	75	75	75	75			57
58	70	72	74	75	75	75	75	75	75		58
59	70	72	74	75	75	75	75	75	75	75	59
60	70	72	74	75	75	75	75	75	75	75	60
61	70	72	74	75	75	75	75	75	75	75	61
62	70	72	74	75	75	75	75	75	75	75	62
63	70	72	74	75	75	75	75	75	75	75	63

An example of how this table is used to determine the amount of annuity per month is as follows:

Assume a police officer retires at age 57 with 32 years of service. The above table shows that he is entitled to an annuity equal to 74% of his average salary. (Average salary is defined to be average for 4 consecutive years of highest salaries within the last 10 years of service before retirement.) If such average salary is $30,987.75 a year and $2,582.31 a month, the monthly annuity in this example would be 74% of $2,582.31 or $1,910.91 a month.

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PREPARING FOR RETIREMENT

You must have all optional service paid for before retirement. Several months before you retire you should be certain that you have established credit for all possible service.

Have you made payment to the Fund for the following optional creditable service?

1. Temporary Service
2. Qualified leaves of absence
3. Refund repayable accounts
4. Fire Department Service
5. Miscellaneous other service approved by the Retirement Board

Payment for Park Consolidation Account is **mandatory** and **must** be paid **before** retirement. If you should die before paying for this prior Park service your spouse must pay for it in full before he or she is entitled to any survivor's benefits.

If you have questions about possible creditable service, please inquire well in advance of your retirement. It is too late to get credit for such services **after** you retire.

For more details refer to pages 48 and 49 of the **Illinois Revised Statutes Chapter 108½ Pensions,** Article 5-214 Credit for other service.

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Applying For Retirement

Your first step is to officially terminate your service with the Chicago Police Department. To do this, you must sign a PAR (Personnel Action Request) form. All officers that are working out of a unit should sign the PAR form at their unit. Officers that are on a leave of absence must sign the PAR form at the Department of Personnel, 1121 S. State Street. Your PAR form should be signed approximately two weeks prior to your effective retirement date.

Immediately after submitting your PAR form you must go to the pension office (221 N. LaSalle, Room 1626) where you will apply for retirement. You will be asked to sign the following papers:

1. Application for retirement
2. Application for hospitalization
3. Yellow signature card
4. New death benefit directive (if you wish to change the beneficiaries). If you are not sure whom you have named, ask the person taking care of you and he or she will look it up.
5. Affidavit waiving annuity, if you continue working beyond age 63.
6. Reversionary designation.

If you would like a calculation of your annuity, you must request it at the time you are applying for retirement. No computation is done automatically. If you wish to wait, the calculation can be done then or it can be sent to you before you receive your first annuity check.

When your papers have been completed, you will be told the monthly meeting at which your application will be processed and the approximate date you can expect your first check.

NOTE: Your application for annuity must be filed with the pension office no later than the 15th of any given month **and** your date of retirement cannot be **beyond** the 15th of any given month in order for your application to be approved at the following month's Board Meeting. Your application for annuity cannot be approved by the Retirement Board in the same month in which you apply.

EXAMPLE 1: If a police officer retires effective September 14, 1986, and applies for annuity September 14, 1986, the annuity will be awarded at the October 1986 Board meeting and a check issued November 1, 1986, retroactive to September 14, 1986.

EXAMPLE 2: If a police officer retires September 16, 1986, and applies for annuity September 16, 1986, the annuity will be awarded at the November 1986 Board Meeting and a check issued December 1, 1986, retroactive to September 16, 1986.

Your annuity check is mailed on the last working day of each month. By request, you may have your check deposited directly to either a savings or checking account at your bank.

Age 63 — Still Working

Those officers who continue to work beyond attainment of age 63, no longer make contributions to the Fund. Their annuities and the prospective annuities of their spouses are fixed as of the officer's 63rd birthday.

The reversionary election, cancellation or change in the amount of the reversionary option **cannot be made after the officer has retired.**

Upon resignation, call the pension office to process your application for continued hospitalization coverage and to inform the Fund of your last day of employment.

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IMPORTANT NOTE: You will also receive an income tax letter; be sure to put the letter away for safekeeping. You will not become taxable on your annuity until you recover the total amount of contributions. This letter will contain: (1) the amount of your contributions from your date of appointment through Dec. 31, 1981 inclusive (tax deferment effective date 1/1/82, (2) the year in which you become taxable, and (3) the amount which you must report to the IRS for that year. In conjunction with this letter, at the end of January each annuitant will receive a form W-2P for the previous year indicating gross annuity received and taxable amount to be reported. In the year during which you become taxable, you may have an amount directed by you withheld from your check each month for Federal Income Tax purposes. This amount also will be shown on the form W-2P. (For details see next section - Deductions.)

Your annuity checks and all letters of correspondence to you from the pension office will contain an AP (Annuity Payment) number. It is important that you remember this number; it is your identification number with the pension office once you retire. If you have to contact the pension office for any reason, always supply them with your AP number.

Deductions

As a general rule, the City Plan, the hospitalization you had as an active member of the Police Department, may be continued **only** at the time you apply for annuity. (1) The hospitalization premium for the retired employee is paid by the Retirement Board. The premium for any eligible dependent would be automatically be deducted from your annuity checks, beginning with your first check. (2) Children may be covered until age 19 provided they are unmarried and until the age 22 if attending an accredited college on a **full-time basis.** The coverage is the same as that of the active employees with the exception of the elimination of the $1,000.00 accidental death benefit. Because you may be in one of several situations, it is advised that you discuss with the pension office the coverage best suited for you. (3) The pension office only withholds and forwards your monthly benefit premium to the City of Chicago Benefits Division. Any questions about claims or coverage should be directed to the **BENEFITS MANAGEMENT OFFICE of the City of Chicago, 794-5100.** When you reach age 65 and **qualify** for Medicare, your premium may be lowered. To make this adjustment in your premium, you must send a copy of your

Medicare card to the pension office. When your spouse reaches age 65 and also **qualifies** for Medicare, a copy of the Medicare card should be sent to the pension office and again your premium may be reduced.

After your annuity becomes taxable, you may authorize the Fund to withhold Federal Income Tax from your check. An IRS form W-4P can be submitted or in lieu of, send your name, AP number, and the amount to be withheld to the pension office on a sheet of paper with your signature. **You must determine** the monthly deduction you want withheld. Your income tax preparer can perhaps assist you in determining this amount. The amount, however, must be in even dollars, e.g. $10.00, $25.00, $100.00, and the minimum that can be withheld is $10.00. You can increase or decrease this amount at any time by submitting the change **in writing** to the pension office.

Your annuity is not taxable by the State of Illinois and therefore the pension office has no authority to withhold any State Tax.

If there are questions or doubts in your mind about your income tax liability in relation to your annuity, consult **your own tax advisor** or the District Director of your local income tax office.

Death Benefits

Effective January 1, 1962, upon your death, an ordinary death benefit is paid to the beneficiary or beneficiaries named by you and acknowledged with your signature on the most recent death benefit directive filed by you with the pension office, provided the death occurs:

1. in active service while you are in receipt of salary
2. while on an authorized and approved leave of absence, without salary, **and** within 60 days from the date you were in receipt of salary; or otherwise in the service and not separated by resignation or discharge beginning January 1, 1962, if your death occurs before your resignation or discharge from service.
3. while you are receiving duty disability or ordinary disability benefit
4. within 60 days from the date of termination of duty disability or ordinary disability benefit if re-entry into service had not occurred
5. while on retirement and, in receipt of an annuity provided:
   (a) you retired on or after January 1, 1962 and

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(b) your separation from service was effective on or after your attainment of age 50 and

(c) your application for annuity was made within 60 days after your separation from service.

This benefit is in addition to all other benefits provided. The amount of the ordinary death benefit is determined by your age at **death** (if death occurs while you are in active service and in receipt of salary or disability benefits) **or** your age at **retirement** (if death occurs after retirement). See the following table for amounts.

Computation of Ordinary Death Benefit

Effective 1/1/86

Death while in active service and in receipt of salary or disability benefits:		Death after retirement:	
Age at death	**Amount**	**Age at retirement**	**Amount**
49 (or younger)	$12,000.00	50 (or older)	$6,000.00
50	11,600.00		
51	11,200.00		
52	10,800.00		
53	10,400.00		
54	10,000.00		
55	9,600.00		
56	9,200.00		
57	8,800.00		
58	8,400.00		
59	8,000.00		
60	7,600.00		
61	7,200.00		
62	6,800.00		
63	6,400.00		

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Be sure that you have a death benefit directive on file with the pension office and that you update it as changes occur in your family. If you wish to change the beneficiaries on your directive, you must do so in person at the pension office. Under no circumstances will these directives be mailed out.

Surviving Spouse's Annuities

Your surviving spouse is entitled to an annuity upon your death if you were in the active service or on retirement. The amount of the spouse's annuity for a policeman who retires on or after January 1, 1986, and subsequently dies while receiving a retirement annuity shall be equal

to 40% of the policeman's annuity at the time of the policeman's death.

If the deceased policeman was an active policeman at the time of his death, after December 31, 1985, and had at least 1½ years of creditable service, the widow's annuity shall be 30% of the annual maximum salary attached to the classified civil service position of a first class patrolman at the time of his death. **This annuity is fixed at the time of the policeman's death and does not increase.**

In other instances a short period of service may provide a small annuity. There are so many factors that enter into the determination of the amount of a spouse's annuity that inquiries can be answered only if based on SPECIFIC cases. The spouse's annuity is payable until death or remarriage. The following are exceptions concerning remarriage:

If a spouse remarries **before** reaching age 60, annuity payment shall be suspended, but the spouse's annuity shall be resumed, if within one year after such payments were suspended, the subsequent marriage ends either by divorce, annulment or by the death of the spouse. However, if the subsequent marriage lasts for a period of one year, the spouse's annuity shall be terminated. If a spouse remarries **after** attaining age 60, the spouse's annuity shall continue without interruption.

An option is now available, if chosen by the police officer **prior to retirement** to reduce the officer's own annuity and thereby provide a **reversionary annuity** to begin upon the officer's death, for the officer's spouse. **A reversionary annuity is in addition to the regular spouse's annuity.** Various conditions must be met:

1. The election must be made by filing a written designation with the Pension Board **prior to retirement.**
2. The election must have been in effect for 730 days prior to the police officer's death to enable the spouse to receive the annuity.
3. The police officer must have retired. Death before retirement voids the election.
4. The death of the spouse prior to the police officer's retirement voids the option. If the reversionary annuitant dies after the police officer's retirement, but before the police officer, the reduced annuity being paid to the officer shall be increased to the amount of annuity before reduction for the reversionary annuity and no reversionary annuity shall be payable.
5. Officers resigning **prior to age 63** cannot change or alter the reversionary annuity after the effective date of resignation.

SPOUSE'S AGE	POLICEMAN'S AGE 50-52	53-55	56-58	59-61	62-64	65 & over
30 or more years younger	2.92	2.48	2.10	1.77	1.48	1.24
25-29 years younger	3.06	2.60	2.20	1.86	1.57	1.32
20-24 years younger	3.25	2.76	2.35	2.00	1.69	1.42
15-19 years younger	3.50	2.99	2.56	2.19	1.86	1.57
10-14 years younger	3.86	3.31	2.85	2.45	2.10	1.79
5-9 years younger	4.36	3.77	3.26	2.83	2.44	2.10
0-4 years younger	5.06	4.40	3.85	3.36	2.93	2.55
1-5 years older	6.04	5.30	4.68	4.13	3.63	3.19
6-10 years older	7.40	6.56	5.86	5.23	4.63	4.09
11-15 years older	9.31	8.33	7.51	6.75	6.01	5.31
16-20 years older	11.95	10.78	9.78	8.84	7.90	7.02
21-25 years older	15.54	14.07	12.86	11.73	10.60	9.56
26-30 years older	20.37	18.55	17.15	15.94	14.73	13.62
31 or more years older	27.03	24.90	23.51	22.52	21.60	20.90

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Officers **retiring at the age of 63** who wish to cancel or change the reversionary annuity must do so **before** the retirement date.

6. The police officer may not reduce his own monthly annuity by more than $200 nor elect to provide a reversionary annuity less than $50 a month.

The reversionary annuity must be in even amounts in increments as provided by the schedule approved by the Pension Board.

The amount of the monthly reversionary annuity is determined by multiplying the elected reduction by the applicable factor in the above table based on the age of the policeman and the difference in the age of the policeman and the age of the policeman's spouse at the starting date of his annuity.

Compensation Annuity

If a police officer dies as a result of AN INJURY RECEIVED IN THE PERFORMANCE OF A SPECIFIC ACT OF DUTY, his or her spouse is entitled to receive an annuity of 75 percent of the salary attached to the position held by certification and appointment as a result of career service examination or classification. If he or she has children, the total amount of the spouse's annuity and children's benefits shall not exceed the salary attached to his or her career service position at the time of death. If a spouse remarries, the conditions previously described above would prevail.

Ordinary Death In the case of a family of a police officer (spouse and children) who dies on or after September 20, 1969, as the result of any cause other than the performance of an act of duty, the amounts of benefits paid cannot exceed 60 percent of the salary of the police officer at the time of his or her death.

Child's Annuity

Each of your natural or legally adopted children under 18 years of age is entitled to an annuity of 10 percent of the salary of a first class police officer annually, while unmarried and during any period while the spouse receives an annuity. If there is no spouse each child receives 15 percent of the salary of a first class police officer annually.

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Child's benefit terminates at age 18 unless the child has a mental or physical impairment, an inability to engage in substantial gainful employment in which case child's benefit is for life or as long as such condition exists.

Any children of a police officer who resigns or is discharged from the Department before accumulating 10 years of service, or before reaching the age of 50, are not entitled to any benefits, but the minor children of a police officer who dies in the service irrespective of his length of service are entitled to benefits.

Adoption In the case of an adopted child you shall be married and living with your spouse at the time of the adoption, and the proceedings for adoption must have been initiated at least 6 months prior to death. The requirements that the proceedings for adoption be intitated at least 6 months prior to death does not apply if death occurs as a result of an ACT OF DUTY.

Only one annuity shall be granted and paid for the benefit of any child if both parents have been police officers.

DISABILITY BENEFITS

Ordinary and Duty Disability Benefits

You probably often wonder what would happen to you and your family if one day you find that through illness or injury, you no longer can perform your duties. To eliminate these fears, the following have been provided by city ordinances and the disability provisions set forth by state statutes which govern the Police Pension Board.

Medical Roll - Non-Duty Related Injury or Illness For many medical reasons, you may not be able to perform your duties and subsequently are placed on the medical rolls by the Chief Surgeon of the Chicago Police Department according to the City Ordinance which covers medical benefits; you may receive your full salary if you are unable to perform your duties, for a period not to exceed one year. If it is the medical judgment of the Chief Surgeon that your condition is such that it would prevent you from returning to your duties, disability benefits are then recommended.

Ordinary Disability According to the Statues that govern the Police Pension Fund, you are entitled to ordinary disability benefits if you become disabled from causes not connected with the performance of an act of police duty. The length of time during which you can receive this disability benefit depends upon the length of your

service. To determine the length of ordinary disability benefits, you would divide your net active service by four; however, in no event could you receive more than five years of ordinary disability benefits, and not beyond age 63.

Example: If you have 16 years of net active service:
16 ÷ 4 = 4 years of ordinary disability

The time during which you received ordinary disability benefits is added to your total service for annuity purposes.

Example: 16 years of net active service plus 4 years of disability benefits provides a total of 20 years of service for annuity purposes. The amount of the ordinary disability benefit is 50 percent of the salary you were receiving when placed on the medical rolls. This amount remains the same for the duration of your disability and the city will contribute your annuity deduction on a monthly basis. If your disability ceases at any time before your benefits would expire, you shall return to active duty.

Also, for annuity purposes and the determination of your average monthly salary, if you are retiring from ordinary disability, the salaries used are those that you would have received had you been able to remain working.

Medical Roll - Duty Related When you are unable to perform your duties because of INJURIES RECEIVED IN THE PERFORMANCE OF AN ACT OF POLICE DUTY, the city ordinance provides that your salary shall continue for a period not to exceed one year, or any part of year, while you are on the medical roll. If it is the medical judgment of the Chief Surgeon that your condition is such that would prevent you from returning to your duties at the expiration of one year, disability benefits are then recommended.

Duty Disability According to the Statutes that govern the Police Pension Fund, IF YOU ARE DISABLED AS A RESULT OF AN INJURY RECEIVED IN THE PERFORMANCE OF AN ACT OF POLICE DUTY, you are entitled to disability benefits during any period of such disability for which you do not have a right to receive salary, equal to 75 percent of your salary at the **time the disability is allowed.** (Effective date 7/1/82). If you were on duty disability and return to active employment at any time for a period of at least two years and are again disabled from the same cause or causes, you are entitled to 75 percent of your salary at the **time the disability is allowed.** If your disability resulted from any physical defect or mental disorder or any disease which existed at the time

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your injury was sustained, or if your disability is less than 50 percent of total disability for any service of a remunerative character, your duty disability benefit shall be 50 percent of your salary.

If you should suffer a heart attack and **as the natural and proximate result of an injury occuring at some definite time and place while in the performance and discharge of your duties** as a police officer, you will be eligible for any and all benefits provided for police officers injured in the performance of an act of duty.

The time during which you received duty disability benefits is added to your total service for annuity purposes.

Duty Disability - Child Benefit You shall have a right to child's benefit of $30.00 per month for each unmarried child of your own issue, under the age of 18, but the total amount of child's benefit shall not exceed 25 percent of your salary.

You shall continue to receive your benefits while your disability persists, but not beyond age 63. Child's benefit shall be paid during your period of disability until the child attains age 18.

NOTE: While in receipt of ordinary or duty disability benefits, you are permitted by the State Statutes that govern the Police Pension Fund, to augment your disability benefits by outside employment. However, the total amount received both in disability benefits and outside employment cannot exceed the rate of salary which you would be paid if you were working in your regular Career Service position. If the amount received exceeds that rate of salary, your disability benefit is reduced proportionately. While in receipt of disability benefits, you will be required, each month, to sign an affidavit for this purpose. It must be properly filled out and filed with the Office of the Policemen's Annuity and Benefit Fund of Chicago, before further disability benefits will be paid to you.

REFUNDS

General Refund If you have become separated from the Department either through the actions of the Department or of your own accord and have not attained the age of 50, you are entitled to receive a refund of your contributions to the Fund upon filing an application for such refund at the pension office. The amount of service you have does **not** have any bearing on whether a refund can

be received. Termination from the Department is the **only** way you can get a refund. **There is no way of borrowing from your contributions.** If you are receiving a refund, the amount received will be your contributions plus 1½%, simple interest per year on each deduction or contribution from the date of each deduction until the date of your resignation. Upon receiving a refund, you surrender and forfeit all rights to any annuity or other benefit from the Fund for yourself and for any other person or persons who might otherwise have benefited through you. If you have received a refund and subsequently get reinstated to the Department, you have the option of repaying that refund in order to restore those rights to you, your spouse and your children, but **only** after having worked for a period of three years from the date of your reinstatement. There is no time limit by which to repay your refund; however, it must be repaid in full before retirement. If you are eligible to repay your refund and would like to know the amount, simply contact the pension office and the information will be mailed to you within a reasonable period of time. You may repay the refund in full or you may set your own pace and make individual payments. All payments must be made by check. Cash will not be accepted. It should be noted that interest will charged for monies due until date of full repayment.

Exempt Refund Beginning January 1, 1970, if you have served in an exempt rank, e.g. Commander, Detective, Youth Officer, etc., and **return** to the career service rank held prior to your going into the exempt rank, you are entitled to a refund of the difference in contributions.

NOTE: Applications for General Refund and Exempt Refunds must be filed with the pension office no **later** than the 15th of any given month in order to be presented before the following month's Board Meeting. Also, if you are applying for a General Refund, your date of termination cannot be beyond the 15th of any given month if you want your application to be processed for the following month's Board Meeting.

Spouse's Annuity Accumulations Refund If you are not married on the day you become separated from the Department to go on pension, the accumulations for spouse's annuity will be refunded to you. **You** will sign an application for this refund. **However, if you were ever married, any and all documents terminating any and all marriages must be submitted to the pension office before your refund check will be issued.**

Refund of Remaining Amounts If the amounts deducted from the salary for annuity purposes have not been paid in the form of employee, spouse or children's annuity the difference between such amount and the amounts paid as annuity, without interest on either, shall be paid to a surviving spouse not entitled to annuity. If there is no spouse, then to the children in equal parts unless otherwise directed by the police officer in writing, filed with the Board before his or her death. If there are no children, refund will be paid to the executor of estate — may be applied to burial expenses if there is no executor — remainder paid to heirs.

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CIRCUIT COURT OF
COOK COUNTY, ILLINOIS
CHANCERY DIVISION
CLERK DOROTHY BROWN

EXHIBIT 8A

ILLINOIS PENSION CODE
GROUP HEALTH BENEFIT PROVISIONS
AS IN EFFECT PRIOR TO
ENACTMENT OF P.A. 86-273

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S.H.A. ch. 108 1/2 ¶ 5-167.5

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CHAPTER 108 1/2 . PENSIONS
PENSION CODE
ARTICLE 5. POLICEMEN'S ANNUITY AND BENEFIT FUND--CITIES OVER 500,000

Pension Code § 5-167.5

5-167.5. Group health benefit

§ 5-167.5. Group health benefit. (a) For the purposes of this Section:
"Annuitant" means a person receiving an age and service annuity or a prior service annuity under this Article on or after January 1, 1983.
"Carrier" means an insurance company, or a corporation organized under the Nonprofit Hospital Service Plan Act, [FN1] the Medical Service Plan Act [FN2] or the Voluntary Health Services Plan Act, [FN3] which is authorized to do group health insurance business in Illinois.
(b) The Board shall contract with one or more carriers to provide group health insurance for all annuitants. Such group health insurance shall provide for protection against the financial costs of health care expenses incurred in and out of hospital including basic hospital-surgical-medical coverages and major medical coverage. The program may include such supplemental coverages as out- patient diagnostic X-ray and laboratory expenses, prescription drugs and similar group benefits.
The group health insurance program may also include:
(1) prepaid preventive health care through health maintenance organizations;
(2) coverage for those who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a recognized religious denomination;
(3) optional coverage for dependents of the annuitant;
(4) other optional coverage, such as for dental, psychological, or optometric services.
(c) The group contract shall be on terms deemed by the Board to be in the best interest of the Fund and its annuitants, based on, but not limited to, such criteria as administrative cost factors, the service capabilities of the carrier, and the premiums charged.
The term of any contract made under authority of this Section may not extend beyond 2 fiscal years, with such renewal options, for not more than 2 one-year periods, as may be deemed by the Board to be most advantageous to and in the best interest of the Fund and its annuitants. No renewal may be exercised without the conclusion of a qualified independent actuary that any increase in premium requested by a carrier is justified on the basis of audited experience data, increases in the cost of health care services, carrier performance, or any combination thereof.
(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. The full cost of any optional coverage elected by the annuitant shall be deducted from his monthly annuity.

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Laws 1963, p. 161, § 5-167.5, added by P.A. 82-1044, § 1, eff. Jan. 12, 1983.

[FN1] Chapter 32, ¶ 551 et seq.

[FN2] Chapter 32, ¶ 563 et seq.

[FN3] Chapter 32, ¶ 595 et seq.

REFERENCES

LIBRARY REFERENCES

1987 Main Volume Library References

States ⚷93.
C.J.S. States § 156.
Words and Phrases (Perm. Ed.)

S. H. A. **ch. 108 1/2 ¶ 5-167.5**
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S.H.A. **ch. 108 1/2 ¶ 6-164.2**

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CHAPTER 108 1/2 . PENSIONS
PENSION CODE
ARTICLE 6. FIREMEN'S ANNUITY AND BENEFIT FUND--CITIES OVER 500,000

Pension Code § 6-164.2

6-164.2. Group health benefit

§ 6-164.2. Group health benefit. (a) For the purposes of this Section:
"Annuitant" means a person receiving an age and service annuity or a prior service annuity under this Article on or after January 1, 1983.
"Carrier" means an insurance company, or a corporation organized under the Nonprofit Hospital Service Plan Act, [FN1] the Medical Service Plan Act [FN2] or the Voluntary Health Services Plan Act, [FN3] which is authorized to do group health insurance business in Illinois.
(b) The Board shall contract with one or more carriers to provide group health insurance for all annuitants. Such group health insurance shall provide for protection against the financial costs of health care expenses incurred in and out of hospital including basic hospital-surgical-medical coverages and major medical coverage. The program may include such supplemental coverages as out- patient diagnostic X-ray and laboratory expenses, prescription drugs and similar group benefits. The group health insurance program may also include:
(1) prepaid preventive health care through health maintenance organizations;
(2) coverage for those who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a recognized religious denomination;
(3) optional coverage for dependents of the annuitant;
(4) other optional coverage, such as for dental, psychological, or optometric services.
(c) The group contract shall be on terms deemed by the Board to be in the best interest of the Fund and its annuitants, based on, but not limited to, such criteria as administrative cost factors, the service capabilities of the carrier, and the premiums charged.
The term of any contract made under authority of this Section may not extend beyond 2 fiscal years, with such renewal options, for not more than 2 one-year periods, as may be deemed by the Board to be most advantageous to and in the best interest of the Fund and its annuitants. No renewal may be exercised without the conclusion of a qualified independent actuary that any increase in premium requested by a carrier is justified on the basis of audited experience data, increases in the cost of health care services, carrier performance, or any combination thereof.
(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. The full cost of any optional coverage elected by the annuitant shall be deducted from his monthly annuity.

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Laws 1963, p. 161, § 6-164.2, added by P.A. 82-1044, § 1, eff. Jan. 12, 1983.

[FN1] Chapter 32, ¶ 551 et seq.

[FN2] Chapter 32, ¶ 563 et seq.

[FN3] Chapter 32, ¶ 595 et seq.

REFERENCES

LIBRARY REFERENCES

1987 Main Volume Library References

States ⇐93.
C.J.S. States § 156.
Words and Phrases (Perm.Ed.)

S. H. A. **ch. 108 1/2 ¶ 6-164.2**
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S.H.A. **ch. 108 1/2 ¶ 8-164.1**

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CHAPTER 108 1/2. PENSIONS
PENSION CODE
ARTICLE 8. MUNICIPAL EMPLOYEES', OFFICERS' AND OFFICIALS' ANNUITY AND BENEFIT
FUND--CITIES OVER 500,000 INHABITANTS

Pension Code § 8-164.1

8-164.1. Group Health Care Plan

§ 8-164.1. Group Health Care Plan. 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.
The group hospital care plan and group medical and surgical plan established under this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

Laws 1963, p. 161, § 8-164.1, added by P.A. 84-23, § 1, eff. July 18, 1985.

REFERENCES

LIBRARY REFERENCES

1987 Main Volume Library References

Municipal Corporations ⚷186(1), 187(2).
C.J.S. Municipal Corporations §§ 586, 588 et seq.

S. H. A. **ch. 108 1/2 ¶ 8-164.1**
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CHAPTER 108 1/2 . PENSIONS
PENSION CODE
ARTICLE 11. LABORERS' AND RETIREMENT BOARD EMPLOYEES' ANNUITY AND BENEFIT
FUND--CITIES OVER 500,000 INHABITANTS

Pension Code § 11-160.1

11-160.1. Group health care plan

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§ 11-160.1. Group Health Care Plan. 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 11-178 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.

The group hospital care plan and group medical and surgical plan established under this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

Laws 1963, p. 161, § 11-160.1, added by P.A. 84-159, § 1, eff. Aug. 16, 1985.

S. H. A. ch. 108 1/2 ¶ 11-160.1
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EXHIBIT 8B

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ILLINOIS PENSION CODE
GROUP HEALTH BENEFIT PROVISIONS
AS AMENDED BY P.A. 86-273
EFFECTIVE AUGUST 23, 1989

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P.A. 82-342, in the second paragraph, in the first sentence, inserted "from January 1, 1976 to July 1, 1981, and $250 per month"; and at the end of cl. (a), added "or who dies in the service after June 30, 1981".

Section 2 of P.A. 82-342 provided:

"The General Assembly finds that the changes made by this amendatory Act of 1981 relating to Articles 5 and 6 of the Illinois Pension Code accommodate a request from local governments or organizations thereof, and therefore reimbursement of local governments is not required of the State under the State Mandates Act, by reason of the exclusion specified in clause (1) of subsection (1) of Section 8 of that Act."

P.A. 84-1104, in the second paragraph, substituted "January 1, 1986, the minimum amount of widow's annuity shall be $325 per month for the following classes of widows", for "July 1, 1975 the minimum amount of widow's annuity shall be $175 per mon[illegible] July 1, 1975 to January 1, 1976 and $[illegible] month from January 1, 1976 to July [illegible] and $250 per month thereafter for all [illegible] hereinafter described"; inserted "of 198[illegible] ceding "(b)", inserted "and"; and in [illegible] substituted "and does" for "who does".

P.A. 86-273, in the first paragraph, sub[illegible]ed "$200 per month, without regard to whe[illegible] the deceased policeman was in service o[illegible] effective date of this amendatory Act of 19[illegible] for "$150 per month"; in the second pa[illegible]graph, substituted "1990" for "1986", "$400" [illegible] "$325", "whether the deceased policeman w[illegible] in service on" for "the fact that the death of th[illegible] policeman occurred prior to" and "1989" [illegible] "1985".

P.A. 87-849 inserted the paragraph increas[illegible]ing the minimum amount of a widow's annui[illegible] effective Jan. 1, 1992.

Library References

Municipal Corporations ⇐187(7).
WESTLAW Topic No. 268.
C.J.S. Municipal Corporations §§ 588, 589.

5/5-167.5. Group health benefit

§ 5-167.5. Group health benefit. (a) For the purposes of this Section, "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity on or after January 1, 1988, under Article 5, 6, 8 or 11, by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city").

(b) The city shall continue to offer to annuitants and their dependents the same basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan), and may offer additional plans at its sole discretion.

(c) Effective the date the initial increased annuitant payments pursuant to subsection (g) take effect, the city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, of annuitants and their dependents under all health care plans offered by the city. The claims or premiums of all annuitants and their dependents under all of the plans offered by the city shall be aggregated for the purpose of calculating the city's payment required under this subsection, as well as for the setting of rates of payment for annuitants as required under subsection (g).

(d) From January 1, 1988 until December 31, 1992, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $65 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $35 per month for each such annuitant who is qualified to receive medicare benefits. From January 1, 1993 until December 31, 1997, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the

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following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

For the period January 1, 1988 through the effective date of this amendatory Act of 1989, payments under this Section shall be reduced by the amounts paid by or on behalf of the board's annuitants covered during that period.

The payments described in this subsection shall be paid from the tax levy authorized under Section 5-168; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on December 31, 1997, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(g) The aggregate cost of claims and premiums for each calendar year from 1989 through 1997 of all annuitants and dependents covered by the city's group health care plans shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If such estimated cost is more than the estimated amount to be contributed by the city during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all participating annuitants. The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The initial determination of such payments shall be prospective only and shall be based upon the estimated costs for the balance of the year. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants.

(h) An annuitant may elect to terminate coverage in a plan at any time, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

Laws 1963, p. 161, § 5-167.5, added by P.A. 82-1044, § 1, eff. Jan. 12, 1983. Amended by P.A. 86-273, § 1, eff. Aug. 23, 1989.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 5-167.5.

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above 4% a year, to the extent necessary and available to finance the cost of such increases for the following year, shall be transferred each year beginning with the year 1969 to a fund account designated as the Supplementary Payment Reserve from the Interest and Investment Reserve set forth in Section 6-203.

If the money in the Supplementary Payment Reserve in any year arising from interest income above 4% a year as defined in this Section accruing in the preceding year; and the contributions by retired persons, are insufficient to make the total payments to all persons entitled to the annuity under this Section; and any investment earnings over 4% a year beginning with the year 1969 not previously used to finance such increases and transferred to the Prior Service Annuity Reserve, may be used to the extent necessary and available to provide sufficient funds to finance such increases for the current year. Such sums shall be transferred from the Prior Service Annuity Reserve. If the total money available in the Supplementary Payment Reserve from such sources are insufficient to make the total payments to all persons entitled to such increases for the year, a proportionate amount computed as the ratio of the money available to the total of all the payments specified for that year shall be paid to each person for that year.

No part of any such increase under this Section is an obligation of the fund otherwise established under this Article 6.

Laws 1963, p. 161, § 6-164.1, added by P.A. 76-1163, § 1, eff. Aug. 29, 1969. Amended by P.A. 77-1496, § 1, eff. Sept. 8, 1971; P.A. 79-633, § 1, eff. Oct. 1, 1975; P.A. 82-971, § 1, eff. Sept. 8, 1982.

Formerly Ill.Rev.Stat.1991, ch. 108½, ¶ 6-164.1.

Historical and Statutory Notes

P.A. 77-1496 substituted "2%" for "1½%" in the first and second sentences of the first paragraph.

P.A. 79-633 substituted "The provisions of the preceding paragraph of this Section apply" for "This Section applies" at the beginning of the second paragraph, inserted the third and fourth paragraphs, and in the fifth paragraph, substituted "the increases indicated in the preceding part of this Section" for "such increases".

P.A. 82-971, in the third paragraph, made the following substitutions: "in July, 1982" for "on July 1, 1975"; "1976" for "1967"; and "$400" for "$350.00 a month thereafter"; in the fourth paragraph, inserted "minimum"; substituted "specified in the preceding paragraph" for "of $350.00"; and following "6-128.1", inserted a comma.

For retroactive application of P.A. 82-971, see note following 40 ILCS 5/5-167.2.

5/6-164.2. Group health benefit

§ 6-164.2. Group health benefit. (a) For the purposes of this Section, "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity on or after January 1, 1988, under Article 5, 6, 8 or 11, by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city").

(b) The city shall continue to offer to annuitants and their dependents the same basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan), and may offer additional plans at its sole discretion.

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(c) Effective the date the initial increased annuitant payments pursuant to subsection (g) take effect, the city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, of annuitants and their dependents under all health care plans offered by the city. The claims or premiums of all annuitants and their dependents under all of the plans offered by the city shall be aggregated for the purpose of calculating the city's payment required under this subsection, as well as for the setting of rates of payment for annuitants as required under subsection (g).

(d) From January 1, 1988 until December 31, 1992, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $65 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $35 per month for each such annuitant who is qualified to receive medicare benefits. From January 1, 1993 until December 31, 1997, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

For the period January 1, 1988 through the effective date of this amendatory Act of 1989, payments under this Section shall be reduced by the amounts paid by or on behalf of the board's annuitants covered during that period.

The payments described in this subsection shall be paid from the tax levy authorized under Section 6-165; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on December 31, 1997, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(g) The aggregate cost of claims and premiums for each calendar year from 1989 through 1997 of all annuitants and dependents covered by the city's group health care plans shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If such estimated cost is more than the estimated amount to be contributed by the city during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all participating annuitants. The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The initial determination of such payments shall be prospective only and shall be based upon the estimated costs for the balance

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of the year. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants.

(h) An annuitant may elect to terminate coverage in a plan at any time, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

Laws 1963, p. 161, § 6-164.2, added by P.A. 82-1044, § 1, eff. Jan. 12, 1983. Amended by P.A. 86-273, § 1, eff. Aug. 23, 1989.

Formerly Ill.Rev.Stat.1991, ch. 108½, ¶ 6-164.2.

Historical and Statutory Notes

P.A. 86-273 rewrote this section which, prior thereto, provided:

"(a) For the purposes of this Section:

"'Annuitant' means a person receiving an age and service annuity or a prior service annuity under this Article on or after January 1, 1983.

"'Carrier' means 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.

"(b) The Board shall contract with one or more carriers to provide group health insurance for all annuitants. Such group health insurance shall provide for protection against the financial costs of health care expenses incurred in and out of hospital including basic hospital-surgical-medical coverages and major medical coverage. The program may include such supplemental coverages as out-patient diagnostic X-ray and laboratory expenses, prescription drugs and similar group benefits.

"The group health insurance program may also include:

"(1) prepaid preventive health care through health maintenance organizations;

"(2) coverage for those who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a recognized religious denomination;

"(3) optional coverage for dependents of the annuitant;

"(4) other optional coverage, such as for dental, psychological, or optometric services.

"(c) The group contract shall be on terms deemed by the Board to be in the best interest of the Fund and its annuitants, based on, but not limited to, such criteria as administrative cost factors, the service capabilities of the carrier, and the premiums charged.

"The term of any contract made under authority of this Section may not extend beyond 2 fiscal years, with such renewal options, for not more than 2 one-year periods, as may be deemed by the Board to be most advantageous to and in the best interest of the Fund and its annuitants. No renewal may be exercised without the conclusion of a qualified independent actuary that any increase in premium requested by a carrier is justified on the basis of audited experience data, increases in the cost of health care services, carrier performance, or any combination thereof.

"(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. The full cost of any optional coverage elected by the annuitant shall be deducted from his monthly annuity."

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Library References

Municipal Corporations ⟹220(6), 220(9).
WESTLAW Topic No. 268.
C.J.S. Municipal Corporations §§ 722, 727.

5/8-164.1. Group health benefit

§ 8-164.1. Group health benefit. (a) For the purposes of this Section, "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity on or after January 1, 1988, under Article 5, 6, 8 or 11, by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city").

(b) The city shall continue to offer to annuitants and their dependents the same basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan), and may offer additional plans at its sole discretion.

(c) Effective the date the initial increased annuitant payments pursuant to subsection (g) take effect, the city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, of annuitants and their dependents under all health care plans offered by the city. The claims or premiums of all annuitants and their dependents under all of the plans offered by the city shall be aggregated for the purpose of calculating the city's payment required under this subsection, as well as for the setting of rates of payment for annuitants as required under subsection (g).

(d) From January 1, 1988 until December 31, 1992, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $65 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $35 per month for each such annuitant who is qualified to receive medicare benefits. From January 1, 1993 until December 31, 1997, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

For the period January 1, 1988 through the effective date of this amendatory Act of 1989, payments under this Section shall be reduced by the amounts paid by or on behalf of the board's annuitants covered during that period.

Commencing on the effective date of this amendatory Act of 1989, the board is authorized to pay to the board of education on behalf of each person who chooses to participate in the board of education's plan the amounts specified in this subsection (d) during the years indicated. For the period January 1, 1988 through the effective date of this amendatory Act of 1989, the board shall pay to the board of education annuitants who participate in the board of education's health benefits plan for annuitants the following amounts: $10 per month to each annuitant who is not qualified to receive medicare

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benefits, and $14 per month to each annuitant who is qualified to receive medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 8-189; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on December 31, 1997, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(g) The aggregate cost of claims and premiums for each calendar year from 1989 through 1997 of all annuitants and dependents covered by the city's group health care plans shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If such estimated cost is more than the estimated amount to be contributed by the city during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all participating annuitants. The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The initial determination of such payments shall be prospective only and shall be based upon the estimated costs for the balance of the year. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants.

(h) An annuitant may elect to terminate coverage in a plan at any time, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

Laws 1963, p. 161, § 8-164.1, added by P.A. 84-23, § 1, eff. July 18, 1985. Amended by P.A. 86-273, § 1, eff. Aug. 23, 1989.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 8-164.1.

Historical and Statutory Notes

P.A. 86-273 rewrote the section which prior thereto, provided:

"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

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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.

"The group hospital care plan and group medical and surgical plan established under this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970."

Library References

Municipal Corporations ⇐186(1), 187(2).
WESTLAW Topic No. 268.
C.J.S. Municipal Corporations §§ 586, 588, 589.

5/8–165. Re-entry into service

§ 8–165. Re-entry into service. (a) When an employee receiving age and service or prior service annuity who has withdrawn from service after the effective date re-enters service before age 65, any annuity previously granted and any annuity fixed for his wife shall be cancelled. The employee shall be credited for annuity purposes with sums sufficient to provide annuities equal to those cancelled, as of their ages on the date of re-entry; provided, the maximum age of the wife for this purpose shall be as provided in Section 8–155 of this Article.

The sums so credited shall provide for annuities to be fixed and granted in the future. Contributions by the employees and the city for the purposes of this Article shall be made, and when the proper time arrives, as provided in this Article, new annuities based upon the total credit for annuity purposes and the entire term of his service shall be fixed for the employee and his wife.

If the employee's wife died before he re-entered service, no part of any credits for widow's or widow's prior service annuity at the time annuity for his wife was fixed shall be credited upon re-entry into service, and no such sums shall thereafter be used to provide such annuity.

(b) When an employee re-enters service after age 65, payments on account of any annuity previously granted shall be suspended during the time thereafter that he is in service, and when he again withdraws, annuity payments shall be resumed. If the employee dies in service, his widow shall receive the amount of annuity previously fixed for her.

Laws 1963, p. 161, § 8–165, eff. July 1, 1963. Amended by P.A. 81–1187, § 1, eff. Jan. 1, 1981; P.A. 81–1536, § 1, eff. Jan. 1, 1981.
Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 8–165.

Historical and Statutory Notes

P.A. 81–1187 inserted "or on behalf of" in the second paragraph of subd. (a).

P.A. 81–1536 in the second sentence of the second paragraph of subd. (a), following "Contributions by", deleted "or on behalf of".

Prior Laws:

Laws 1921, p. 203, § 34.
Laws 1935, p. 303, § 34.
Laws 1935, p. 303, § 38½, added by Laws 1949, p. 829, § 1.

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EXHIBIT 8C

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ILLINOIS PENSION CODE
GROUP HEALTH BENEFIT PROVISIONS
AS AMENDED BY P.A. 90-32
EFFECTIVE JUNE 27, 1997

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) any interest earnings over 4% a year
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rrections in P.A. 90-567 through P.A. 90-810.

Article, beginning January 1, 1996, the
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a refund, provided that the widow is
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-12, § 5, eff. April 20, 1995; P.A. 90-766, § 5,

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e deceased policeman was in service on the
tive date of P.A. 86-273.

Effective January 1, 1990, the minimum amount
idow's annuity shall be $400 per month for the
wing classes of widows, without regard to
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effective date of P.A. 86-273: (a) the widow of
liceman who dies in the service with at least 10
s of service credit at date of death in the
or who dies in the service after June 30,

1981; and (b) the widow of a policeman who withdraws after 20 or more years of service and does not withdraw a refund, provided the widow is married to the policeman before he withdraws from the service.

"Effective January 1, 1992, the minimum amount of widow's annuity shall be $500 per month for the following classes of widows, without regard to whether the deceased policeman is in service on or after the effective date of P.A. 87-849: (1) the widow of a policeman who dies in service with at least 10 years of service credit, or who dies in service after June 30, 1981; and (2) the widow of a policeman who withdraws from service with 20 or more years of service credit and does not withdraw a refund, provided that the widow is married to the policeman before he withdraws from service.

"Effective January 1, 1993, the minimum amount of widow's annuity shall be $600 per month for the following classes of widows, without regard to whether the deceased policeman is in service on or after the effective date of this amendatory Act of 1993: (1) the widow of a policeman who dies in service with at least 10 years of service credit, or who dies in service after June 30, 1981; and (2) the widow of a policeman who withdraws from service with 20 or more years of service credit and does not withdraw a refund, provided that the widow is married to the policeman before he withdraws from service.";

inserted subsec. (a); and inserted subsection designations for the former fifth and sixth paragraphs.

P.A. 90-766, in subsec. (a), added the second paragraph.

5/5-167.5. Group health benefit

§ 5-167.5. Group health benefit.

(a) For the purposes of this Section: (1) "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity, under Article 5, 6, 8 or 11,[1] by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city"); (2) "Medicare Plan annuitant" means an annuitant described in item (1) who is eligible for Medicare benefits; and (3) "non-Medicare Plan annuitant" means an annuitant described in item (1) who is not eligible for Medicare benefits.

(b) The city shall offer group health benefits to annuitants and their eligible dependents through June 30, 2002. The basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan) shall cease to be a plan offered by the city, except as specified in subparagraphs (4) and (5) below, and shall be closed to new enrollment or transfer of coverage for any non-Medicare Plan annuitant as of the effective date of this amendatory Act of 1997. The city shall offer non-Medicare Plan annuitants and their eligible dependents the option of enrolling in its Annuitant Preferred Provider Plan and may offer additional plans for any annuitant. The city may amend, modify, or terminate any of its additional plans at its sole discretion. If the city offers more than one annuitant plan, the city shall allow annuitants to convert coverage from one city annuitant plan to another, except the basic city plan, during times designated by the city, which periods of time shall occur at least annually. For the period dating from the effective date of this amendatory Act of 1997 through June 30, 2002, monthly premium rates may be increased for annuitants during the time of their participation in non-Medicare plans, except as provided in subparagraphs (1) through (4) of this subsection.

(1) For non-Medicare Plan annuitants who retired prior to January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall not exceed the highest premium rate chargeable under any city non-Medicare Plan annuitant coverage as of December 1, 1996.

(2) For non-Medicare Plan annuitants who retire on or after January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall be the rate in effect on December 1, 1996, with monthly premium increases to take effect no sooner than April 1, 1998 at the lower of (i) the premium rate determined pursuant to subsection (g) or (ii) 10% of the immediately previous month's rate for similar coverage.

(3) In no event shall any non-Medicare Plan annuitant's share of monthly premium for non-Medicare Plan coverage exceed 10% of the annuitant's monthly annuity.

(4) Non-Medicare Plan annuitants who are enrolled in the basic city plan as of July 1, 1998 may remain in the basic city plan, if they so choose, on the condition that they are not entitled to the caps on rates set forth in subparagraphs (1) through (3), and their premium rate shall be the rate determined in accordance with subsections (c) and (g).

(5) Medicare Plan annuitants who are currently enrolled in the basic city plan for Medicare eligible annuitants may remain in that plan, if they so choose, through June 30, 2002. Annuitants shall not be allowed to enroll in or transfer into the basic city plan for Medicare eligible annuitants on or after July 1, 1999. The city shall continue to offer annuitants a supplemental Medicare Plan for Medicare eligible annuitants through June 30, 2002, and the city may offer additional plans to Medicare-eligible annuitants in its sole discretion. All Medicare Plan annuitant monthly rates shall be determined in accordance with subsections (c) and (g).

(c) The city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, as determined in accordance with subsection (g), of annuitants and their dependents under all health care plans offered by the city. The city may reduce its obligation by application of price reductions obtained as a result of financial arrangements with providers or plan administrators.

(d) From January 1, 1993 until June 30, 2002, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans, the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 5-168; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on June 30, 2002, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(g) For each annuitant plan offered by the city, the aggregate cost of claims, as reflected in the claim records of the plan administrator, shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If the estimated annual cost for each annuitant plan offered by the city is more than the estimated amount to be contributed by the city for that plan pursuant to subsections (b) and (c) during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all annuitants participating in the plan, except as provided in subsection (b). The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city as determined under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants, except as provided in subsection (b).

(h) An annuitant may elect to terminate coverage in a plan at the end of any month, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

(i) The city shall advise the board of all proposed premium increases for health care at least 75 days prior to the effective date of the change, and any increase shall be prospective only.

Amended by P.A. 90-32, § 5, eff. June 27, 1997.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 5-167.5.

1 40 ILCS 5/5-101 et seq., 5/6-101 et seq., 5/8-101 et seq. or 5/11-101 et seq.

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January of the year following the year he attains the age of 65, or in January, 1970, if he is then over age 65, his then fixed and payable monthly annuity increased by an amount equal to 2% of the original grant of annuity, for each year he received annuity payments after the year in which he attains age 65. An additional 2% increase in such fixed and payable original granted annuity shall accrue in each January thereafter.

However, beginning January 1, 1996, the increases payable under this subsection (a) to a fireman born before January 1, 1945 shall be at the rate of 3% of the originally granted annuity amount, notwithstanding that the fireman terminated service prior to the effective date of this amendatory Act of 1995.

(b) The provisions of subsection (a) of this Section apply only to a retired fireman eligible for such increases in his annuity if he contributed to the fund a sum equal to 1% of the final average monthly salary used in the computation of the annuity for each full year of credited service upon which his annuity was computed. All such sums contributed shall be placed in a Supplementary Payment Reserve and used for the purposes of such fund account.

(c) Beginning with the monthly annuity payment due in July, 1982, the monthly annuity payment for any fireman who retired from the service before September 1, 1976 at age 50 or over with 20 or more years of service or who was granted duty disability benefits prior to September 1, 1957 and entitled to an annuity or duty disability benefits on July 1, 1975 shall be not less than $400.

(d) The difference in amount between the minimum monthly annuity specified in subsection (c) and the minimum monthly annuity to which the fireman was entitled before July 1, 1975, in accordance with the provisions of Section 6-128.1, shall be paid as a supplement in the manner set forth in subsection (e).

(e) To defray the annual cost of the increases indicated in the preceding part of this Section, the annual income accruing from investments held by this fund, above 4% a year, to the extent necessary and available to finance the cost of such increases for the following year, shall be transferred each year beginning with the year 1969 to a fund account designated as the Supplementary Payment Reserve from the Interest and Investment Reserve set forth in Section 6-203.

If the money in the Supplementary Payment Reserve in any year arising from interest income above 4% a year as defined in this Section accruing in the preceding year; and the contributions by retired persons, are insufficient to make the total payments to all persons entitled to the annuity under this Section; and any investment earnings over 4% a year beginning with the year 1969 not previously used to finance such increases and transferred to the Prior Service Annuity Reserve, may be used to the extent necessary and available to provide sufficient funds to finance such increases for the current year. Such sums shall be transferred from the Prior Service Annuity Reserve. If the total money available in the Supplementary Payment Reserve from such sources are insufficient to make the total payments to all persons entitled to such increases for the year, a proportionate amount computed as the ratio of the money available to the total of all the payments specified for that year shall be paid to each person for that year.

No part of any such increase under this Section is an obligation of the fund otherwise established under this Article 6.

Amended by P.A. 89-136, § 15, eff. July 14, 1995.

Formerly Ill.Rev.Stat.1991, ch. 108½, ¶ 6-164.1.

Historical and Statutory Notes

P.A. 89-136 inserted the section heading; designated the subsections; in subsec. (a), in the first paragraph, in the first sentence, inserted "on or"; added the second paragraph; in subsec. (b), in the first sentence, substituted "subsection (a)" for "the preceding paragraph"; and in subsec. (d), substituted "subsection (c)" for "the preceding paragraph" and "subsection (e)" for "the immediately following paragraph".

5/6-164.2. Group health benefit

§ 6-164.2. Group health benefit.

(a) For the purposes of this Section: (1) "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or

a minimum annuity, under Article 5, 6, 8 or 11,[1] by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city"); (2) "Medicare Plan annuitant" means an annuitant described in item (1) who is eligible for Medicare benefits; and (3) "non-Medicare Plan annuitant" means an annuitant described in item (1) who is not eligible for Medicare benefits.

(b) The city shall offer group health benefits to annuitants and their eligible dependents through June 30, 2002. The basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan) shall cease to be a plan offered by the city, except as specified in subparagraphs (4) and (5) below, and shall be closed to new enrollment or transfer of coverage for any non-Medicare Plan annuitant as of the effective date of this amendatory Act of 1997. The city shall offer non-Medicare Plan annuitants and their eligible dependents the option of enrolling in its Annuitant Preferred Provider Plan and may offer additional plans for any annuitant. The city may amend, modify, or terminate any of its additional plans at its sole discretion. If the city offers more than one annuitant plan, the city shall allow annuitants to convert coverage from one city annuitant plan to another, except the basic city plan, during times designated by the city, which periods of time shall occur at least annually. For the period dating from the effective date of this amendatory Act of 1997 through June 30, 2002, monthly premium rates may be increased for annuitants during the time of their participation in non-Medicare plans, except as provided in subparagraphs (1) through (4) of this subsection.

(1) For non-Medicare Plan annuitants who retired prior to January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall not exceed the highest premium rate chargeable under any city non-Medicare Plan annuitant coverage as of December 1, 1996.

(2) For non-Medicare Plan annuitants who retire on or after January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall be the rate in effect on December 1, 1996, with monthly premium increases to take effect no sooner than April 1, 1998 at the lower of (i) the premium rate determined pursuant to subsection (g) or (ii) 10% of the immediately previous month's rate for similar coverage.

(3) In no event shall any non-Medicare Plan annuitant's share of monthly premium for non-Medicare Plan coverage exceed 10% of the annuitant's monthly annuity.

(4) Non-Medicare Plan annuitants who are enrolled in the basic city plan as of July 1, 1998 may remain in the basic city plan, if they so choose, on the condition that they are not entitled to the caps on rates set forth in subparagraphs (1) through (3), and their premium rate shall be the rate determined in accordance with subsections (c) and (g).

(5) Medicare Plan annuitants who are currently enrolled in the basic city plan for Medicare eligible annuitants may remain in that plan, if they so choose, through June 30, 2002. Annuitants shall not be allowed to enroll in or transfer into the basic city plan for Medicare eligible annuitants on or after July 1, 1999. The city shall continue to offer annuitants a supplemental Medicare Plan for Medicare eligible annuitants through June 30, 2002, and the city may offer additional plans to Medicare eligible annuitants in its sole discretion. All Medicare Plan annuitant monthly rates shall be determined in accordance with subsections (c) and (g).

(c) The city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, as determined in accordance with subsection (g), of annuitants and their dependents under all health care plans offered by the city. The city may reduce its obligation by application of price reductions obtained as a result of financial arrangements with providers or plan administrators.

(d) From January 1, 1993 until June 30, 2002, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 6–165; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

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(e) The city's obligations under subsections (b) and (c) shall terminate on June 30, 2002, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(g) For each annuitant plan offered by the city, the aggregate cost of claims, as reflected in the claim records of the plan administrator, shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If the estimated annual cost for each annuitant plan offered by the city is more than the estimated amount to be contributed by the city for that plan pursuant to subsections (b) and (c) during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all annuitants participating in the plan, except as provided in subsection (b). The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city as determined under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants, except as provided in subsection (b).

(h) An annuitant may elect to terminate coverage in a plan at the end of any month, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

(i) The city shall advise the board of all proposed premium increases for health care at least 75 days prior to the effective date of the change, and any increase shall be prospective only.

Amended by P.A. 90–32, § 5, eff. June 27, 1997.

Formerly Ill.Rev.Stat.1991, ch. 108½, ¶ 6–164.2.

[1] 40 ILCS 5/5–101 et seq., 5/6–101 et seq., 5/8–101 et seq. or 5/11–101 et seq.

Historical and Statutory Notes

P.A. 90–32 rewrote this section, which prior thereto read:

"Group health benefit. (a) For the purposes of this Section, 'annuitant' means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity on or after January 1, 1988, under Article 5, 6, 8 or 11, by reason of previous employment by the City of Chicago (hereinafter, in this Section, 'the city').

"(b) The city shall continue to offer to annuitants and their dependents the same basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan), and may offer additional plans at its sole discretion.

"(c) Effective the date the initial increased annuitant payments pursuant to subsection (g) take effect, the city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, of annuitants and their dependents under all health care plans offered by the city. The claims or premiums of all annuitants and their dependents under all of the plans offered by the city shall be aggregated for the purpose of calculating the city's payment required under this subsection, as well as for the setting of rates of payment for annuitants as required under subsection (g).

"(d) From January 1, 1988 until December 31, 1992, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $65 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $35 per month for each such annuitant who is qualified to receive medicare benefits. From January 1, 1993 until December 31, 1997, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

"For the period January 1, 1988 through the effective date of this amendatory Act of 1989, payments under this Section shall be reduced by the amounts paid by or on behalf of the board's annuitants covered during that period.

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paid by or on behalf of the board's annui-
ered during that period.

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"The payments described in this subsection shall be paid from the tax levy authorized under Section 6-165; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

"(e) The city's obligations under subsections (b) and (c) shall terminate on December 31, 1997, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

"(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

"(g) The aggregate cost of claims and premiums for each calendar year from 1989 through 1997 of all annuitants and dependents covered by the city's group health care plans shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If such estimated cost is more than the estimated amount to be contributed by the city during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all participating annuitants. The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The initial determination of such payments shall be prospective only and shall be based upon the estimated costs for the balance of the year. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

"If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants.

"(h) An annuitant may elect to terminate coverage in a plan at any time, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g)."

Notes of Decisions

Construction with other law 1

1. Construction with other law

City did not engage in "any kind of insurance or surety business" so as to entitle attorney for class of annuitant intervenors to award of fees under Illinois Insurance Code where Pension Code requiring city to contribute specified amount for annuitants' health care coverage focused upon governmental purpose and plainly did not place the city in the insurance business as contemplated by the Insurance Code. City of Chicago v. Korshak, App. 1 Dist.1995, 213 Ill.Dec. 144, 276 Ill.App.3d 597, 658 N.E.2d 1165, rehearing denied, appeal denied 217 Ill.Dec. 663, 167 Ill.2d 551, 667 N.E.2d 1056.

5/6-165. Financing; tax

§ 6-165. Financing; tax.

(a) Except as expressly provided in this Section, each city shall levy a tax annually upon all taxable property therein for the purpose of providing revenue for the fund. For the years prior to the year 1960, the tax rate shall be as provided for in the "Firemen's Annuity and Benefit Fund of the Illinois Municipal Code".[1] The tax, from and after January 1, 1968 to and including the year 1971, shall not exceed .0863% of the value, as equalized or assessed by the Department of Revenue, of all taxable property in the city. Beginning with the year 1972 and each year thereafter the city shall levy a tax annually at a rate on the dollar of the value, as equalized or assessed by the Department of Revenue of all taxable property within such city that will produce, when extended, not to exceed an amount equal to the total amount of contributions by the employees to the fund made in the calendar year 2 years prior to the year for which the annual applicable tax is levied, multiplied by 2.23 through the calendar year 1981, and by 2.26 for the year 1982 and for each year thereafter.

To provide revenue for the ordinary death benefit established by Section 6-150 of this Article, in addition to the contributions by the firemen for this purpose, the city council shall for the year 1962 and each year thereafter annually levy a tax, which shall be in addition to and exclusive of the taxes authorized to be levied under the foregoing provisions of this Section, upon all taxable property in the city, as equalized or assessed by the Department of Revenue, at such rate per cent of the value of such property as shall be sufficient to produce for each year the sum of $142,000.

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w[illegible]nuity at the rate of 1% throughout his th[illegible]rest on such amounts at the effective

90-655, § 48, eff. July 30, 1998.

atutory Notes

1983 (increasing the maximum from $400 to $500 a month) shall be effective as of January 1, 1984 and apply in the case of every qualifying widow whose husband dies in the service on or after January 1, 1984 or withdraws and enters on annuity on or after January 1, 1984.

P.A. 90-655, the First 1998 General Revisory Act, amended various Acts to delete obsolete text, to correct patent and technical errors, to revise cross references, to resolve multiple actions in the 89th and 90th General Assemblies and to make certain technical corrections in P.A. 89-708 through P.A. 90-566.

is payable monthly after the death of an attainment of age 18, under the following yee attained age 65, and before he withdrew

in the performance of an act of duty; other than injury incurred in the performance years of service after the date of his original d[illegible] of his latest re-entry;

[illegible] service after age 55 (or after age 50 [illegible] after June 27, 1997) and who has

[illegible]766, § 5, eff. Aug. 14, 1998.

utory Notes

P.A. 90-766 incorporated the amendment by P.A. -31.

on the effective date of this amendatory e, $220 per month for each child while the nd $250 per month for each child when no lowing limitations:

d children of an employee whose death f duty, or for the children where a widow monthly salary, the annuity for each child uities for the family shall not exceed such

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(2) For the family of an employee whose death is the result of any cause other than injury incurred in the performance of duty, in which the combined annuities for the family exceed 60% of the employee's final monthly salary, the annuity for each child shall be reduced pro rata so that the combined annuities for the family shall not exceed such limitation.

(3) The increase in child's annuity provided by this amendatory Act of 1997 shall apply to all child's annuities being paid on or after the effective date of this amendatory Act of 1997. The limitations on the combined annuities for a family in parts (1) and (2) of this Section do not apply to families of employees who died before the effective date of this amendatory Act of 1997.

(4) The amendments to parts (1) and (2) of this Section made by Public Act 84-1472 (eliminating the further limitation that the monthly combined family amount shall not exceed $500 plus 10% of the employee's final monthly salary) shall apply in the case of every qualifying child whose employee parent dies in the service or enters on annuity on or after January 23, 1987.

Amended by P.A. 90-32, § 5, eff. June 27, 1997; P.A. 90-511, § 2, eff. Aug. 22, 1997.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 8-159.

Historical and Statutory Notes

The amendments by P.A. 90-32 and P.A. 90-511, which were identical, in the introductory paragraph, substituted "on the effective date of this amendatory Act of 1997" for "January 1, 1988", "$220" for "$120", and "$250" for "$150"; in subpar. (3), in the first sentence, substituted "1997" for "1987" and "the effective date of this amendatory Act of 1997," for "January 1, 1988, subject to"; in the second sentence, deleted "above" preceding "limitations" and added "in parts (1) and (2) of this Section do not apply to families of employees who died before the effective date of this amendatory Act of 1997".

5/8-160. Duty disability benefit—Child's disability benefit

Cross References

Early retirement incentive, see 40 ILCS 5/8-138.1.

5/8-161. Ordinary disability benefit

Cross References

Early retirement incentive, see 40 ILCS 5/8-138.1.

5/8-164.1. Group health benefit

§ 8-164.1. Group health benefit.

(a) For the purposes of this Section: (1) "annuitant" means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity, under Article 5, 6, 8 or 11,[1] by reason of previous employment by the City of Chicago (hereinafter, in this Section, "the city"); (2) "Medicare Plan annuitant" means an annuitant described in item (1) who is eligible for Medicare benefits; and (3) "non-Medicare Plan annuitant" means an annuitant described in item (1) who is not eligible for Medicare benefits.

(b) The city shall offer group health benefits to annuitants and their eligible dependents through June 30, 2002. The basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan) shall cease to be a plan offered by the city, except as specified in subparagraphs (4) and (5) below, and shall be closed to new enrollment or transfer of coverage for any non-Medicare Plan annuitant as of the effective date of this amendatory Act of 1997. The city shall offer non-Medicare Plan annuitants and their eligible dependents the option of enrolling in its Annuitant Preferred Provider Plan and may offer additional plans for any annuitant. The city may amend, modify, or terminate any of its additional plans at its sole discretion. If the city offers more than one annuitant plan, the city shall allow annuitants to convert coverage from one city annuitant plan to another, except the

basic city plan, during times designated by the city, which periods of time shall occur at least annually. For the period dating from the effective date of this amendatory Act of 1997 through June 30, 2002, monthly premium rates may be increased for annuitants during the time of their participation in non-Medicare plans, except as provided in subparagraphs (1) through (4) of this subsection.

(1) For non-Medicare Plan annuitants who retired prior to January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall not exceed the highest premium rate chargeable under any city non-Medicare Plan annuitant coverage as of December 1, 1996.

(2) For non-Medicare Plan annuitants who retire on or after January 1, 1988, the annuitant's share of monthly premium for non-Medicare Plan coverage only shall be the rate in effect on December 1, 1996, with monthly premium increases to take effect no sooner than April 1, 1998 at the lower of (i) the premium rate determined pursuant to subsection (g) or (ii) 10% of the immediately previous month's rate for similar coverage.

(3) In no event shall any non-Medicare Plan annuitant's share of monthly premium for non-Medicare Plan coverage exceed 10% of the annuitant's monthly annuity.

(4) Non-Medicare Plan annuitants who are enrolled in the basic city plan as of July 1, 1998 may remain in the basic city plan, if they so choose, on the condition that they are not entitled to the caps on rates set forth in subparagraphs (1) through (3), and their premium rate shall be the rate determined in accordance with subsections (c) and (g).

(5) Medicare Plan annuitants who are currently enrolled in the basic city plan for Medicare eligible annuitants may remain in that plan, if they so choose, through June 30, 2002. Annuitants shall not be allowed to enroll in or transfer into the basic city plan for Medicare eligible annuitants on or after July 1, 1999. The city shall continue to offer annuitants a supplemental Medicare Plan for Medicare eligible annuitants through June 30, 2002, and the city may offer additional plans to Medicare eligible annuitants in its sole discretion. All Medicare Plan annuitant monthly rates shall be determined in accordance with subsections (c) and (g).

(c) The city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, as determined in accordance with subsection (g), of annuitants and their dependents under all health care plans offered by the city. The city may reduce its obligation by application of price reductions obtained as a result of financial arrangements with providers or plan administrators.

(d) From January 1, 1993 until June 30, 2002, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

Commencing on the effective date of this amendatory Act of 1989, the board is authorized to pay to the board of education on behalf of each person who chooses to participate in the board of education's plan the amounts specified in this subsection (d) during the years indicated. For the period January 1, 1988 through the effective date of this amendatory Act of 1989, the board shall pay to the board of education annuitants who participate in the board of education's health benefits plan for annuitants the following amounts: $10 per month to each annuitant who is not qualified to receive medicare benefits, and $14 per month to each annuitant who is qualified to receive medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 8-189; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on June 30, 2002, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

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(g) For each annuitant plan offered by the city, the aggregate cost of claims, as reflected in the claim records of the plan administrator, shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If the estimated annual cost for each annuitant plan offered by the city is more than the estimated amount to be contributed by the city for that plan pursuant to subsections (b) and (c) during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all annuitants participating in the plan, except as provided in subsection (b). The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city as determined under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants, except as provided in subsection (b).

(h) An annuitant may elect to terminate coverage in a plan at the end of any month, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g).

(i) The city shall advise the board of all proposed premium increases for health care at least 75 days prior to the effective date of the change, and any increase shall be prospective only.

Amended by P.A. 90-32, § 5, eff. June 27, 1997.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 8-164.1.

¹ 40 ILCS 5/5-101 et seq., 5/6-101 et seq., 5/8-101 et seq. or 5/11-101 et seq.

Historical and Statutory Notes

P.A. 90-32 rewrote this section, which prior thereto read:

"Group health benefit. (a) For the purposes of this Section, 'annuitant' means a person receiving an age and service annuity, a prior service annuity, a widow's annuity, a widow's prior service annuity, or a minimum annuity on or after January 1, 1988, under Article 5, 6, 8 or 11, by reason of previous employment by the City of Chicago (hereinafter, in this Section, 'the city').

"(b) The city shall continue to offer to annuitants and their dependents the same basic city health care plan available as of June 30, 1988 (hereinafter called the basic city plan), and may offer additional plans at its sole discretion.

"(c) Effective the date the initial increased annuitant payments pursuant to subsection (g) take effect, the city shall pay 50% of the aggregated costs of the claims or premiums, whichever is applicable, of annuitants and their dependents under all health care plans offered by the city. The claims or premiums of all annuitants and their dependents under all of the plans offered by the city shall be aggregated for the purpose of calculating the city's payment required under this subsection, as well as for the setting of rates of payment for annuitants as required under subsection (g).

"(d) From January 1, 1988 until December 31, 1992, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $65 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $35 per month for each such annuitant who is qualified to receive medicare benefits. From January 1, 1993 until December 31, 1997, the board shall pay to the city on behalf of each of the board's annuitants who chooses to participate in any of the city's plans the following amounts: up to a maximum of $75 per month for each such annuitant who is not qualified to receive medicare benefits, and up to a maximum of $45 per month for each such annuitant who is qualified to receive medicare benefits.

"For the period January 1, 1988 through the effective date of this amendatory Act of 1989, payments under this Section shall be reduced by the amounts paid by or on behalf of the board's annuitants covered during that period.

"Commencing on the effective date of this amendatory Act of 1989, the board is authorized to pay to the board of education on behalf of each person who chooses to participate in the board of education's plan the amounts specified in this subsection (d) during the years indicated. For the period January 1, 1988 through the effective date of this amendatory Act of 1989, the board shall pay to the board of education annuitants who participate in the board of education's health benefits plan for annuitants the following amounts: $10 per month to each annuitant who is not qualified to receive medicare benefits, and $14 per month to each annuitant who is qualified to receive medicare benefits.

"The payments described in this subsection shall be paid from the tax levy authorized under Section 8-189; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

"(e) The city's obligations under subsections (b) and (c) shall terminate on December 31, 1997, except with regard to covered expenses incurred but not paid as of that date. This subsection shall not affect other obligations that may be imposed by law.

"(f) The group coverage plans described in this Section are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

"(g) The aggregate cost of claims and premiums for each calendar year from 1989 through 1997 of all annuitants and dependents covered by the city's group health care plans shall be estimated by the city, based upon a written determination by a qualified independent actuary to be appointed and paid by the city and the board. If such estimated cost is more than the estimated amount to be contributed by the city during that year plus the estimated amounts to be paid pursuant to subsection (d) and by the other pension boards on behalf of other participating annuitants, the difference shall be paid by all participating annuitants. The city, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by the participating annuitants. The initial determination of such payments shall be prospective only and shall be based upon the estimated costs for the balance of the year. The board may deduct the amounts to be paid by its annuitants from the participating annuitants' monthly annuities.

"If it is determined from the city's annual audit, or from audited experience data, that the total amount paid by all participating annuitants was more or less than the difference between (1) the cost of providing the group health care plans, and (2) the sum of the amount to be paid by the city under subsection (c) and the amounts paid by all the pension boards, then the independent actuary and the city shall account for the excess or shortfall in the next year's payments by annuitants.

"(h) An annuitant may elect to terminate coverage in a plan at any time, which election shall terminate the annuitant's obligation to contribute toward payment of the excess described in subsection (g)."

Notes of Decisions

Construction with other law 1

1. Construction with other law

City did not engage in "any kind of insurance or surety business" so as to entitle attorney for class of annuitant intervenors to award of fees under Illinois Insurance Code where Pension Code requiring city to contribute specified amount for annuitants' health care coverage focused upon governmental purpose and plainly did not place the city in the insurance business as contemplated by the Insurance Code. City of Chicago v. Korshak, App. 1 Dist.1995, 213 Ill.Dec. 144, 276 Ill.App.3d 597, 658 N.E.2d 1165, rehearing denied, appeal denied 217 Ill.Dec. 663, 167 Ill.2d 551, 667 N.E.2d 1056.

5/8-165. Re-entry into service

Cross References

Early retirement incentive, see 40 ILCS 5/8-138.1.

5/8-173. Financing; tax levy

§ 8-173. Financing; tax levy.

(a) Except as provided in subsection (f) of this Section, the city council of the city shall levy a tax annually upon all taxable property in the city at a rate that will produce a sum which, when added to the amounts deducted from the salaries of the employees or otherwise contributed by them and the amounts deposited under subsection (f), will be sufficient for the requirements of this Article, but which when extended will produce an amount not to exceed the greater of the following: (a) the sum obtained by the levy of a tax of .1093% of the value, as equalized or assessed by the Department of Revenue, of all taxable property within such city, or (b) the sum of $12,000,000. However any city in which a Fund has been established and in operation under this Article for more than 3 years prior to 1970 shall levy for the year 1970 a tax at a rate on the dollar of assessed valuation of all taxable property that will produce, when extended, an amount not to exceed 1.2 times the total amount of contributions made by employees to the Fund for annuity purposes in the calendar year 1968, and, for the year 1971 and 1972 such levy that will produce, when extended, an amount not to exceed 1.3 times the total amount of contributions made by employees to the Fund for annuity purposes in the calendar years 1969 and 1970, respectively; and for the year 1973 an amount not to

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ILLINOIS COMPILED STATUTES ANNOTATED
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*** THIS SECTION IS CURRENT THROUGH PUBLIC ACT 91-712 ***
*** ANNOTATIONS CURRENT THROUGH 721 N.E.2d 1118 ***

CHAPTER 40. PENSIONS
ILLINOIS PENSION CODE
TICLE 11. LABORERS' AND RETIREMENT BOARD EMPLOYEES' ANNUITY AND BENEFIT FUND
-- CITIES OVER 500,000 INHABITANTS

40 ILCS 5/11-160.1 (2000)

[Prior to 1/1/93 cited as: Ill. Rev. Stat., Ch. 108 1/2, para. 11-160.1]

40 ILCS 5/11-160.1. Group health benefit

Sec. 11-160.1. Group health benefit. (a) For the purposes of this Section:
) "annuitant" means a person receiving an age and service annuity, a prior
rvice annuity, a widow's annuity, a widow's prior service annuity, or a
nimum annuity, under Article 5, 6, 8 or 11, by reason of previous employment
the City of Chicago (hereinafter, in this Section, "the city"); (2) "Medicare
an annuitant" means an annuitant described in item (1) who is eligible for
dicare benefits; and (3) "non-Medicare Plan annuitant" means an annuitant
scribed in item (1) who is not eligible for Medicare benefits.

(b) The city shall offer group health benefits to annuitants and their
gible dependents through June 30, 2002. The basic city health care plan
ailable as of June 30, 1988 (hereinafter called the basic city plan) shall
be a plan offered by the city, except as specified in subparagraphs (4)
below, and shall be closed to new enrollment or transfer of coverage for
n-Medicare Plan annuitant as of the effective date of this amendatory Act
1997. The city shall offer non-Medicare Plan annuitants and their eligible
pendents the option of enrolling in its Annuitant Preferred Provider Plan and
offer additional plans for any annuitant. The city may amend, modify, or
rminate any of its additional plans at its sole discretion. If the city offers
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verage from one city annuitant plan to another, except the basic city plan,
ring times designated by the city, which periods of time shall occur at least
nually. For the period dating from the effective date of this amendatory Act
1997 through June 30, 2002, monthly premium rates may be increased for
nuitants during the time of their participation in non-Medicare plans, except
provided in subparagraphs (1) through (4) of this subsection.

(1) For non-Medicare Plan annuitants who retired prior to January 1, 1988,
e annuitant's share of monthly premium for non-Medicare Plan coverage only
ill not exceed the highest premium rate chargeable under any city non-Medicare
an annuitant coverage as of December 1, 1996.

(2) For non-Medicare Plan annuitants who retire on or after January 1, 1988,
e annuitant's share of monthly premium for non-Medicare Plan coverage only
ill be the rate in effect on December 1, 1996, with monthly premium increases
take effect no sooner than April 1, 1998 at the lower of (i) the premium

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te determined pursuant to subsection (g) or (ii) 10% of the immediately
evious month's rate for similar coverage.

In no event shall any non-Medicare Plan annuitant's share of monthly
em m for non-Medicare Plan coverage exceed 10% of the annuitant's monthly
nuity.

(4) Non-Medicare Plan annuitants who are enrolled in the basic city plan as
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ndition that they are not entitled to the caps on rates set forth in
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(5) Medicare Plan annuitants who are currently enrolled in the basic city
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dicare Plan for Medicare eligible annuitants through June 30, 2002, and the
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scretion. All Medicare Plan annuitant monthly rates shall be determined in
cordance with subsections (c) and (g).

(c) The city shall pay 50% of the aggregated costs of the claims or premiums,
ichever is applicable, as determined in accordance with subsection (g), of
nuitants and their dependents under all health care plans offered by the city.
e city may reduce its obligation by application of price reductions obtained
a result of financial arrangements with providers or plan administrators.

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(d) From January 1, 1993 until June 30, 2002, the board shall pay to the city
behalf of each of the board's annuitants who chooses to participate in any of
e city's plans the following amounts: up to a maximum of $75 per month for
ch annuitant who is not qualified to receive medicare benefits, and up to
m mum of $45 per month for each such annuitant who is qualified to receive
dicare benefits.

The payments described in this subsection shall be paid from the tax levy
thorized under Section 11-178 [40 ILCS 5/11-178]; such amounts shall be
edited to the reserve for group hospital care and group medical and surgical
an benefits, and all payments to the city required under this subsection shall
charged against it.

(e) The city's obligations under subsections (b) and (c) shall terminate on
ne 30, 2002, except with regard to covered expenses incurred but not paid as
that date. This subsection shall not affect other obligations that may be
posed by law.

(f) The group coverage plans described in this Section are not and shall not
construed to be pension or retirement benefits for purposes of Section 5 of
ticle XIII of the Illinois Constitution of 1970.

(g) For each annuitant plan offered by the city, the aggregate cost of
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dependent actuary to be appointed and paid by the city and the board. If the

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ie estimated amount to be contributed by the city for that plan pursuant to
[illegible]tions (b) and (c) during that year plus the estimated amounts to be paid
[illegible] nt to subsection (d) and by the other pension boards on behalf of other
articipating annuitants, the difference shall be paid by all annuitants
articipating in the plan, except as provided in subsection (b). The city, based
pon the determination of the independent actuary, shall set the monthly amounts
o be paid by the participating annuitants. The board may deduct the amounts to
e paid by its annuitants from the participating annuitants' monthly annuities.

If it is determined from the city's annual audit, or from audited experience
ata, that the total amount paid by all participating annuitants was more or
ess than the difference between (1) the cost of providing the group health care
lans, and (2) the sum of the amount to be paid by the city as determined under
ubsection (c) and the amounts paid by all the pension boards, then the
ndependent actuary and the city shall account for the excess or shortfall in
he next year's payments by annuitants, except as provided in subsection (b).

(h) An annuitant may elect to terminate coverage in a plan at the end of any
onth, which election shall terminate the annuitant's obligation to contribute
oward payment of the excess described in subsection (g).

(i) The city shall advise the board of all proposed premium increases for
ealth care at least 75 days prior to the effective date of the change, and any
ncrease shall be prospective only.

STORY:
urce: P.A. 86-273; 90-32, @ 5.

TES
TE
[illegible] section was Ill.Rev.Stat., Ch. 108 1/2, para. 11-160.1.

F AMENDMENTS.
The 1997 amendment by P.A. 90-32, effective June 27, 1997, added the
bdivision (a)(1) designation; in subdivision (a)(1) deleted "on or after
nuary 1, 1988" preceding "under Article 5"; added subdivisions (a)(2) and
)(3)"; rewrote subsections (b) and (c); in subsection (d), in the first
ragraph, deleted the former first sentence regarding payments from January 1,
88 until December 31, 1992 and substituted "June 30,2002" for "December 31,
97" and deleted the former second paragraph which read "For the period January
1988 through the effective date of this amendatory Act of 1989, payments
der this Section shall be reduced by the amounts paid by or on behalf of the
ard's annuitants covered during that period"; in subsection (e) substituted
une 30, 2002" for "December 31, 1997"; rewrote subsection (g); in subsection
) substituted "the end of any month" for "any time"; and added subsection (i).

SE NOTES

TY NOT INSURER
The Illinois Pension Code, which specifically provides that a city must
ntribute a specified amount for an annuitant's health care coverage, focuses
on a governmental purpose and plainly does not place the city in the insurance
siness as contemplated by the Code. City of Chicago v. Korshack, 276 Ill. App.
597, 213 Ill. Dec. 144, 658 N.E.2d 1165 (1 Dist. 1995), appeal denied, 167

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ILLINOIS PENSION CODE
GROUP HEALTH BENEFIT PROVISIONS
AS AMENDED BY P.A. 93-42
EFFECTIVE JULY 1, 2003

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5/11–160.1. Payments to city

§ 11–160.1. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) From July 1, 2008 through June 30, 2013, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 11–169; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

Laws 1963, p. 161, § 11–160.1, added by P.A. 84–159, § 1, eff. Aug. 16, 1985. Amended by P.A. 86–273, § 1, eff. Aug. 23, 1989; P.A. 90–32, § 5, eff. June 27, 1997; P.A. 92–599, § 10, eff. June 28, 2002; P.A. 93–42, § 5, eff. July 1, 2003.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 11–160.1.

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5/5-167.5. Payments to city

§ 5-167.5. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) From July 1, 2008 through June 30, 2013, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 5-168; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

Laws 1963, p. 161, § 5-167.5, added by P.A. 82-1044, § 1, eff. Jan. 12, 1983. Amended by P.A. 86-273, § 1, eff. Aug. 23, 1989; P.A. 90-32, § 5, eff. June 27, 1997; P.A. 92-599, § 10, eff. June 28, 2002; P.A. 93-42, § 5, eff. July 1, 2003.

Formerly Ill.Rev.Stat.1991, ch. 108 ½, ¶ 5-167.5.

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5/6–164.2. Payments to city

§ 6–164.2. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) From July 1, 2008 through June 30, 2013, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 6–165; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

Laws 1963, p. 161, § 6–164.2, added by P.A. 82–1044, § 1, eff. Jan. 12, 1983. Amended by P.A. 86–273, § 1, eff. Aug. 23, 1989; P.A. 90–32, § 5, eff. June 27, 1997; P.A. 92–599, § 10, eff. June 28, 2002; P.A. 93–42, § 5, eff. July 1, 2003.

Formerly Ill.Rev.Stat.1991, ch. 108½, ¶ 6–164.2.

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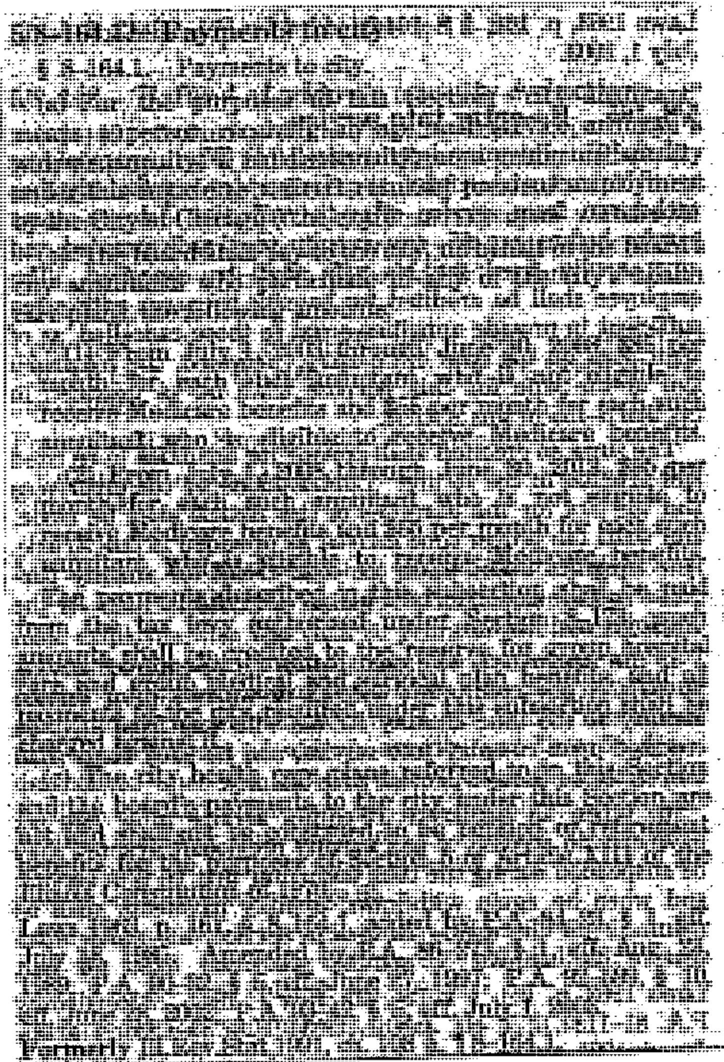
8-164.1. Payments to city.

§ 8-164.1. Payments to city.

[illegible]

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40 ILCS 5/5-167.5) (from Ch. 108 1/2, par. 5-167.5)

Sec. 5-167.5. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) Beginning July 1, 2008 and until such time as the city no longer provides a health care plan for such annuitants or December 31, 2016, whichever comes first, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 5-168; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(Source: P.A. 98-43, eff. 6-28-13.)

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(40 ILCS 5/6-164.2) (from Ch. 108 1/2, par. 6-164.2)

Sec. 6-164.2. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) Beginning July 1, 2008 and until such time as the city no longer provides a health care plan for such annuitants or December 31, 2016, whichever comes first, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 6-165; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(Source: P.A. 98-43, eff. 6-28-13.)

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(40 ILCS 5/8-164.1) (from Ch. 108 1/2, par. 8-164.1)

Sec. 8-164.1. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) Beginning July 1, 2008 and until such time as the city no longer provides a health care plan for such annuitants or December 31, 2016, whichever comes first, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 8-173; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(Source: P.A. 98-43, eff. 6-28-13.)

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(40 ILCS 5/11-160.1) (from Ch. 108 1/2, par. 11-160.1)

Sec. 11-160.1. Payments to city.

(a) For the purposes of this Section, "city annuitant" means a person receiving an age and service annuity, a widow's annuity, a child's annuity, or a minimum annuity under this Article as a direct result of previous employment by the City of Chicago ("the city").

(b) The board shall pay to the city, on behalf of the board's city annuitants who participate in any of the city's health care plans, the following amounts:

(1) From July 1, 2003 through June 30, 2008, $85 per month for each such annuitant who is not eligible to receive Medicare benefits and $55 per month for each such annuitant who is eligible to receive Medicare benefits.

(2) Beginning July 1, 2008 and until such time as the city no longer provides a health care plan for such annuitants or December 31, 2016, whichever comes first, $95 per month for each such annuitant who is not eligible to receive Medicare benefits and $65 per month for each such annuitant who is eligible to receive Medicare benefits.

The payments described in this subsection shall be paid from the tax levy authorized under Section 11-169; such amounts shall be credited to the reserve for group hospital care and group medical and surgical plan benefits, and all payments to the city required under this subsection shall be charged against it.

(c) The city health care plans referred to in this Section and the board's payments to the city under this Section are not and shall not be construed to be pension or retirement benefits for the purposes of Section 5 of Article XIII of the Illinois Constitution of 1970.

(Source: P.A. 98-43, eff. 6-28-13.)

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COOK COUNTY, ILLINOIS
CHANCERY DIVISION
CLERK DOROTHY BROWN

EXHIBIT 9

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1 STATE OF ILLINOIS)
2) SS:
3 COUNTY OF C O O K)
4 IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
5 COUNTY DEPARTMENT - CHANCERY DIVISION
6 THE CITY OF CHICAGO,)
7 Plaintiff,)
8 vs.) No. 87 CH 10134
9 MARSHALL KORSHAK, et. al.,)
10 Defendant.)
11
12 Before the Honorable
13 Albert Green
14 Judge of said Court
15
16 June 22, 1988
17 1:45 o'clock p.m.
18
19 APPEARANCES:
20
21 (Same as hereinbefore noted.)
22
23
24

1 INDEX

2

WITNESS	DX	CX	RDX	RCX
RONALD PICUR	114			
	134			
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	141			
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S. NATHAN WILLIAMS	150			
AL JOHN FATTORE	169			
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14

15 EXHIBITS

NUMBER	MARKED FOR ID
Defendant's Exhibit	
Number 26	P. 174
Number 21	P. 176
Number 24	P. 177
Number 27	P. 182

22
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1 A. Well, assuming they have medical costs as
2 opposed to protection that they've actually incurred
3 costs under deductibility, assuming that the type of
4 cost falls under the terms of a deductible or
5 co-insurance they would pay that portion.
6 Q. So I guess that is that they do pay a portion
7 of their medical costs?
8 A. Yes. Those would be our costs, yes.
9 Q. Okay. Let's go back to this meeting that took
10 place.
11 You have a deficit you're trying to cover that
12 took place in the spring of '87?
13 A. No. The discussion did not focus on the
14 deficit. The discussion focused on the pension-related
15 matters.
16 Q. How do we cut these costs, right?
17 A. That was part of it but that was not speaking
18 to a deficit.
19 Q. And the Ryan case was brought up and discussed
20 as part of it?
21 A. Some place along the line, yes.
22 Q. In fact, it's as a result of the Ryan case
23 that the corporation counsel comes to all of you and
24 says we've discovered a way to offset the Ryan case;

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1 right?

2 A. I believe that's correct.

3 Q. And the next decision is made to go to the

4 Funds and say, we've discovered this problem. We'll

5 offset one against the other; right? That was the game

6 plan, wasn't it?

7 A. That was part of the game plan.

8 MR. KRISLOV: No further questions, your Honor.

9 THE COURT: No further questions.

10 Ms. Beckett, any cross-examination?

11 MS. BECKETT: Yes, your Honor.

12 CROSS-EXAMINATION

13 BY MS. BECKETT:

14 Q. Mr. Picur, referring back to pending pension

15 legislation in Springfield last year in 1987, it's your

16 testimony that to the best of your recollection, none

17 of the proposed changes in pension legislation

18 addressed the question of health care.

19 Isn't it a fact that the four pension funds

20 did introduce language proposing an extension of

21 subsidy to widows of annuitants?

22 MR. HEISS: I'm going to object to the revelancy of

23 subsidy of widows as it applies to the counterclaim and

24 keeping health care benefits in place. That has to do

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EXHIBIT 10

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, et al., Defendant-Counterplaintiffs.	)	No. 87 CH 10134
MARTIN RYAN, WALTER RUCINSKI, BERNARD McKAY, JOSEPH COGLIANESE, LOUIS EISEN, BERNARD HOGAN, PATRICIA DARCY, SYLVIA WALSH, AND KATHERINE DOYLE, Intervenors.	)	

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AGREED ORDER

This cause coming to be heard for entry of an Agreed Order implementing the terms of a certain settlement entered into by the City of Chicago ("the City") and the co-trustees of the Municipal Employees', Officers' and Officials' Annuity and Benefit Fund of Chicago, Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago, Firemen's Annuity and Benefit Fund of Chicago, and the Policemen's Annuity and Benefit Fund of Chicago ("the Funds") and all parties having been given due notice and the Court being fully advised in the premises, now, therefore,

THE COURT HEREBY FINDS:

1. On August 23, 1989, the Governor signed into law Senate Bill 95 as Public Act 86-273, codified in part at Sections 5-167.5, 6-164.2, 8-164.1 and 11-160.1. Those portions of Public Act 86-273 are hereby expressly incorporated by reference. This Agreed Order is intended to supplement those provisions of Public Act 86-273 and, unless otherwise indicated, pertains only to the period ending December 31, 1997.

Pursuant to the agreement of the City and the Funds,

IT IS HEREBY ORDERED:

A. The City and the Funds shall each pay their own internal costs of administering the annuitants' medical benefits plan. The City shall pay 50% of the claims billed by Blue Cross, Banker's Life and Home Pharmacy and all of the administrative costs charged by Banker's Life and Home Pharmacy.

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B. The City shall advise the Funds of all proposed premium increases for health care at least 90 days prior to the effective date of such change. Any such increase shall be prospective only.

C. Any premiums to be charged the annuitants shall be uniform among the four Funds. Following the initial setting of premiums pursuant to this agreement, any increases shall not discriminate between retired employees and widows in setting premiums, or on the basis of age or claim experience.

D. If the City offers more than one plan, an annuitant may elect to convert coverage from one City plan to another, during times designated by the City which shall occur at least annually. There shall be no limit on the number of times an annuitant may convert coverage. If an annuitant leaves or fails to enroll in a City plan, he or she may later enroll in a City plan under the same terms and conditions which existed prior to implementation of this agreement.

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E. The City agrees that its health care plan administrators, Blue Cross, Bankers, and Home Pharmacy, will be directed to continue their ordinary practices regarding the processing of claims. For example, the City will not permit or direct annuitants' claims to be backlogged so as to result in a disproportionate amount of claims being processed during 1990.

F. The City agrees that any actuary hired by the Funds will be provided the same data as the independent actuary and will have the right to consult with the independent actuary concerning the premiums to be charged annuitants.

G. The City agrees that it will be responsible for notifying the annuitants of any increased health benefits premiums.

H. The City shall not pursue its right of appeal from this Court's Order of May 16, 1988, dismissing its Complaint with prejudice, without prejudice to its rights to seek whatever relief may seem appropriate at the conclusion of the ten year period covered by the parties' agreement as embodied herein.

I. The Funds shall dismiss their pending counterclaims without prejudice to their rights to seek whatever relief may seem appropriate at the conclusion of the ten year period covered by the parties' agreement as embodied herein.

J. The parties agree to negotiate in good faith toward achieving a permanent resolution of this dispute on or before December 31, 1997. Failing agreement, the parties shall be restored to the same legal status which existed as of October 19, 1987, with the exception that the City agrees not to pursue any claim for past amounts allegedly due it for the costs of annuitants' health benefits incurred prior to March of 1990. The Funds,

intervenors or any annuitant may contend that the City is obligated to provide and pay for the health care benefits of its retired employees and their dependents to the extent that such cost exceeds the premiums which went into effect in April of 1982. Similarly, the City may contend, as it did in the trial of this case, that it has no obligation to provide or pay for health care benefits for its retired employees or their dependents.

K. Within 60 days the City shall pay to the actuary firm of Donald F. Campbell the sum of $7,698.65 for services rendered by the firm, at the City's request, in conjunction with the agreement embodied herein.

L. The Court otherwise reserves jurisdiction of this cause solely to enforce the terms of this Agreed Order.

DEC 15 1989 129 A. GREEN

ENTER: ______________________

AGREED TO:
The City of Chicago

By: Joseph A Moore
One of its Attorneys

Policemen's Annuity & Benefit Fund of Chicago

By: Katrina Veerhusen
One of its Attorneys

Firemen's Annuity & Benefit Fund of Chicago

By: Martin J. Burns
One of its Attorneys

Municipal Employees', Officers' and Officials' Annuity & Benefit Fund of Chicago

By: William Marovitz (by KV)
One of its Attorneys

Laborers' and Retirement Board Employees' Annuity & Benefit Fund of Chicago

By: Frederick Heiss by KV
One of its Attorneys

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EXHIBIT 11

(original)

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

CITY OF CHICAGO, a municipal corporation, Plaintiff-Counterdefendant, vs. MARSHALL KORSHAK, et al. Defendant-Counterplaintiff.	)	No. 87 CH 10134
MARTIN RYAN, WALTER RUCHINSKI, BERNARD McKAY, JOSEPH COGLIANESE, LOUIS EISEN, BERNARD HOGAN, PATRICIA DARCY, SYLVIA WALSH and KATHERINE DOYLE, Intervenors.	)	

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OPINION AND MEMORANDUM OF LAW

On November 27, 1989, this Court presided over an evidentiary hearing to consider the proposed settlement between the City of Chicago, the four Pension Funds, and the annuitants of the Funds who participate in the City of Chicago Annuitant Health Benefits Plan.

A brief history of this litigation is warranted in light of the fact that there has been a full two years since this litigation commenced, and 1 1/2 years since this Court presided over a trial of the Funds' Counterclaims.

In October of 1987, the City of Chicago ("City") advised the four Pension Funds that it would no longer include the City's retired employees in the City's health care plan or pay for the

medical services rendered to those persons. The City then filed a complaint in this Court, naming as defendants the trustees of the four Funds, in which it sought to end the annuitants' health care coverage and recover approximately $58,000,000.00 it had spent on annuitants' health care benefits since 1980. In response to the complaint, the Funds argued that they were not responsible for the past or future costs of annuitant health care, beyond the subsidies provided for in the Illinois Pension Code, because they had no authority to do so and were legally required to limit use of the assets to meet pension obligations.

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The Funds each filed Counterclaims on behalf of the annuitants to attempt to prevent the City from terminating the annuitants' coverage under the City's health care plan and to force the City to continue paying for most of the cost of the coverage. The City agreed to continue annuitants health care benefits while the litigation was pending.

This Court eventually dismissed the City's complaint with prejudice, finding that the Funds had no obligation to reimburse the City for the health care benefits received by the annuitants since 1980. The claims asserted in the Funds' Counterclaims, were the subject of a bench trial before this Court in June of 1988. However, before the Court could reach its decision at the conclusion of the trial, the City and the Funds agreed to sponsor legislation amending the various pension codes and to enter into a settlement of the Court action consistent with the legislation.

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TERMS OF THE SETTLEMENT

The settlement provides in general terms, that the City will pay at least 50% of the participating annuitants' health care costs through the end of 1997, the Funds will increase the subsidies, and the annuitants will pay any balance due after the funds subsidies are deducted. (Nothing in the agreement or the statute precludes the City from paying more, as it has in the past.) Because the increase in Funds' subsidies could not be effective until the Pension Code was amended to permit them to do so, the proposed settlement was essentially put on hold until the Legislature, in June of 1989, passed amendatory legislation to implement this term of the settlement. The legislation (Public Act 86-273) was signed by the Governor August 23, 1989.

The basic terms of the settlement are contained in the new legislation. They are as follows: Commencing with the date the increased annuitant payments take effect, the City is required by state law to pay at least 50% of the cost of the health care claims of the annuitants who participate in the City's health care plan. For the period January 1, 1988 until December 31, 1992, the four Funds will pay the City, on behalf of the annuitants who participate in the City plan, up to $65,00 per month for each non-Medicare annuitant and up to $35.00 per month for each Medicare-annuitant. From January 1, 1993 until December 31, 1997, the Funds' subsidies will increase by $10.00 per annuitant per month. For the first time, the widows of annuitants will receive the same subsidies as the annuitants themselves.

The legislation further provides that the City's obligations to continue coverage and to pay at least 50% of the cost of coverage will terminate at the end of 1997, but that this provision "does not affect other obligations that may be imposed by law;" that the group coverage plans described in the statute "are not and shall not be construed to be pension or retirement benefits for the purposes of" the Illinois Constitution of 1970; that the cost of claims of the annuitants will be estimated by the City on the basis of a written determination by an independent actuary to be appointed and paid by the City and the four Funds; and that the annuitant may elect to terminate coverage in a plan at any time.

In addition to the terms contained in the legislation, counsel for the Funds and the Corporation Counsel for the City committed to a letter agreement which contained other terms and conditions with the proposed settlement. In pertinent part, those additional terms and conditions are as follows:

> The City is obligated to give notice of proposed increases in rates at least 90 days prior to the effective date of such changes.
>
> The Funds have the right to retain a separate actuary to monitor the work of the independent actuary and to consult with the independent actuary concerning the payments to be charged annuitants.
>
> The City has agreed to pay all of the administrative costs proposed by Banker's Life and Home Pharmacy and 50% of the claims billed by Blue Cross (at a discounted rate) to the City.
>
> If the city offers more than one health benefits plan, an annuitant may elect to convert coverage from one City plan to

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another, during times designated by the City, which shall occur at least annually. There will be no limit on the number of times an annuitant may convert coverage. If an annuitant leaves or fails to enroll in the City plan, he or she may later enroll in a City plan under the same terms and conditions which existed prior to implementation of this agreement.

The Court had the benefit of hearing the testimony of witnesses opposing the proposed settlement hereinabove set out and was further aided by the post-trial memorandum filed by the City and the Funds, the Funds' memorandum was a joint memorandum;a memorandum filed by the Participant Class opposing the proposed settlement. The Participant Class also renewed their motion for summary judgment, and their motion for permanent injunction against the City's changing the terms of health care benefits provided to existing annuitant participants in the City's annuitant health care plan.

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Further the Court reviewed all of its original notes and the testimony taken during the bench trial conducted by this Court in June of 1988.

The Participant Class in opposing the proposed settlement states that the settlement is unfair because:

A: The participants are entitled to the status quo coverage under principles of contract, detrimental reliance, promissory estoppel and the Illinois Constitution.

B: The participants are being denied, their coverage in retaliation for the Courts stopping the City's illegal use of Pension Fund tax levies.

C: The settlement subjects the class to extreme hardship while it relieves the City of costs which are a minimal portion its annual budget (less than 1 or 1/2%).

They contend that the proponents of the settlement fail to meet their burden of proof to show that the settlement is fair; that the facts show that the settlement is unfair and should be rejected; that the annuitants relied upon the City's promise and the City should be estopped from changing the terms of coverage; that the annuitants and their families will be unable to obtain coverage elsewhere; that the City's whole basis for this litigation is bad faith; and that the annuitants presented a strong likelihood of success on the merits.

The Court has taken into consideration all of the testimony of the opponents and has reviewed very carefully the brief in opposition to the proposed settlement.

The Court finds the brief filed by the Pension Funds to be extremely persuasive and most exact in its factual presentation.

The procedural and substantive standards governing class action settlement hearings are well established. This Court must evaluate the fairness of the settlement in light of the benefits provided thereunder and the risks of further litigation. In addition, the Court should satisfy itself that the settlement was reached after arm's length negotiations between counsel authorized to act on behalf of the respective parties and that the Class was adequately notified of the proposed settlement and the opportunity to object. People ex rel. Wilcox v. Equity Funding Life Ins. Co., 61 Ill.2d 303, 335 N.E.2d 448 (1975); Gowdey v. Commonwealth Edison Co., 37 Ill.App.3d 140, 345 N.E.2d 785 (1st Dist. 1976). See also, City of Detroit v. Grinnell

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Corp., 495 F.2d 448 (2d Cir. 1974); Weinberger v. Kendrick,, 698 F.2d 61 (2d Cir. 1982), cert. denied, 464 U.S. 818 (1983).

Only a small percentage of class members have indicated their objection to the agreement. By their silence, the vast majority of the class members have indicated their approval of the terms of the settlement. The settlement clearly satisfies all prerequisites for judicial approval, and is in the best interests of class members. The settlement should be approved by this Court.

GENERAL CONSIDERATIONS AND BACKGROUND

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As a general rule, the law favors and encourages the settlement of class action suits. Weinberger v. Kendrick, 698 F.2d 61, 73 (2d Cir. 1982), cert. denied, 464 U.S. 818 (1983); West Virginia v. Chas. Pfizer & Co., 440 F.2d 1079, 1085 (2d Cir.), cert. denied, 404 U.S. 871 (1971). Before approving a class action settlement, the Court must find the proposal to be "fair, adequate and reasonable." People ex rel. Wilcox v. Equity Funding Life Ins. Co., 61 Ill.2d 303, 335 N.E.2d 448, 456 (1975); Weinberger, supra, 698 F.2d at 73. The assessment of those factors rests within the discretion of the trial court. Gowdey v. Commonwealth Edison Co., 37 Ill.App.3d 140, 345 N.E.2d 785, 793 (1st Dist. 1976). This is because the trial judge has been exposed to the "strategies, positions and proofs" of the litigation and is well "aware of the expense and possible legal bars to success." Ace Heating & Plumbing Co. v. Crane Co., 453 F.2d 30, 34 (3d Cir. 1971). A trial court "should not disapprove a settlement nor should its approval be overturned on review

unless, taken as a whole, the settlement appears on its face so unfair as to preclude judicial approval." Gowdey, supra, 345 N.E.2d at 793.

The determination of whether a settlement is fair, reasonable and adequate requires the examination of an amalgam of factors, the principle factor is a balancing or comparison of "the terms of the compromise with the likely rewards of litigation." Wilcox, supra, 335 N.E.2d at 456, quoting Protective Committee for Independent Stockholders of TMT Trailer Ferry Inc. v. Anderson, 380 U.S. 414, 424-25 (1968).

Criteria for evaluating the fairness of a proposed class action settlement were set forth by the Second Circuit in City of Detroit v. Grinnell Corp., 495 F.2d 448 (2d Cir. 1974). Although these criteria are obviously not binding on this Court, they provide a convenient framework within which to examine the relevant factors. They are:

(1) the complexity, expense and likely duration of the litigation;

(2) the reaction of the class to the settlement;

(3) the stage of the proceedings and the amount of discovery completed;

(4) the risks of establishing liability;

(5) the risks of establishing damages;

(6) the risks of maintaining the class action through the trial;

(7) the ability of the defendants to withstand a greater judgment;

(8) the range of reasonableness of the settlement fund in light of the possible recovery; and

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(9) the range of reasonableness of the settlement fund to a possible recovery in light of all the atendant risks of litigation.

Grinnell, 495 F.2d at 463 (citations omitted).

In assessing the fairness of a settlement under the Grinnell criteria, a court's function is not "to reopen and enter into negotiations with the litigants in the hope of improving the terms of the settlement." Levin v. Mississippi River Corp., 59 F.R.D. 353, 361 (S.D.N.Y.), aff'd., 486 F.2d 1398 (2d Cir. 1973), cert. denied, 414 U.S. 1112 (1974). Rather, the court should examine the settlement terms, the process by which the settlement was reached and the judgment of counsel to determine whether the settlement falls within the broad range which may be categorized as "reasonable". Weinberger, supra; Grinnell, supra; Cannon v. Texas Gulf Sulphur Co, 55 F.R.D. 309 (S.D.N.Y. 1971). Each of these factors will be examined in the context of the instant settlement.

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1. Complexity, Expense and Duration of Litigation

There can be little argument with the fact that this case presents the kind of dispute where a fair and reasonable settlement would be beneficial to all parties concerned and to the public interest, and as a consequence the policy of the law to encourage settlements should be extended to it.

Approval of the agreement will obligate the City to pay at least 50% of the total cost of the annuitants' health benefits until December 31, 1997. As noted above, nothing precludes the City from paying more, as it has in the past. If the agreement is not approved, the litigation will return to the posture it was

in in June of 1988, when the parties reached a settlement in principle. Post-trial briefs will be submitted and this Court will issue its judgment on the merits of the Funds' Counterclaims. Appeals are sure to follow, both from dismissal of the City's Complaint and from this Court's judgment as to the Counterclaims. During the lengthy appeal process, the annuitants' health benefits will continue to be in limbo -- both as to coverage and who pays the cost of coverage. The agreement is clearly in the best interest of both the class members and the public.

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2. Reaction of the Class to the Settlement

In cases of this nature, which are highly visible and where there are numerous members of the class, objections are to be expected. Even significant oppositition to the settlements from class members "cannot serve as an automatic bar to a settlement that a (trial) judge, after weighing all the strengths and weaknesses of a case and the risks of litigation, determines to be manifestly reasonable." TBK Partners, L.T.D. v. Western Union Corp., 675 F.2d 456, 462 (2d Cir. 1982). The court must independently assess the adequacy of the settlement, even in the absence of any objections. In re Traffic Executive Association - Eastern Railroads, 627 F.2d 631, 634 (2d Cir. 1980).

When objections are presented, however, they must be weighed according to their substantive merit.

The Notice of Class Certification, which was sent to approximately 16,000 persons in early November, 1989, informed the class members that any notice of intent to appear at the fairness hearing had to be filed in writing with the Court by November 21, 1989, and that copies of such notices should be mailed to <u>one</u> of the attorneys for the parties. Counsel for the Funds were made aware of only one notice of intent to appear at the November 27th hearing. Counsel have received a number of letters indicating annuitants' approval of the terms of the settlement and a number of letters indicating opposition to it. Counsel for the opponents presented in excess of 500 preprinted form letters opposing the proposed settlement. The Court has considered these objections in making its decision. Although a number of class members apparently oppose the settlement because it will result in some paying increased premiums for coverage, in the past these rates have reflected the political processes and nothing in the agreement prevents the City from paying much more than 50%.

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In addition to the notice of class certification, which was mailed to all class members in early November, the annuintants have also received a letter from the City advising them of the cost to them of continued coverage in the City health benefits plan, assuming this proposed settlement is approved. <u>Not surprisingly, many annuitants have indicated these new rates are too high or that they cannot afford them.</u>

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Since 1982, when the last rate increase occurred, most retired employees of the City have been paying nothing for their health benefits. The $55 (for non-Medicare) or $21 (for Medicare-eligible annuintants) contributed by the Police and Fire Funds, was equal to the amount of "premium" charged by the City. By contrast, under the 1990 rates just announced by the City, a singly annuitant not covered by Medicare will be paying $105 per month. Although this is a substantial increase, the important fact is that the actual cost of annuitant's coverage is $340. If the City were successful in this litigation, these annuitants could required to pay $285 per month (after deducting the Funds' $55 contribution) or $3,420 per year out of their own pockets. Annuitants in other rate classifications could required to pay even more to maintain coverage.

The raison d'etre of a settlement is to eliminate the risk of not prevailing on the merits. The Fund submit that under the circumstances presented here, the proposed settlement, which obligates the City to continue coverage and to pay at least 50% of the annuitants' health care costs until the end of 1997, is in the best interests of all parties.

The substantial benefits conferred upon the annuitants under the proposed settlement must be viewed in light of the risk that the annuitants would not prevail on the merits of the litigation. The Funds submit that this "balancing test" compels the conclusion that the proposed settlement is in the best interests of all parties and should be approved by this Court.

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3. <u>The Stage of Proceeding and Discovery</u>

The purpose of considering the "state of proceeding and the discovery taken" is to ensure that the class members have had access to sufficient material to evaluate their case and to assess the adequacy of the settlement proposal in light of an informed judgment of the strengths and weaknesses of their position.

The proposed settlement here was reached after discovery was completed and after a full trial on the merits of the Funds' Counterclaims.

This case has thus advanced to the eve of a judgment on the merits, in contrast to most other cases where settlements have been approved. Here, this Court has had the benefit of presiding over a full trial on the merits of the claims raised by the Funds on behalf of the annuitant-class members and is thus uniquely qualified to evaluate the reasonableness of the settlement.

4-5. <u>The Risks of Establishing Liability and Damages</u>

In assessing the fairness, reasonableness and adequacy of the settlement, the Court must balance the amount of the proposed settlement and the immediacy of a prospective recovery for class members against the continuing risks of litigation. The risks in this case involve primarily the establishment of the City's liability for the cost of its retired employees' health benefits. This proposed settlement eliminates the risk that the Funds and their annuitants will not be successful in establishing that liability. A secondary benefit of the settlement is elimination

of the delay and expense which will be incurred if the proposed agreement is not approved. For the past two full years, the annuitants have been aware of the City's position that it was legally entitled to terminate both the annuitants' participation in the City's health benefits plan and its payment of any of the bills for those benefits. Bringing an end to this uncertainty is another benefit of the proposed agreement.

6. The Risks of Maintaining the Class Action Through the Trial

Because this is not the typical class action, this factor is generally irrelevant.

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7. The Ability of the Defendant to Withstand a Greater Judgment

This factor requires the Court to consider whether the City would be financially able to satisfy a judgment in excess of the settlement amount. This factor is not particularly relevant in the instant cause because there is no "settlement amount" as such. Nonetheless, it is relevant to point out that this settlement will cost the City an estimated $261 million (actual cost of $25.3 million in 1988, $35.7 million in 1989, and another eight years at an estimated minimum of $25 million per year).

8-9. The Range of Reasonableness of the Settlement in Light of the Possible Recovery and All the Attendant Risks of Litigation

The determination of a "reasonable" settlement is not susceptible of a mathematical equation yielding a particularized sum. Rather, as Judge Friendly has explained, "(i)n any case, there is a range of reasonableness with respect to a settlement." Newman v. Stein, 464 F.2d 689, 693 (2d Cir.), cert. denied, 409 U.S. 1039 (1972). See denied, Zerkle v. Clevand-Cliffs Iron, Inc., 52 F.R.D. 15, 159 (S.D.N.Y. 1871); Glicken v. Bradford, 35 F.R.D. 144, 152 (S.D.N.Y. 1964).

The Second Circuit has held that a settlement can be approved even though the benefits amount to a small percentage of the recovery sought. City of Detroit v. Grinnell Corp.,495 F.2d 448, 455 (2d Cir. 1974): "The fact that a proposed settlement may only amount to a fraction of the potential recovery does not, in and of itself, mean that the proposed settlement is grossly inadequate and should be disapproved." In a footnote, the Court buttressed its conclusion: "In fact there is no reason, at least in theory, why a satisfactory settlement could not amount to a hundreth or even a thousandth part of a single percent of the potential recovery." Id. at 455 n.2.

Here, by contrast to the usual class action settlement, the Funds and annuitants have not sued for money damages and are not settling for some percentage of their actual damages. Instead, the proposed agreement eliminates the risk that the annuitants would have to pay the entire bill for their health benefits and the further and more serious risk that they may not be able to obtain coverage at any price. The agreement eliminates these risks by committing the City to pay at least 50% of the cost of

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the annuitants' health benefits through the end of 1997. At the conclusion of that period, if no "permanent solution" has been found, the parties will return to the legal postures they were in in June of 1988, before this compromise was negotiated.

On balance, no one can reasonably state that the porposed settlement is anything but fair, adequate and reasonable. It is in the best interests of the class that the settlement receive this Court's final approval.

The Court finds that the settlement was achieved only after arduous arm's length negotiations.

To avoid the burden of unduly extended inquiry into the claims asserted and benefits resulting from the settlement, the federal courts often have focused on the "negotiating process by which the settlement was reached...." Weinberger v. Kendrick, 698 F.2d 61, 74 (2d Cir. 1982), cert. denied, 464 U.S. 818 (1983). The courts have thus insisted that a settlement be the result of "arm's length negotiations" effected by counsel possessed of the "experience and ability...necessary to effective representation of the class' interest." Weinberger, supra, 698 F.2d at 74 (citation omitted).

In evaluating the negotiations, the trial court is permitted to rely on the judgment of counsel. Weinberger, supra, 698 F.2d at 74; West Virginia v. Chas. Pfizer & Co., 314 F.Supp. 710, 741 (S.D.N.Y. 1970), aff'd, 440 F.2d 1079 (2d Cir.), cert. denied, 404 U.S. 871 (1971). In fact, the opinion of counsel is entitled to considerable weight by the court. Cannon v. Texas Gulf Sulphur Co., 55 F.R.D. 308 (S.D.N.Y. 1971); Josephson v.

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Campbell,. (1967-69 Tr. Binder) Fed. Sec. L. Rep (CCH), 92, 347 at p. 96, 658 (S.D.N.Y. 1969). In Lyons v. Marrud, (1972 Transfer Binder) Fed. Sec. L. Rep. (CCH) 93, 525 (S.D.N.Y. 1972), the court noted that:

> Experienced and competent counsel have assessed these problems and the probability of success on the merits. They have concluded that compromise is well advised and necessary. The parties' decision regarding the respective merits of their positions has an important bearing on this case.

Id. at p. 92, 520,. Indeed, in the absence of fraud, collusion or the like, the Court should be hesitant to substitute its own judgment for that of counsel. Weinberger, supra, 698 F.2d AT 74.

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This court has had the opportunity to acquaint itself fully with the facts and law of this case and has been apprised of the procedural aspects of this ligitation to date. Similarly, the Court is aware that this has been a hard-fought case and that competent and experienced counsel represent both the City and the Funds, the parties who negotiated the settlement.

This is an unusual case in a number of respects, including the fact that the Funds, who were permitted by this Court to act on behalf of the annuitants throughout the discovery and trial phases of this litigation, negotiated and support the proposed settlement. By contrast, counsel for the class, which was certified on the eve of the settlement hearing, opposes the settlement on various grounds. Consequently, this Court must consider the City's and Funds' reasons for supporting the settlement and class counsel's reasons for opposing it.

There can be no hint of collusion in conjunction with either the vigorously contested litigation or the hard bargaining that preceded the agreement. Many of the details in the negotiations surrounding the settlement were hotly disputed. Thus, the settlement was produced by "arm's length" bargaining after energetically contested litigation and in the context of numerous contested issues of fact and law, many of which have not yet been decided.

The Court finds that the notice given the annuitants meets the requirements of due process and Section 2-806 of the Illinois Code of Civil Procedure.

Each of the approximately 16,000 annuitants and widows of annuitants who participate in the City health benefits plan was given notice of the proposed settlement and fairness hearing, by first class mail, in accordance with this Court's Order of October 30, 1989. This notice clearly meets the due process requirements of Section 2-806 of the Illinois code of Civil Procedure, which calls for such "notice as the Court may direct."

The notice informed the class members of their right to appear at the fairness hearing and to enter appearances through their own counsel, if desired.

The notice fully and explicitly explained the litigation, the proposed settlement and the rights and options of the class members. The notice complies with the requirements of due process and is similar to the procedures approved in other cases. See, e.g., Weinberger, supra, 698 F. 2d at 71-72; Grunin v.

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International House of Pancakes, 513 F.2d 114, 121 (8th Cir.), cert. denied, 423 U.S. 864 (1975).

IV.

THE SETTLEMENT HEARING

The purpose of a settlement hearing is to enable the trial court to assess the adequacy of the proposed settlement. As expressed by one Federal appeals court: "While we do not expect the district judges to convert settlement hearings into mini-trials on the merits, we do expect them to explore the facts sufficiently to make intelligent determinations of adequacy and fairness." Malchman v. Davis, 706 F.2D 426, 433 (2d Cir. 1983). And, as the court stated in Newman v. Stein, 464 F. 2d 689, 692 (2d Cir.), cert. denied, 409 U.S. 1039 (1972), "the court must not turn the settlement hearing into a trial or a rehearsal of the trial."

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At the hearing, Donald Franklin, Deputy Comptroller, was called by the City as a witness. Mr. Franklin testified that one of his duties is to supervise the City's insurance and benefits program. Franklin described what has happened with the City's expenditures for annuitant health care over the past decade, during which period the total cost of annuitant health care has skyrocketed from $6.3 million in 1980 to an estimated $46.6 million in 1989. In 1980, the City was spending $1.9 Million for annuitant health care and in 1989 its projected expenditure for annuitant health care is $35.7 million, an increase of 1800%.

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Stated in percentages, in 1980 the City was paying 31% of the total while the annuitants were paying 69%. By 1989, these percentages had reversed, with the City paying 77.5% of the total cost while the Funds paid 9% and the annuitants 13.5%.

Franklin also explained that almost 36% of the affected annuitants will pay nothing for their coverage in 1990 because they are medicare eligible and the $70 cost is covered by the Funds' $35 subsidy and the City's payment of the other 50% of the cost. Another 19% of the annuitants (two Medicare-eligible individuals) will pay only $14 per month more than at present. On cross examination, Franklin acknowledged that the rates for each category were not required to be set in this fashion. In fact, the agreeement gives the City discretion to categorize the annuitants in any logical fashion and to allocate the costs thereof in any reasonable fashion.

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Ten annuitant witnesses testified, explaining their opposition to the settlement. Eight of the ten witnesses wre retired policemen (or their widows). One Municipal Fund annuittant and one retired laborer also testified. The Court listened attentively, with compassion and understood their objections.

A number of the police annuitants testified that they had attended a pre-retirement seminar at which they had been advised that their health care would be paid for by the City "for life." Based on these representations, which some of the witnesses believed created a contractual obligation on the part of the City, the annuitants testified that the proposed settlement is

unfair. This Court must consider the merits of this alleged contractual obligation and the annuitants' likelihood of establishing the City's liability on this basis if the case were to be adjuciated to a final judgment.

A few of the witnesses testified to their belief that under the proposed agreement they would have no coverage at all after 1997. As noted above, this is simply incorrect. The City and the Funds have agreed that at the conclusion of the 10 years covered by the settlement the parties will return to the same positions they were in before the proposed settlement was negotiated. In the words of the stipulation between the City and the Funds, which was read into the record before this Court on November 27, 1989:

> On January 1, 1998, the parties will be in the same legal positions they were in as of June of 1988. To the extent the City had any obligation in June of 1988, they will have that same obligation or obligations on January 1, 1998.

Consequently, the annuitants have not "given up" anything through this settlement. (Other than the claimed right to have the City pay more than 50% of the costs between March of 1990 and December of 1997.) On January 1, 1998, if some "permanent solution" has not been achieved, the annuitants will be permitted to reargue

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the claims which were asserted in the Funds' Counterclaims as well as the Intervenors' initial pleading.

This confusion as to what will happen after 1997 was reflected as well in the annuitants' general lack of knowledge as to the underlying litigation. For example, one annuitant testified that he was unaware that in 1987 the City announced it was going to drop all annuitants from the health care plan and that he was generally unfamiliar with the terms of the settlement or the underlying litigation. A second annuitant similarly did not recall that in June of 1988 the City took the position that it did not have to pay anything for annuitant health care. Another annuitant testified that he did not know what happens if the Court rejects the settlement and stated it would be "financial ruin" for him if the annuitants lost the case on the merits. In evaluating the opinions of such individuals as to the fairness of the settlement, this Court should take into consideration their misunderstanding of the complexity of the underlying litigation and the legal issues involved therein.

Finally, most ot the annuitant witnesses testified that the proposed settlement was unfair because it simply cost too much. The Funds and the Court are sympathetic with the plight of annuitants who will find it a real hardship to pay the increased rates which have been set by the City. Nonetheless, the dollars involved are only peripherally relevant to this Court's determination of the fairness of the settlement. The major premise of the settlement is that the City will pay at least 50% of the cost of the annuitants' health care with the Funds'

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subsidies defraying a portion of the annuitants' share of the cost. There is no real dispute as to the amount of the actual cost of annuitant health care at the present time; the issue instead is who pays for it and whether the 50/50 sharing arrangement set forth in the proposed settlement is in the best interests of the annuitants generally. The Funds believe that only one conclusion can be drawn, and the Court agrees: In light of the risk that the City might prevail in its position that it has no legal obligation to provide or pay for annuitant health care, this proposed settlement is eminently fair and reasonable and should be approved by this Court.

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CONCLUSION
AND
ORDER

The Court taking all of the evidence in its totality and having reviewed all of the briefs finds that the proposed settlement is clearly in the interest of the Class and the Parties and that all criteria covering the approval of class action settlements have been satisfied.

Further, the Court having found the proposed settlement to be fair, it need not address the Participant Class' motion for summary judgment and its motion for a permanent injunction.

ENTER

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JUDGE

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CIRCUIT COURT OF
COOK COUNTY, ILLINOIS
CHANCERY DIVISION
CLERK DOROTHY BROWN

EXHIBIT 12

FOURTH DIVISION
June 15, 2000

NOTICE
The text of this order may be changed or corrected prior to the time for filing of a Petition for Rehearing or the disposition of the same.

No. 1-98-3465 & 1-98-3667, consol.

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

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MARTIN RYAN, et al,	APPEAL FROM THE CIRCUIT COURT OF COOK COUNTY
Intervening Plaintiffs-Appellants,	
v.	No. 87 CH 10134
THE CITY OF CHICAGO,	
Plaintiff-Counter defendant-Appellee,	
and	
MARSHALL KORSHAK, ET AL.,	Honorable Albert E. Green, Judge Presiding.
Defendants-Counter plaintiffs-Appellees.	

ORDER

The intervening plaintiffs, class representatives of the participants in the City of Chicago's annuitant health care program (plaintiffs), appeal from the circuit court's September 1, 1998, order denying their motion to restore this case to the active calendar, add intervenors, file an amended complaint, and schedule this case for a

decision on the merits and dismissing this case. The proposed intervenors, Olsen, Walsh, and Sweeney, appeal from the trial court's September 1, 1998, order denying their petition to intervene as class members. These actions arose from a prior settlement in this case which guaranteed the participants a right to have the case restored and their claims decided if they had not reached a "permanent solution" to their healthcare coverage dispute with the City by December 1, 1997. The trial court found that because a "permanent solution" was reached, it lacked subject matter jurisdiction to consider plaintiffs' claims. Plaintiffs filed a timely notice of appeal on September 15, 1998. The proposed intervenors, also filed a timely notice of appeal on September 25, 1998. For the following reasons we affirm in part and reverse in part.

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BACKGROUND:

The City's retired employees are covered by four annuity and benefit funds, the Policemen's Annuity and Benefit Fund, the Firemen's Annuity and Benefit Fund, the Municipal Employees' Officers' and Officials' Annuity Fund, and the Laborers' and Retirement Board Employees' Annuity and Benefit Fund (collectively the Funds), which are governed by the Illinois Pension Code. In October 1987, the City provided health care coverage for annuitants in the Funds at a fixed monthly rate of $12 for Medicare qualified participants and $55 for non-medicare qualified participants.

On October 19, 1987, the City sued the trustees of the Funds for mandamus and restitution. The City sought to compel the Funds to pay for annuitants' health care benefits and to recover $58 million it had previously spent for health insurance for the

Funds' annuitants. The City also informed the Funds that it intended to cease payment of the annuitants' health care benefit costs as of December 31, 1987. The City's basis for these actions was that it had provided retiree healthcare coverage under an appropriation that, for most years, did not explicitly mention annuitants. The Funds counterclaimed on behalf of their annuitants to prevent the City from terminating the annuitants coverage under the City's plan and to compel the City to continue paying for a portion of the coverage. Certain individual annuitants, who are the plaintiffs in this matter, were granted leave to intervene in the trial court proceedings.

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On May 16, 1988, the trial court dismissed the City's complaint with prejudice, finding that the Funds had no obligation to reimburse the City for the health care benefits received by the annuitants since 1980. In June 1988 a bench trial was held on the Funds' counterclaims. Before the trial court issued its decision, however, the City and the Funds agreed to support legislation amending the Pension Code and to enter into a settlement agreement consistent with the legislation. Following a fairness hearing on December 12, 1989, the trial court approved the settlement, over the objection of the intervenors. According to the terms of the settlement, the City paid at least 50% of the cost of the claims of annuitants and dependants participating in the City's plan..

On December 15, 1989, the trial court entered an agreed order memorializing the settlement agreement. The Order stated in relevant part:

> "The City and the Funds have agreed that at the conclusion of the 10 years covered by the settlement the parties will return to the same

positions they were in before the proposed settlement was negotiated. In the words of the stipulation between the City and the Funds, which was read into the record before this Court on November 27, 1989:

> On January 1, 1998, the parties will be in the same legal positions they were in as of June of 1988. To the extent the City had any obligation in June of 1988, they will have that same obligation or obligations on January 1, 1998.
>
> Consequently, the annuitants have not "given up" anything through this settlement. (Other than the claimed right to have the City pay more than 50% of the costs between March of 1990 and December of 1997.) On January 1, 1998, if some "permanent solution" has not been achieved, the annuitants will be permitted to reargue the claims which were asserted in the Funds' Counterclaim as well as the Intervenors' initial pleading."

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On November 28, 1990, this court affirmed the settlement agreement. City of Chicago v. Korshak, 206 Ill. App. 3d 968, 565 N.E.2d 68 (1990).

On June 27, 1997, the General Assembly enacted P.A. 90-32, extending the City's obligation to pay some of the costs of the annuitants' health benefits through June 30, 2002.

In June 1998, arguing that no "permanent solution" had been reached, plaintiffs filed a motion seeking to return the case to the active calendar, add or substitute additional intervenors, file an amended complaint, and set a schedule for a resolution of their claims on the merits. Additional annuitants, Olsen, Walsh, and Sweeney, moved for leave to intervene as class members on July 24, 1998. On September 1, 1998, the trial court denied the plaintiffs' motion, denied the proposed intervenors petition to intervene, and dismissed this case. The trial court held that with the legislature's adoption of a "permanent solution" for annuitant health care coverage, the

1989 consent decree had expired and the court lacked subject matter jurisdiction.

On appeal, the intervening plaintiffs and the proposed intervenors contend: (1) that the circuit court erred in finding that it lacked subject matter jurisdiction to consider plaintiff's claims; (2) that the 1997 amendments to the Pension Code unconstitutionally impair vested contractual rights; (3) that the 1997 amendments to the Pension Code were unconstitutional special legislation; and (4) that the circuit court abused its discretion in denying the proposed intervenors leave to intervene in this case.

Discussion:

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At issue in this case is whether the circuit court had subject matter jurisdiction to address the plaintiffs' claims. Under the express terms of the consent decree, the circuit court's jurisdiction lasted until December 31, 1997. The agreement further provided that the circuit court's jurisdiction could continue after January 1, 1998, if no "permanent solution" to the annuitant health care problem had been reached. In dismissing plaintiffs' claims, the circuit court held that it had no jurisdiction over those claims because the General Assembly had achieved such a "permanent solution" through P.A. 90-32. The parties disagree as to whether P.A. 90-32 amounted to a "permanent solution" under the terms of the 1989 settlement agreement.

The Funds and the City argue that the intervening plaintiffs are bound by the 1997 settlement and the Funds' decision to treat the 1997 Amendments to the Pension Code as a "permanent solution." However, the intervening plaintiffs were made full parties to this action when they were allowed to intervene. See Redmond v. Devine,

152 Ill. App. 3d 68, 504 N.E.2d 138 (1987)(holding that Intervenor is entitled to all the rights of an original party). The settlement agreement reaffirmed the intervening plaintiffs' position in the case by expressly providing that if a "permanent solution" is not achieved by January 1, 1998, "the annuitants will be permitted to reargue the claims which were asserted in the Funds' counterclaim as well as the intervenors' initial pleading."

The sole issue before this court then, is whether the 1997 amendment to the Pension Code was a "permanent solution" within the meaning of the settlement agreement. We find that it was not.

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The 1997 amendment by its very terms states that the City's responsibility to pay for annuitant health benefits ends on June 30, 2002. Anything bounded in time cannot possibly be considered permanent. Webster's defines permanent as "lasting indefinitely." Webster's II New Riverside Dictionary 509 (1996). The Supreme Court has defined "permanent" as "a relationship of continuing or lasting nature, as distinguished from temporary." Castillo v. Jackson, 149 Ill. 2d 165, 180, 594 N.E.2d 323 (1992), quoting, Holley v. Lavine, 553 F.2d 845, 850 (2nd Cir. 1977). A 5 year plan clearly does not last indefinitely.

In Castillo, the Supreme Court also recognized that "permanent" does not equal "perpetual", stating "a relationship may be permanent even though it is one that may be dissolved eventually at the insistence either of the [State] or of the individual, in accordance with law." Castillo, 149 Ill. 2d at 180. The Funds argue that the 1997

Amendments fall within this definition because pursuant to the Amendments, the City can discontinue or amend annuitants' health care benefits at any time, as long as they act subject to and in accordance with the law. However, this ability to discontinue or amend annuitant's health care benefits does not change the fact that the legislation expires after 5 years. It simply does not create the continuing or lasting relationship necessary to make it permanent.

We find that the 1997 Amendments to the Pension Code do not constitute a "permanent solution" within the meaning of the settlement agreement. Therefore, under the express terms of the settlement agreement, the intervening plaintiffs are entitled to reargue the claims originally asserted in the Funds' counterclaims as well as the Intervenors' initial pleading.

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II. Proposed - Intervenors

The proposed intervenors contend that the circuit court abused its discretion in denying their petition for leave to intervene in this case. The proposed intervenors sought to intervene as of right pursuant to section 5/2-408(a) of the Code of Civil Procedure (735 ILCS 5/2-408(a) (West 1996)) because "representation by the existing parties may be inadequate and the applicants may be bound by an Order and Judgement in this action." The decision whether to grant a petition to intervene as of right lies within the trial court's discretion, however, that discretion is limited to determining timeliness of the petition, the inadequacy of the representation by existing parties, and the sufficiency of interest of the potential intervenors. Joyce v. Explosives

Technologies Int'l, 253 Ill. App. 3d 613, 625 N.E.2d 446 (1993). Once these requirements are met, the party must be allowed to intervene.

A petitioner seeking to intervene may establish inadequate representation by the existing parties by demonstrating that his interests are different from those of the existing parties. Redmond v. Devine, 152 Ill. App. 3d 68, 504 N.E.2d 138 (1987). The proposed intervenors have failed to demonstrate how their interests are any different from the annuitants who have already intervened in this matter.

In Warbucks Inv. Ltd. Partnership v. Rosewell, 241 Ill. App. 3d 814, 609 N.E.2d 832 (1993), the court noted "[a]lthough it is well settled that the intervention statute is remedial and should be liberally construed (citation omitted), the petitioner is nevertheless required to allege specific facts that demonstrate that he has a right to intervene. Allegations that are conclusory in nature and merely recite statutory language are insufficient to meet the requirements of section 2-408." 241 Ill. App. 3d at 817. In the present case, the prospective intervenors allege no specific facts to demonstrate their right to intervene. Their petition to intervene merely recites the statutory language in a conclusory fashion.

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The proposed intervenors also make an argument based on section 2-804(a) of the Code of Civil Procedure (735 ILCS 5/2-804(a) (West 1996). This argument, however, has been waived. The proposed intervenors admit that they never raised this argument below in their petition for leave to intervene. Arguments not raised in the trial court are waived and may not be raised for the first time on appeal. E&E Hauling, Inc.

v. Ryan, 306 Ill. App. 3d 131, 713 N.E.2d 178 (1999).

We find that the proposed intervenors petition to intervene was properly denied.

Accordingly, for the reasons set forth above the judgment of the Circuit Court of Cook County is affirmed in part and reversed in part, and the cause is remanded to the Circuit Court.

Affirmed in part and Reversed in part, Cause Remanded.

HALL, J,, with HOFFMAN, P.J. and BARTH, J., concurring.

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