SUMMARY OF MATERIAL MODIFICATIONS TO THE CITY OF MATTOON GROUP HEALTH BENEFITS PLAN

This Summary of Material Modifications ("SMM") describes certain changes made to the City of Mattoon Group Health Benefits Plan (the "Plan"), effective January 1, 2010, unless otherwise noted.

Changes in Eligible Dependents Section

The section on Eligible Dependents beginning on page 20 of your Summary Plan Description is hereby amended as follows:

ELIGIBLE DEPENDENTS

- Your legal spouse---See definition of "Spouse".
- Your unmarried children under age twenty-six (26)---See definition of "Child".
- Your unmarried children under age twenty-six (26) placed with you for adoption and for whom you have assumed and retained a legal obligation for total or partial support in anticipation of adoption of such child.
- Your unmarried children older than age twenty-six (26) but under the age of thirty (30) who (i) are Illinois residents, (ii) have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) have received a release or discharge other than a dishonorable discharged. (To be eligible for coverage as a dependent based upon prior military service, the eligible dependent must submit proof of such service using a DD2-14 (Member 4 or 6) "Certificate of Release or Discharge from Active Duty" form stating the date on which the dependent was released from the service.)
- A child you must cover due to a Qualified Medical Child Support Order (QMCSO) subject to the conditions and limits of the law.
- Your unmarried disabled children over age twenty-six (26) if the child was disabled prior to attaining age twenty-six (26). You must provide satisfactory proof of the child's incapacity and dependency within thirty-one (31) days after the child's twenty-sixth (26th) birthday. Continuing proof of disability and dependency will be required periodically.

Note: Anyone who is eligible for coverage as an employee will not be eligible for coverage as both an employee and as a dependent. Dependent children may not be covered by more than one employee. If both a husband and a wife are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage.

Changes in Special Enrollment Periods Section

The section on Special Enrollment Periods beginning on page 21 of your Summary Plan Description is hereby amended as follows:

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

1. Individual losing other coverage. An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions are met:

a. The Employee (or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
c. The coverage of the Employee (or Dependent) who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated.
d. The Employee requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee (or Dependent) lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

2. **Dependent beneficiaries.** A Dependent who is eligible, but not enrolled in this Plan, may enroll as a dependent beneficiary of a Covered Employee if each of the following conditions are met:

a. The Employee is a Covered Person under this Plan (or has met the waiting period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.
2. In the case of a Dependent's birth, as of the date of the birth; or
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

3. **Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.** Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in the Plan if either of the following two conditions are satisfied.

a. **Termination of Medicaid or CHIP Coverage.** The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

b. **Eligibility for Employment Assistance Under Medicaid or SCHIP**. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification. An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage. Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

Changes in Cessation of Dependent Eligibility Section

The section on When Dependents Cease to be Eligible beginning on page 22 of your Summary Plan Description is hereby amended as follows:

WHEN DEPENDENTS CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

- In the case of all your Dependents, the date your coverage terminates or the Dependent ceases to be a Dependent as defined in this Plan.
- In the case of your Spouse, when you are legally separated or divorced.
- In the case of a Dependent Child, other than those who have served and been released or honorably discharged from the military, attaining age twenty-six (26) or marriage, whichever occurs first.
- In the case of a Dependent child who has served and been released or honorably discharged from the military, attaining age thirty (30) or when the child marries, whichever occurs first.
- In the case of a Disabled Child, when the Dependent is no longer disabled or dependent upon you for support.
- The date the Dependent Coverage is discontinued under the Plan.
- The date the Dependent becomes covered as an employee.
- If your Dependent materially violates the terms of the Plan.
- If your Dependent participates in fraudulent or criminal behavior.
  Examples of fraudulent or criminal behavior include, but are not limited to:
  - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using an identification card to obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled.
  - Allowing any other person to use an identification card to obtain services.
  - Threatening or perpetrating violent acts against the Plan, a Provider, the Claims Administrator, or an employee of the Plan, Provider or Claims Administrator.
- If your Dependent knowingly misrepresents or gives false information on any enrollment application form which is material to the Plan's acceptance of such application.
- The date the Dependent enters the armed forces of any country on a full-time active duty basis.
- The end of the period for which you made any required contributions, if you fail to make any further required contributions.

Refer to the section in this Booklet entitled CONTINUATION RIGHTS for information regarding continued coverage after a Dependent ceases to be eligible under the Plan.

Changes in Covered Medical Expenses Section

The following items contained in the Covered Medical Expenses section beginning on page 25 of your Summary Plan Description have been added or modified as follows:

COVERED MEDICAL EXPENSES

13. Charges for physical and/or occupational therapy rendered by a licensed or registered physical or occupational therapist for the purposes of training to aid the restoration of normal physical functions lost due to an illness or injury; includes coverage for preventive physical therapy for members diagnosed with and treated for multiple sclerosis.

33. Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending physician and the patient:

a. Reconstruction of the breast on which the mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Breast cancer pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

40. Mammograms and pap smears, including low-dose mammography and digital mammography. Coverage for mammograms shall be provided at no cost to the member and shall not be applied to an annual or lifetime maximum when **PPO providers** are used. When mammogram services are available through **PPO providers** and a member receives those services from a non-PPO provider, coverage shall be at least as favorable as for other radiological examinations covered by the Plan

Additions to Special Coverages Section

The following items have been added to the Special Coverages section beginning on page 30 of your Summary Plan Description:

SPECIAL COVERAGES

AUTISM SPECTRUM DISORDERS

Care and services for the diagnosis of and treatment for Autism Spectrum Disorders in children under 21 years of age up to a maximum of $36,000 annually when prescribed, provided, or ordered for a child diagnosed with an Autism Spectrum Disorder by a physician licensed to practice medicine in all its branches or a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a physician licensed to practice medicine in all of its branches. Covered services for the treatment of Autism Spectrum Disorders shall include the following:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a

licensed psychiatrist.

(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavioral analysis, intervention and modification, (v) motor planning, and (vi) sensory processing.

HABILITATIVE SERVICES

Habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as all of the following conditions are me:

1) a physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder

2) the treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, physician, nurse, optometrist, nutritionist, social worker or psychologist upon the referral of a physician licensed to practice medicine in all its branches.

3) The initial or continued treatment must be Medically Necessary and therapeutic and not Experimental or Investigational.

Habilitative services means occupational therapy, physical therapy, speech therapy and other services prescribed by the member's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder.

A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury

Coverage for habilitative services shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services, including review of medical necessity, case

management, experimental and investigational treatments and other managed care provisions.

GENETIC COUNSELING

Genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities. You are not covered for diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question.

Note: Pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008 ("GINA"), the Plan will not adjust premium or contribution amounts on the basis of genetic information; request or require an individual or a family member of such individual to undergo a genetic test; or request, require or purchase genetic information for underwriting purposes.

Changes to Special Coverages Section

The items as contained in the Special Coverages section beginning on page 30 of your Summary Plan Description have been modified as follows:

SPECIAL COVERAGES

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES BENEFITS

The Plan will coordinate, determine the Medical Necessity of and Preauthorize the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and substance abuse issues ("Mental Health and Substance Abuse"). Except in the event of an emergency, Prior Authorization for all in-patient Mental Health and Substance Abuse must be obtained before receiving services. You may obtain Prior Authorization by contacting the Claims Administrator's Customer Service Department. All mental health, alcoholism and substance abuse benefits are subject to utilization management. If you have any questions about your Mental Health and Substance Abuse coverage or the appropriate way to access coverage, please contact the Claims Administrator at (866) 557-8751.

The following Mental Health and Substance Abuse services are covered:

Outpatient Services. Medically Necessary individual outpatient mental health or rehabilitation care visits to qualified Physicians, duly licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services. You should consult your Schedule of Benefits to determine the amount of your payment responsibility per visit. Outpatient visits for mental health are covered under the same terms and conditions as outpatient visits for the treatment of physical illness.

Inpatient Services. Your coverage for treatment of serious medically necessary mental illness or rehabilitation care at an inpatient facility or hospital shall be under the same terms and conditions for coverage for hospital or medical expenses related to other illnesses and diseases. Inpatient services are subject to Prior Authorization by the Plan except in the event of an Emergency. You should consult your Schedule of Benefits to determine the amount of your payment responsibility per hospitalization.

Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Coverage for these services is the same as coverage for non-mental health services for any other illness, condition or disorder.

Addition to Prescription Drug Plan

The following provisions are added to and incorporated in your separate Prescription Drug Plan:

IMMUNOSUPPRESSANT DRUGS

The Plan covers immunosuppressant drugs that have been prescribed for members to prevent the rejection of transplanted organs and tissues, subject to any applicable co-payments, deductibles and other terms and conditions of the Plan. When your prescribing physician has indicated "may not substitute" on the prescription for such immunosuppressant drugs, the Plan will not require or cause your pharmacist to interchange another immunosuppressant drug or formulation issued on your behalf without notification and the documented consent of your prescribing physician and you, or your parent or guardian if you are a child, or the spouse of a member who is authorized to consent to your treatment. Except as provided below, your co-payments, deductibles or other charges for the prescribed drug for which another immunosuppressant drug or formulation is not interchanged shall remain the same for the enrollment period established by the Plan.

We will, to the extent possible, notify your prescribing physician and you, or your parent or guardian if you are a child, or the spouse of a member who is authorized to consent to your treatment, at least 60 days prior to making any formulary change that alters the terms of coverage for patients receiving immunosuppressant drugs or that discontinues coverage for a prescribed immunosuppressant drug that you are receiving. The notification will be in writing and will disclose the formulary change, indicate that your prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the Plan's appeal process. Alternatively, we may provide you with written notification, along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed, at the time you request a refill of the immunosuppressant drug.

Notwithstanding the foregoing, the Plan will continue to use managed pharmacy care tools, including, but not limited to, formulary tiers, generic substitution, therapeutic interchange, prior authorization, and step therapy programs, but will have an exception

process in place that will allow your prescribing physician to petition for coverage of a non-preferred drug if sufficient clinical reasons justify an exception to the normal protocol.

Changes to Medical Expense Exclusions and Limitations Section

The following items as contained in the Medical Expense Exclusions and Limitations section beginning on page 32 of your Summary Plan Description have been modified as follows:

MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

13. Except as otherwise specifically provided for herein as a covered expense, expenses for physical therapy or occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.
14. Except as otherwise specifically provided for herein as a covered expense, speech therapy unless it is required because of a physical impairment caused by an illness, injury, or congenital deformity.
26. Except as otherwise specifically provided for herein as a covered expense, charges for testing, training or rehabilitation for educational, developmental or vocational purposes.
36. Charges for medical services or supplies for the treatment of Illness or Injury arising out of the commission or attempt to commit a Serious Illegal Act are not covered. For purposes of this section, a Serious Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed. It is not necessary that criminal charges be filed or that a sentence of imprisonment for a term in excess of one (1) year actually be imposed. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a Covered medical (including both physical and mental health) condition. It also does not apply if the expenses were incurred as a result of and related to an Injury or Illness acquired while the member is intoxicated or under the influence of any narcotics, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.

Addition to Continuation Rights Section and COBRA

The following provisions have been added to the Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) subsection of the Continuation Rights section beginning on page 41 of your Summary Plan Description:

Effective Date. This Amendment is effective as of March 1, 2009.

COBRA American Recovery and Reinvestment Act of 2009 ("ARRA") provisions. The Plan's provisions concerning COBRA are amended as provided below to allow for (1) payment of reduced premiums and the provision of a second election period by certain COBRA qualified beneficiaries, (2) the provision for additional COBRA notices, and (3) an exception to the rules for crediting certain prior coverage. This amendment does not apply to a health flexible spending account.

The COBRA continuation coverage provisions of the Plan shall be administered in accordance with the requirements of ARRA Section 3001 with respect to "assistance eligible individuals," as defined in ARRA Section 3001(a)(3). Notwithstanding any other Plan provision to the contrary, the Plan shall determine whether an individual has had a 63-day break in coverage for purposes of determining creditable coverage under the Health Insurance Portability and Accountability Act (HIPAA), in accordance with the terms of ARRA Section 3001.

Addition to HIPAA Privacy Section

The following provisions have been added to the HIPAA Privacy section beginning on page 48 of your Summary Plan Description:

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

Changes to Terms in Definitions of Terms Section

The following terms as contained in the Definitions of Terms section beginning on page 51 of your Summary Plan Description have been modified as follows:

CHILD - The Employee's unmarried children under twenty-six (26) years of age. The term "Child" shall include natural children, a step-child, a foster child, a child related to the Employee by blood or marriage and for whom the Employee has assumed legal

guardianship, a child whom the Employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law, or a legally adopted child (including the period of probation when the child is placed with the adopting parents). The child's placement with the Employee terminates upon the termination of the legal obligation. An unmarried child who is physically or mentally incapable of self-support, upon attaining age twenty-six (26), may be covered under the health care benefits, while remaining incapacitated and unmarried, subject to the covered employee's own coverage continuing in effect. Such child will be considered a Covered Dependent if he was disabled either prior to his twenty-sixth (26th) birthday. To continue Covered Dependent status of a child under this provision, proof of incapacity must be received by the City within thirty-one (31) days after coverage would otherwise terminate. An unmarried child, upon attaining age twenty-six (26), may continue to be covered up to age thirty (30) if they are an Illinois resident, have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and have received a release or discharge other than a dishonorable discharged. (To be eligible for coverage as a dependent based upon prior military service, the eligible dependent must submit proof of such service using a DD2-14 (Member 4 or 6) "Certificate of Release or Discharge from Active Duty" form stating the date on which the dependent was released from the service.) Additional proof may be required from time to time. Evidence satisfactory to the City of dependent eligibility under the Plan may be requested, including, but not limited to, copies of birth or adoption records, qualified medical child support orders, guardianship orders or form DD2-14 (Member 4 or 6).

DEPENDENT - For the purposes of this Plan, the Employee's spouse and children up to the age of twenty-six (26) (or up to the age of thirty (30) if released or honorably discharged from active or reserve military duty) (see definition of "Child"), and disabled children, if such incapacity occurred prior to the limiting age specified.

The following term as contained in the Definitions of Terms section beginning on page 51 of your Summary Plan Description is hereby deleted:

~~**STUDENT** - Means the Employee's unmarried child under twenty-four (24) years of age attending an accredited educational institution who is enrolled for at least twelve (12) hours of credit in any one (1) semester of, if the institution is not organized on a semester system, the equivalent of twelve (12) semester hours. Full-time student status will continue during semesters when the Plan receives notification that the student is registered for the following semester. **Note: When benefits are paid on behalf of the student between semesters, and if the student does not resume attendance the following semester, benefits paid during this time will be the responsibility of the Employee and there will be monies due back to the Plan. The Plan will be immediately entitled to a complete recovery in full of all such benefits paid.** Proof of student status, verified by the school, is required within thirty (30) days of the child's twentieth (20th) birthday and at the beginning of each semester.~~

Please contact the Plan's Customer Service Department at 866-557-8751 for more information about the foregoing changes and additions to your Summary Plan Description. All other provisions of the Plan Document and Summary Plan Description remain unchanged. The above changes become effective January 1, 2010, unless otherwise stated.

CITY OF MATTOON

By: _____

Title: Mayor

Date: 12-01-09

SUMMARY OF MATERIAL MODIFICATIONS TO THE CITY OF MATTOON GROUP HEALTH BENEFITS PLAN

The Plan Sponsor desires to make certain changes to the City of Mattoon Group Health Benefits Plan (the "Plan"). Consequently, the Summary Plan Description and Plan Document ("SPD") for the Plan is hereby amended as set forth below. Effective January 1, 2011, some of the benefits, terms, conditions, limitations, and exclusions contained in your SPD will change as a result of the Patient Protection and Affordable Care Act of 2010. Notwithstanding any other provision of your SPD, the provisions below shall apply. In the event of a conflict between the provisions of any section of your SPD and the provisions of this Summary of Material Modifications ("SMM"), the provisions of this SMM shall prevail.

1) Removal of Lifetime Maximum Benefit

The Lifetime Maximum Benefit of $2,000,000 for all illnesses and injuries, per Covered Person, as outlined in your Schedule of Benefits and your SPD, has been removed. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to re-enroll in the plan. Individuals have 30 days from the date of this notice to request re-enrollment. For more information, contact the Claims Administrator's Customer Service Department at 866-557-8751.

2) Removal of Dollar Limits on Benefits

Private Duty Nursing

The monthly dollar limit of $1,000 per month for Private Duty Nursing as outlined in your Schedule of Benefits and as referenced in your SPD has been removed. Consequently, any reference to monthly dollar limits for this benefit category in the Schedule of Benefits or in the Covered Medical Expenses section of your SPD is hereby deleted effective January 1, 2011.

Chiropractic Services

The $500 contract year maximum for Chiropractic Services as outlined in your Schedule of Benefits and as referenced in your SPD has been removed. Consequently, any reference to a contract year dollar limits for this benefit category in the Schedule of Benefits or in the Covered Medical Expenses section of your SPD is hereby deleted effective January 1, 2011. This benefit will continue to be subject to a limit of 20 visits per contract year

3) Extension of Coverage for Dependents

The **Eligible Dependents** Section of your SPD is deleted in its entirety and replaced with the following provisions:

ELIGIBLE DEPENDENTS

- Your legal spouse---See definition of "Spouse".
- Your children under age twenty-six (26)---See definition of "Child".
- Your children under age twenty-six (26) adopted by you or placed with you for adoption.
- Your children older than age twenty-six (26) but under the age of thirty (30) who (i) are Illinois residents, (ii) have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) have received a release or discharge other than a dishonorable discharged. (To be eligible for coverage as a dependent based upon prior military service, the eligible dependent must submit proof of such service using a DD2-14 (Member 4 or 6) "Certificate of Release or Discharge from Active Duty" form stating the date on which the dependent was released from the service.)
- A child you must cover due to a Qualified Medical Child Support Order (QMCSO) subject to the conditions and limits of the law.
- Your disabled children over age twenty-six (26) if the child was disabled prior to attaining age twenty-six (26). You must provide satisfactory proof of the child's incapacity and dependency within thirty-one (31) days after the child's twenty-sixth (26th) birthday. Continuing proof of disability and dependency will be required periodically.

Note: Anyone who is eligible for coverage as an employee will not be eligible for coverage as both an employee and as a dependent. Dependent children may not be covered by more than one employee. If both a husband and a wife are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage.

The **When Dependents Cease to be Eligible** Section of your SPD is deleted in its entirety and replaced with the following provisions:

WHEN DEPENDENTS CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

- In the case of all your Dependents, the date your coverage terminates or the Dependent ceases to be a Dependent as defined in this Plan.
- In the case of your Spouse, when you are legally separated or divorced.
- In the case of a Dependent Child, other than those who have served and been released or honorably discharged from the military, attaining age twenty-six (26).
- In the case of a Dependent child who has served and been released or honorably discharged from the military, attaining age thirty (30).
- In the case of a Disabled Child, when the Dependent is no longer disabled.
- The date the Dependent Coverage is discontinued under the Plan.
- If your Dependent materially violates the terms of the Plan.
- If your Dependent participates in fraudulent or criminal behavior.

Examples of fraudulent or criminal behavior include, but are not limited to:

- Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using an identification card to obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled.
- Allowing any other person to use an identification card to obtain services.
- Threatening or perpetrating violent acts against the Plan, a Provider, the Claims Administrator, or an employee of the Plan, Provider or Claims Administrator.

- If your Dependent knowingly misrepresents or gives false information on any enrollment application form which is material to the Plan's acceptance of such application.
- The date the Dependent enters the armed forces of any country on a full-time active duty basis.
- The end of the period for which you made any required contributions, if you fail to make any further required contributions.

Refer to the section in this Booklet entitled CONTINUATION RIGHTS for information regarding continued coverage after a Dependent ceases to be eligible under the Plan.

The following definitions of CHILD and DEPENDENT in the **Definitions of Terms** Section of your SPD are deleted in their entirety and replaced with the following provisions:

CHILD - The Employee's children under twenty-six (26) years of age. The term "Child" shall include natural children, a step-child, a foster child, a child related to the Employee by blood or marriage and for whom the Employee has assumed legal guardianship, a child whom the Employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law, or a legally adopted child (including the period of probation when the child is placed with the adopting parents), in the household of such Employee. The child's placement with the Employee terminates upon the termination of the legal obligation. A child who is physically or mentally incapable of self-support upon attaining age twenty-six (26) may be covered under the health care benefits, while remaining incapacitated, subject to the covered employee's own coverage continuing in effect. Such child will be considered a Covered Dependent if he was disabled either prior to his twenty-sixth (26th) birthday. To continue Covered Dependent status of a child under this provision, proof of incapacity must be received by the City within thirty-one (31) days after coverage would otherwise terminate. Additional proof will be required from time to time. Evidence satisfactory to the City of dependent eligibility under the Plan may be requested; for example, birth records or Federal Income Tax returns.

DEPENDENT - For the purposes of this Plan, the Employee's spouse and children to the age of twenty-six (26) (see definition of "Child") and disabled children, if such incapacity occurred prior to the limiting age specified.

The following definition of STUDENT in the **Definitions of Terms** Section of your SPD is deleted in its entirety:

STUDENT - Means the Employee's unmarried child under twenty-four (24) years of age attending an accredited educational institution who is enrolled for at least twelve (12) hours of credit in any one (1) semester of, if the institution is not organized on a semester system, the equivalent of twelve (12) semester hours. Full-time student status will continue during semesters when the Plan receives notification that the student is registered for the following semester. **Note: When benefits are paid on behalf of the student between semesters, and if the student does not resume attendance the following semester, benefits paid during this time will be the responsibility of the Employee and there will be monies due back to the Plan. The Plan will be immediately entitled to a complete recovery in full of all such benefits paid.** Proof of student status, verified by the school, is required within thirty (30) days of the child's twentieth (20th) birthday and at the beginning of each semester.

Notwithstanding the dependent eligibility requirements described in the **Eligible Dependents** section of your SPD, a child in your family is eligible to become a Covered Dependent if the child: 1) is under age 26, and 2) is related to you by one of the relationships listed in the eligibility section; a child's marital status will not be considered in determining eligibility for initial or continued coverage.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice of this notice. Enrollment will be retroactively to January 1, 2011. For more information, contact the Claims Administrator's Customer Service Department at 866-557-8751.

5) Notice of Grandfathered Health Plan Status

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 866-557-8751. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

All other provisions of the Summary Plan Description and Plan Document remain unchanged. The above changes become effective January 1, 2011, unless otherwise noted.

CITY OF MATTOON

By: Timothy D. Gover

Title: Acting Mayor

Date: 02-04-11