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

CITY OF CHICAGO, a municipal corporation,	)	
	)	
Plaintiff-Counterdefendant,	)	
	)	
vs.	)	No. 01 CH 4962
	)	Calendar 12
MARSHALL KORSHAK, et al,	)	
	)	Hon. Lester D. Foreman,
Defendants-Counterplaintiffs,	)	Judge Presiding.
	)	
and	)	
	)	
MARTIN RYAN, et al.,	)	
	)	
Intervening-Plaintiffs.	)	

SETTLEMENT AGREEMENT

The Parties to this Settlement Agreement ("Agreement") are: Plaintiff-Counterdefendant, the City of Chicago ("the City"); Defendants-Counterplaintiffs, Retirement Board of the Policemen's Annuity and Benefit Fund of Chicago, the Retirement Board of the Municipal Employees', Officers' and Officials' Annuity and Benefit Fund of Chicago, the Retirement Board of the Firemen's Annuity and Benefit Fund of Chicago, and the Retirement Board of the Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago (collectively, "the Funds"); and certain intervenor annuitants, certified as representatives of the class of the Funds' annuitants who retired prior to December 31, 1987 (the "Korshak Class"), and seeking to be further certified for the Funds' annuitants who retired after December 31, 1987, but before August 23, 1989 (the "Window Class").

I. INTRODUCTION

The Action, City of Chicago v. Korshak, No. 01 CH 4962 (formerly No. 87 CH 10134), is currently pending in the Circuit Court of Cook County Illinois, Chancery Division. The

Action involves the issue as to whether the City has an obligation to provide health benefits to the Funds' annuitants and who is responsible for the cost of such benefits.

The Funds contend that the City is required to provide a health care plan and to contribute to the annuitants' health benefits. The City maintains that it is not obliged to provide annuitant health benefits. The Korshak and Window Classes allege that they are entitled to health benefits for life, which are to be subsidized by the Funds.

The Parties have participated in settlement discussions in an effort to resolve the controversy and provide continued health care benefits for current and future annuitants of the Funds. On April __, 2003, the Parties reached a proposed settlement, which is described in this Settlement Agreement.

NOW THEREFORE, in consideration of the mutual covenants and agreement set forth herein and subject to the approval of this Court, it is hereby agreed as follows:

II. DEFINITIONS

A. "The Action" refers to City of Chicago v. Korshak, No. 01 CH 4962 (formerly Case No. 87 CH 10134), pending in the Circuit Court of Cook County, Illinois, Chancery Division.

B. The "Claims Administrator" is the organization(s) engaged by the City to perform the tasks of administering the Settlement Healthcare Plans, including but not limited to, contracting with hospitals and medical professionals, processing claims and making payments thereon.

C. The "Court" refers to the Circuit Court of Cook County, Illinois.

D. The term "Defined Costs" used in this Agreement shall mean the following:

1. For Physician Services: The actual amount paid by the Claims Administrator to a provider for physician services. This is net of any provider contract discounts, patient's co-payments and deductibles, other insurance (such as Medicare) or ineligible amounts. It includes administrative costs and case management fees.

2. For Hospitals and Other Providers: The amount billed by a provider for hospital services, net of any hospital discounts, and less all ineligible amounts, other insurance payments and the patient's co-payments and deductible. It includes administrative costs, access fees and utilization review and case management fees.

3. For Prescriptions: The amounts paid by the Pharmacy Benefits Manager for Class Members' prescription medications, net of the patients' co-payments and deductible, and net of any applicable discounts from the published AWP (Average Wholesale Price). It includes the fees paid to pharmacies for dispensing the prescriptions and administrative charges paid to the Pharmacy Benefits Manager.

E. "Future Annuitant" is a person who becomes eligible for and receives an age and service annuity after the effective date of this Settlement Agreement, and before July 1, 2013, based on Years of City Service without regard for reciprocal service with another agency or unit of government.

F. "Notice" refers to the "Notice of Proposed Class Action Settlement" attached hereto as Exhibit A.

G. "Pharmacy Benefits Manager" ("PBM"), is the organization(s) engaged by the City to perform the tasks of administering the pharmacy benefits of the Settlement Healthcare Plans, including, but not limited to, contracting with a network of retail pharmacies and one or

more mail order pharmacies, processing prescription claims, making payments thereon, providing rebates and other contractual allowances to the Settlement Healthcare Plans.

H. The "Settlement Class" or "Class Members" consists of: all current annuitants of the Funds, who are receiving an annuity based on City Service and who are enrolled in City healthcare plans, and their eligible dependents; and all current and former City employees who will become one of the Funds' Future Annuitants on or before June 30, 2013, and their eligible dependents.

I. The "Settlement Healthcare Plans" are the Settlement Healthcare Plan for Medicare Eligible Class Members and the Settlement Healthcare Plan for Medicare Ineligible Class Members. The Settlement Healthcare Plans will be established in a complete Plan Document(s), the highlights of which are summarized in Exhibit B to this Agreement.

J. The "Settlement Period" is the period of time that begins on July 1, 2003 or on the date of the Final Approval by the Court of this Settlement Agreement, whichever is later, and ends at midnight June 30, 2013. In the event of an appeal from the Court's Final Approval, the Parties agree that this Agreement will take effect and remain in effect while the appeal is pending.

K. "Years of City Service" means years of actual employment with the City, for which pension service credit is also recognized, without regard for reciprocal service with another agency or unit of government. This City Service need not be continuous.

III. SUBMISSION OF AGREEMENT FOR PRELIMINARY APPROVAL AND ORDER

Subsequent to the execution of this Settlement Agreement, counsel for the Parties will submit the Settlement Agreement and the proposed Notice (attached hereto as Exhibit A) to the

judge of the Circuit Court of Cook County, Illinois assigned to this matter, and will request an Order:

A. Preliminarily approving this Settlement Agreement;

B. Certifying the Action as a class action on behalf of the Settlement Class for settlement purposes only, with two subclasses consisting of the Korshak Class and the Window Class, who are represented by Krislov & Associates, Ltd.;

C. Approving the proposed Notice and directing that, within 14 days of the Order: the City will cause the Notice to be sent to every potential Class Member who is a former City employee, and not an annuitant, by first class mail where records are available, and by publication, and to be directly distributed to current employees; and the Funds will cause the Notice to be mailed, by first class mail, to each of their annuitants;

D. Scheduling a hearing to determine the reasonableness, adequacy, and fairness of the Proposed Settlement and whether it should be approved by the Court;

E. Providing that any Class Member may exclude himself/herself from the Class and the Action in the manner and with the consequences described in the Notice and providing that all requests for exclusion must be received by the Court no later than 21 days after the date of the Notice;

F. Providing that any Class Member who objects to the approval of this Settlement Agreement and show cause why the settlement proposed by this Agreement should not be approved as fair, reasonable and adequate and why a judgment should not be entered thereon, and providing, further, that any Class Member who wishes to object or who requests to appear at the hearing must notify the Court and the attorneys for the Parties to this Agreement of his/her objection, the basis for his/her objection, state whether he/she is requesting to appear at the

hearing, provide such further information as is more fully described in the objection, such notice to be postmarked no later than May 22, 2003;

G. Providing that no person will be entitled to contest the approval of the terms and conditions of this Settlement Agreement or the judgment to be entered thereon except by filing and serving written objections in accordance with the provisions of subparagraph F, above, and that any Class Member who fails to exclude himself/herself from the Class in accordance with subparagraph E above or who fails to object in the manner prescribed in subparagraph F above shall be deemed to have waived, and shall be foreclosed forever from raising objections to the settlement or from asserting any claims arising out of, related to, or based in whole or in part on any of the facts or matters alleged, or which could have been alleged or which were otherwise at issue in this Action.

IV. TERMS OF THE AGREEMENT

A. The City will make healthcare coverage available to all Class Members during the Settlement Period and the City will pay at least:

- 55% of the Defined Costs of that coverage for all Class Members: (1) who are annuitants of the Funds based on City Service as of the effective date of this Settlement Agreement, and their eligible dependents; or (2) who become Future Annuitants on or before June 30, 2005, and their eligible dependents.

- 50% of the Defined Costs of that coverage for all Class Members who become Future Annuitants after June 30, 2005, and before June 30, 2013, and who have 20 or more Years of City Service, and their eligible dependents.

- 45% of the aggregate Defined Costs of that coverage, for all Class Members who become Future Annuitants after June 30, 2005, and before June 30, 2013, and who have 15 to 19 Years of City Service, and their eligible dependents.

- 40% of the aggregate Defined Costs of that coverage for all Class Members who become Future Annuitants after June 30, 2005, and before June 30, 2013, and who have 10 to 14 Years of City Service, and their eligible dependents.

- 0% of the aggregate Defined Costs of that coverage for all Class Members who leave the employ of the City after June 30, 2005, and before June 30, 2013, and who have less than

10 Years of City Service. These persons may participate in the City's Settlement Healthcare Plans, but at their own cost.

B. The Settlement Healthcare Plans will replace all current annuitant healthcare plans.

C. A summary of the benefits of the Settlement Healthcare Plans is set forth in Exhibit B to this Agreement. Exhibit B is incorporated into and made an integral part of this Agreement. However, the Settlement Healthcare Plans will be established in complete Plan Documents.

D. During the Settlement Period, a qualified independent actuary will be engaged by, and paid by, the City and the Funds to estimate the aggregate Defined Costs of Settlement Healthcare Plan claims for the next year, based upon the records of the Claims Administrator and, for each Settlement Healthcare Plan offered by the City, to determine the contribution to be made by the City and the contributions/rates to be paid by the Class Members for the year. The City, based upon the determination of the independent actuary, shall set the monthly amounts to be paid by participating Class Members according to the following method: (1) an estimated average unit cost per plan will be derived from the actuary's estimate of Defined Cost; (2) the City's share will be calculated for the estimated unit cost and subtracted from each unit cost; (3) the applicable Pension Funds' subsidy per annuitant will be deducted from the remainder of the unit cost; and (4) the balance will be the amount payable by the annuitant. The Funds shall pay to the City, on behalf of each annuitant enrolled in the Settlement Healthcare Plans, the subsidy amount established by statute. pension statute?

E. Under the procedures set forth in Executive Order 89-4 and the City's annual Classification and Pay Plan, the City Benefits Manager will make initial determinations with regard to eligibility and disputed claims. The City Benefits Committee will handle any appeals by annuitants regarding the denial of eligibility or denial of any claims filed under the Settlement Healthcare Plans and additional plans which may exist.

F. The City shall advise the Funds and Krislov & Associates, Ltd. of any proposed contribution/rates increase at least 75 days prior to the effective date of the increase.

G. During the Settlement Period, the City may not amend or terminate the Settlement Healthcare Plans except as follows:

1. The City may terminate or amend the Settlement Healthcare Plans or make reasonable plan design changes in response to material changes in federal or state law under circumstances which include, but are not limited to, the following: if changes or termination were mandated by law; if the City's coverage were duplicative of other coverage; or if the changes brought about by state or federal law made the City's benefits unduly expensive.

2. The City will not terminate or amend the Settlement Healthcare Plans for reasons other than changes in federal or state law, as described above, for those Class Members who retired prior to August 23, 1989.

3. The City's right to amend the Settlement Healthcare Plans for reasons other than changes in federal or state law for remaining Class Members, is subject to the following restrictions:

(a) The City will make no plan design changes which do not arise out of changes in law for a period of 5 years from July 1, 2003.

(b) After July 1, 2008, the City may make changes to the design of the Settlement Healthcare Plans only with the approval of a majority of the members of a commission, the Retiree Health Benefits Commission ("RHBC"), impaneled by the City to consider proposed plan design changes. The RHBC will consist of experts who will be objective and fair-minded as to the interests of both retirees and taxpayers. The RHBC will also consist of a representative of the City of

Chicago and a representative of the Funds. The City may seek approval of the RHBC to make plan design changes solely under the following circumstances:

(i) in response to material changes in medicine or technology;

(ii) in response to court rulings or the settlement of other litigation;

(iii) in response to material changes in the structure or methods by which health benefits are contracted for or provided;

(iv) in response to material changes in market or economic conditions that would render the provision of any benefit unreasonably expensive under the circumstances.

(c) The RHBC will independently review the City's proposed amendments to the Settlement Healthcare Plans and will make recommendations as to the City's proposal. The RHBC must take into account industry trends and market conditions existing at the time of its recommendations. The decisions of the RHBC shall not be unreasonable or arbitrary and the actions of the City pursuant to decisions of the RHBC shall not be unreasonable or arbitrary.

4. In appointing members of the RHBC, the City is required to choose professionals from one or more of the following categories: health benefits professionals; actuarial and/or benefit consulting professionals; officers or principals responsible for benefits in business; professors or research academics; former officials of health insurance companies; leaders of civic organizations or retiree groups; professionals experienced in municipal finance. The City also will appoint a representative for the City. In addition, each Fund may recommend one person to sit on the RHBC and the

City will select one of the four recommendations to be appointed to the RHBC as the Funds' representative.

5. Other than for the City and Funds' representatives, the following guidelines apply to the selection of the other members of RHBC:

(a) Members or their organizations/employers cannot be then current or potential contractors with the City or the Funds for health benefit coverage or plan administration;

(b) No person appointed to the RHBC may have a conflict of interest by virtue of their employer's/organization's relationship with the City or with one or more of the Pension Funds;

(c) Members and their organizations/employers cannot be current contractors for, or affiliates, of the Funds; and,

(d) Members and those in their immediate family cannot be City or the Funds' employees, or Fund annuitants.

6. Before July 1, 2013, the RHBC will make recommendations concerning the state of retiree healthcare benefits, their related cost trends, and issues affecting the offering of any retiree healthcare benefits after July 1, 2013.

H. The City may offer additional healthcare plans at its own discretion and may modify, amend, or terminate any of such additional healthcare plans at its sole discretion. Any additional healthcare plans that the City may implement will not be subject to review by the RHBC and the City reserves full discretion to modify, amend or terminate any additional healthcare plans.

I. The Action will be dismissed with prejudice on the date of final approval of this Agreement, subject to the provisions of paragraph J., below.

J. After the termination of the Settlement Period, Class Members retain any right they currently have to assert any claims with regard to the provision of annuitant healthcare benefits, other than claims arising under the prior settlement of this Action or under the 1989, 1997, or 2002 amendments to the Pension Code, or for damages relating to the amounts of premiums or other payments that they have paid relating to healthcare under any prior health care plans implemented by the City, including this Settlement Agreement. The Funds agree that they will not, at any time, assert any: (1) claims on behalf of any annuitant for premiums or other payments made under any prior City healthcare plan, including this Settlement Agreement; or (2) claims based on the City's pre-1988 conduct or statements. However, if any separate action relating to health benefits is brought after the end of the Settlement Period against a Fund or its Trustee(s), the Fund or Trustees(s) may seek to assert a cross claim or third party complaint against the City in its defense.

During the Settlement Period, Class Members, the Funds and their current, future or former Trustees are precluded from asserting any claims regarding health care benefits against the City, except that all matters relating to the interpretation, administration, implementation, effectuation and enforcement of this Agreement are governed by the provisions of subsection V. B. 7. below.

The City reserves its right to raise any defenses.

K. The City will pay reasonable attorneys' fees, which may be recoverable by Krislov & Associates, Ltd., as class counsel of record for the Korshak and Window Classes in this Action, in the amount as agreed to by the City and Mr. Krislov or as determined by the Court. The Funds agree not to bring any claim against the City for their attorneys' fees or costs.

L. Class Members who retired before August 23, 1989, and who are not eligible for Medicare will pay rates assessed under the Medicare Settlement Healthcare Plan.

V. HEARING ON THE PROPOSED SETTLEMENT

A. On the date set by the Court for the hearing ("Settlement Hearing") on the Proposed Settlement, the Parties shall jointly request the Court to review any objections to the Agreement which have been timely filed and to conduct such other proceedings (including the taking of testimony, receipt of legal memoranda and hearing of arguments from the Parties or others properly present at the Settlement Hearing) as it may deem appropriate under the circumstances.

B. At the Settlement Hearing the Parties shall jointly request the Court to enter a final judgment and decree:

1. approving, without material alteration, the Proposed Settlement pursuant to the terms of this Agreement;
2. finding that the terms of this Agreement are fair, reasonable and adequate to the Class Members;
3. providing that each Class Member (except those who are excluded as provided for in paragraph III.E) shall be bound by this Agreement;
4. finding that the proposed Notice (Exhibit A), is the only notice required and satisfies the requirements of Sections 2-803 and 2-806 of the Illinois Code of Civil Procedure and the requirements of due process;
5. finding that the distribution and mailing of Notice as described above (¶III.C), satisfies the requirements of Sections 2-803 and 2-806 of the Illinois Code of Civil Procedure and the requirements of due process;

6. approving all requests for exclusion which have been timely submitted to the Court; and

7. retaining jurisdiction of all matters relating to the interpretation, administration, implementation, effectuation and enforcement of this Agreement, only upon petition from the City or counsel for one of the Funds or counsel for intervenor Korshak or Window Classes.

VI. ADDITIONAL COVENANTS

A. This Agreement will not be effective unless the Illinois legislature enacts – was it enacted? legislation increasing, for a period of time not to exceed 10 years (until June 30, 2013), the monthly subsidy to be paid by the Funds to: $85.00 for each annuitant who is ineligible for Medicare and $55.00 for each annuitant who is eligible for Medicare for the period July 1, 2003 to July 1, 2008; and $95.00 for each annuitant who is ineligible for Medicare and $65.00 for each annuitant who is eligible for Medicare, for the period of July 1, 2008 through June 30, 2013. Those Class Members who are covered by section IV.L., above, are entitled only to a Fund subsidy at the Medicare level. The legislation increasing the subsidy may also authorize payments made on behalf of retired sworn Police and uniformed Fire personnel who retired between the ages of 60 and 65.

B. This Agreement represents an integrated document negotiated and agreed to among the Parties and it shall not be amended, modified or supplemented, nor shall any of its provisions be deemed to be waived, unless by written agreement signed by the respective attorneys for the Parties. This document has been drafted jointly and is not to be construed against any Party.

C. This Agreement represents the entire and sole agreement negotiated and agreed to among the Parties to this Agreement.

D. This Agreement shall not be binding on any Party until it has been approved by the Boards of Trustees of each of the Funds, by the City of Chicago, and by the Intervenors, represented by the Korshak and the Window Classes.

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FOR SETTLEMENT PURPOSES ONLY

Major Features of Plan for Medicare Eligible Persons

This Plan design replaces the Standard Plan and the Supplement Plan

Benefit	Plan Coverage
Inpatient Hospital Benefits (No change from current Supplement Plan)	Days 1 to 60: All but $50 of the Medicare Part A Deductible for the first hospital stay in any calendar year is paid by the Plan; Covered person pays $50. Days 61-90 Plan pays 25% of the Medicare Part A Deductible; Covered Person pays $0. Days 91-150 Plan pays 50% of the Medicare Part A Deductible; Covered person pays $0. *Plan pays 100% of the cost for up to 365 days more of inpatient hospital care in lifetime of Covered Person after the Covered Person exhausts all Medicare Benefits.*
Out-Patient Hospital Benefits (No change from current Supplement Plan)	Plan pays 20% of Medicare allowable charge; no expenses covered if not covered by Medicare; Covered Person pays $100 and co-pay based on Medicare Allowable Charge.
Doctor Visits (No change from current supplement Plan if provider accepts assignment)	Covered Person pays Part B deductible; after Part B deductible, plan pays 20% of Medicare Allowable Charge; no expense covered if not covered by Medicare.
Skilled Nursing Expense (No change from current Supplement Plan)	Pays Medicare co-pays for Medicare covered days. No expense covered if not covered by Medicare.
Medicare Part A and Part B (No change from current Supplement Plan)	The Plan will pay benefits as though the Covered Person is enrolled in both Part A and Part B of Medicare without regard to-actual enrollment.
Retail Prescription Drugs	For a thirty day supply: Generic Drugs 20% of cost Brand Drugs on Formulary 20% of cost Brand Drugs not on Formulary 20% of cost plus $15 If Brand dispensed when generic available, no benefit is available. A separate $100 deductible will be applied. Drug claims cannot be submitted to BCBS

FOR SETTLEMENT PURPOSES ONLY

Major Features of Plan for Medicare Eligible Persons

This Plan design replaces the Standard Plan and the Supplement Plan

Mail Order Maintenance Drugs	For up to a ninety day supply: Generic Drugs $15 Brand Drugs on Formulary $40 Brand Drugs Not on Formulary not available at mail If Brand dispensed when generic available, no benefit is available. Maintenance medications must be purchased through the mail order program. Co-payments will increase 5% per year rounded to the nearest dollar. Drug claims cannot be submitted to BCBS.
Other services covered by Medicare (No change from current Supplement Plan if provider accepts assignment)	20% of Medicare allowable charge, after Part B deductible. Any service or supply not covered by Medicare will not be covered by the Plan unless it is specified herein.
Service or programs added by Medicare after the effective date of the plan	If Medicare offers a new program or benefit, the Plan will pay benefits as if the Covered person has enrolled for the program or benefit without regard to whether actual enrollment has occurred.
Means Test for Annuitants with total income below the poverty line	An annuitant may apply each year to have a cap on premiums if the combined adjusted gross income of the annuitant's family as reported to the Internal Revenue Service is at or below 200% of the poverty level for the family size of the annuitant. The annuitant must provide a signed release to the Plan Administrator to allow the Plan Administrator to obtain a copy of the annuitant's most recently filed tax return.
Benefit Differences for Annuitants who qualify as a result of application of the means test	1. Premium shall be capped at 20% of the total household income where total is at or below 200% of poverty level to 150% of poverty level, capped at 15% of poverty level for those at 150% to 100% of poverty level, and capped at 10% of total household income for those at 100% of poverty level or below. 2. Mail order drug co-pays shall be $7 for generic drugs, $20 for Brand Drugs on the Formulary, all other terms will apply except that co-payments will not increase each year. 3. For retail drugs, the separate $100 deductible will not apply.

FOR SETTLEMENT PURPOSES ONLY

Major Features of PPO Plan for Non-Medicare Eligible Persons

This plan design replaces the Standard Indemnity Plan and the Preferred Plan

Benefit/Service	In-Network Benefit	Out-of-Network Benefit	Out-of-Area Benefit
Lifetime Max (includes all amounts paid under prior plans)(No change from current preferred plan)	$1,500,000 per covered person		
Out of Pocket max	$1750 per individual; capped at 2 individual per family; amount increases 3% per year	$3500 Individual; capped at 2 individual per family; amount increases 3% per year	$1750 Individual; capped at 3 individual per family; amount increase 3% per year
Physician Services (No change from current preferred plan)	90%	70%	80%
Hospital Services, In-patient & Out (No change from current preferred plan)	90%	70%	80%
Skilled Nursing Facility Services (No change from current preferred plan)	80%	80%	80%
Physical, Occupational & Speech Therapy for Restoration of Function (No change from current preferred plan)	80%	80%	80%
Chiropractic Services (No change from current preferred plan)	Limited to 15 visits per year and no more than three modalities per visit; 70% payment	Limited to 15 visits per year and no more than three modalities per visit; 70% payment	Limited to 15 visits per year and no more than three modalities per visit; 80% payment

FOR SETTLEMENT PURPOSES ONLY

Major Features of PPO Plan for Non-Medicare Eligible Persons

This plan design replaces the Standard Indemnity Plan and the Preferred Plan

Out-Patient Psychiatric Services No-change from current preferred plan)	80%	80%	80%
Retail Prescription Drugs	For a thirty day supply; Generic Drugs 20% of cost Brand Drugs on Formulary 20% of cost Brand Drugs not on Formulary 20% of Cost plus $15 If Brand dispensed when generic available, no benefit is available. A separate $100 deductible will be applied.		
Mail Order Maintenance Drugs	For up to a ninety day supply: Generic Drugs $15 Brand Drugs on Formulary $40 Brand Drugs Not on Formulary not available at mail If Brand dispensed when generic available, no benefit is available. Maintenance medications must be purchased through the mail order program. Co-payments will increase 5% per year rounded to the nearest dollar.		
Ambulance Services (No change from current preferred plan)	80% payment	80% payment	80% payment
Emergency Room Services (No change from current preferred plan)	90% payment	90% payment	80% payment
Medical Necessity (No change from current preferred plan)	All services must be medically necessary; many medical services are subject to separate utilization review requirements. Services which are not medically necessary will not be covered by the Plan. Any service which was subject to review, and for which review did not occur, will be considered to be not medically necessary and not paid by the Plan.		

FOR SETTLEMENT PURPOSES ONLY

Major Features of PPO Plan for Non-Medicare Eligible Persons

This plan design replaces the Standard Indemnity Plan and the Preferred Plan

Deductible (all services are subject to the deductible)	$300 per person; capped at 3 individual per family; amount increases 3% per year	$700 per person amount increases 3% per year	$300 per person; capped at three individual per person; amount increases 3% per year

Means Test for Annuitants with total income below the poverty line	An annuitant may apply each year to have a cap on premiums if the combined adjusted gross income of the annuitant's family as reported to the Internal Revenue Service is at or below 200% of the poverty level for the family size of the annuitant. The annuitant must provide a signed release to the Plan Administrator to allow the Plan Administrator to obtain a copy of the annuitant's most recently filed tax return.
Benefit Differences for Annuitants who qualify as a result of application of the means test	1. Premium shall be capped at 20% of the total household income where total is at or below 200% of poverty level to 150% of poverty level, capped at 15% of poverty level for those at 150% to 100% of poverty level, and capped at 10% of total household income for those at 100% of poverty level or below. 2. Mail order drug co-pays shall be $7 for generic drugs, $20 for Brand Drugs on the Formulary; all other terms will apply except that co-payments will not increase each year. 3. For retail drugs, the separate $100 deductible will not apply.

BOTH PLANS Eligibility of Dependents	Persons are eligible to enroll if they were covered as a spouse or dependent by a City of Chicago Medical Care Plan for employees on the employee's last day of active employment with the City. Enrollment forms must be submitted within 30 days of the date of application for annuity. A dependent may not be enrolled after the former employee's retirement. – Mentally or physically disabled children of any age who depend upon the annuitant for support may be enrolled, provided all other eligibility requirements are met and that the annuitant provides proof of incapacity when required. **A. If the former employee retired prior to January 1, 1986:** – Unmarried children under age 25 are eligible if they have been continuously covered by the plan; – Unmarried children under age 19; – Unmarried children between ages 19 and 22 if they are enroll as full time undergraduate students in good standing in a community college, college or university accredited by North Central Regional Association or its affiliates, provided all other eligibility requirements are met. **B. Late enrollment or re-enrollment:** If retirees fail to apply for coverage within 30 days of applying for an annuity, then retirees must submit proof of insurability acceptable to the Benefits Management Office. However, if a retiree retired after August 31, 1985 and before age 65, then he or she can enroll within 30 days of the 65th birthday without submitting proof of insurability, provided the retiree has not previously applied for coverage. If the employee retired prior to January 1, 1986, dependents can be covered upon provision of satisfactory proof of insurability to the Benefits Management Office, provided that they also satisfy one of the three categories set forth in section A, above. If the dependent ceases to be covered and then seeks to re-enroll, the dependent will only be eligible to age 19 unless the age 22 eligibility for full-time undergraduates applies.

	If the employee retired on or after January 1, 1986, dependents may be covered only if they were enrolled in a medical plan offered by the City to its employees on the day before the retiree's retirement. Dependents not enrolled or acquired prior to retirement are not eligible. **C. Coverage under more than one plan:** A spouse may not enroll as a dependent if the spouse is eligible for coverage in an active City employee plan or is also a City annuitant who is eligible for coverage under this plan. If a City retiree is eligible for this plan and the spouse is covered by a medical care plan offered by the City, dependents can be covered under either plan, but not both. If the dependent is a City employee or annuitant, then he or she cannot be covered as a dependent under this plan.