SUMMARY OF MATERIAL MODIFICATIONS No. 1

This modification is made as of **July 1, 2013**, by the **City of Rapid City** to the **City of Rapid City Medical and Dental Plans.** All other terms and provisions of the Plan remain unaltered and in effect.

Distribution of the attached amendment will be handled in the following manner:

_____ The Plan Administrator will print the attached amendment for distribution.

_____ First Administrators, Inc. will provide one copy of the attached amendment for the Plan Administrator to print and distribute.

_____ First Administrators, Inc. will print _____ copies of the attached amendment for distribution.

_____ Other:_____

The following text **replaces** the **"Mammogram Screening"** found in the **"Schedule of Benefits"** located within the current Summary Plan Description.

MEDICAL BENEFITS	IN NETWORK	OUT OF NETWORK	GENERAL PLAN LIMITS	PAGE
Mammogram Screening	70%	60%		

The following text **adds** the **"Effective Date and Waiting Period"** found in the **"General Information"** located within the current Summary Plan Description.

GENERAL INFORMATION		PAGE
Effective Date and Waiting Period	First day following one month after date of hire, with proper enrollment, subject to the provisions of Section 1.01	

The following text is **removed** from **"S5.03 Covered Expenses"** in **"Article V Medical Benefits"** section within the current Summary Plan Description.

~~**S5.17 MAMMOGRAPHY BENEFIT**~~

~~Baseline low dose mammography services are limited to one baseline mammogram for females ages 35 to 39, one every two years for ages 40 through 49, and one every year for ages 50 and above.~~

The following text is **removed** from **"Preferred Provider Organization Network"** in **"Plan Specifications"** section within the current Summary Plan Description.

~~***Outside South Dakota or Iowa:***~~

~~Beech Street Network~~
~~A current listing is available on the Internet at www.beechstreet.com.~~

The following text **replaces** the first 2 paragraphs in **"S1.01 Participant Eligibility"** section within the current Summary Plan Description.

An employee is eligible for medical, dental and prescription drug coverage if the employee works an average of 20 or more hours per week on a regular basis. Coverage begins after satisfaction of the waiting period shown in the Schedule of Benefits, completion of the enrollment application provided by the Plan Administrator, and authorization of payment of your cost of coverage, if any, through payroll deduction.

~~If the employee is eligible for coverage, but not actively at work on the day his coverage is scheduled to begin because of any reason other than his own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday~~

The following text **replaces "S2.01 Continuation of Coverage Under Federal Law - COBRA"** section within the current Summary Plan Description.

S2.01 CONTINUATION OF COVERAGE UNDER FEDERAL LAW – COBRA

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand your rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact City of Rapid City, which is the Plan Administrator.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.
COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information of the Plan is available in other portions of this Plan.

WHO IS ENTITLED TO ELECT COBRA? (SEE SECTION 2.04 RETIREE COVERAGE)

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because your hours of employment are reduced; or your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B or both) prior to his/her qualifying event; or
- you become divorced or legally separated from your spouse.

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- the parents become divorced or legally separated; or
- you stop being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage".)

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Benefit Services Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Benefit Services Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Benefit Services Administrator. Under federal law, you must have 60 days after the date the qualified beneficiary plan coverage

terminates, or, if later, 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan.

Mail the completed Election Form to:

COBRA Department
First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479

The Election Form must be completed in writing and mailed to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

Your election must be postmarked no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When you complete the Election Form, you must notify the Benefit Services Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the Benefit Services Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of COBRA may help avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you elect COBRA coverage and does not exhaust COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends

because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's loss of eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. (Also see Section 2.04.)

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Benefit Services Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Benefit Services Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Benefit Services Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE**.

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is available under the Plan when a covered employee becomes entitled to Medicare.)

The extension due to a second qualifying event is available only if you notify the Benefit Services Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full and on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the Benefit Services Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Benefit Services Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you

provide notice to the Benefit Services Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Benefit Services Administrator of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. City of Rapid City will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the Benefit Services Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period).

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

Your first payment and all monthly payments for COBRA coverage must be made payable to City of Rapid City and mailed to:

COBRA Department
First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479

Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election). You are responsible for making sure that the amount of your first payment is correct. You may contact the Benefit Services Administrator to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and has made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Benefit Services Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of that month's grace period. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim(s) you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, **YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN**.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the City of Rapid City during the covered employee's period of employment with City of Rapid City is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

You may obtain information about the Plan and COBRA coverage on request from:

COBRA Department
First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479

(800) 410-4129 (Toll Free)

OR -

City of Rapid City
Human Resources
300 Sixth Street
Rapid City, SD 57701

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

The following text **replaces "S10.03 Appealing a Claim"** in **"Article X General Information"** section within the current Summary Plan Description.

HOW TO FILE AN APPEAL

Claim Inquiry

If a claim has been wholly or partially denied, and if the claimant does not agree with the decision, or if the claimant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the claimant has the right to a full and fair review. An adverse benefit determination is a denial, reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the Notification of Decision. This request must be submitted within 180 days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the "Urgent Care Claims" section below.

The claimant may submit written comments, documents, or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in the participant's case will be consulted. If the decision on appeal is adverse, he/she may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the claimant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

Notification of the decision on appeal will be provided within 72 hours of the plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within 30 days of the plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within 60 days of the plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the plan that will describe:

(a) specific reason(s) for adverse determination;

(b) reference to the specific plan provision(s) on which determination is based;

(c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to, and copies of all documents, records and other information relevant to the participant's claim for benefits;

(d) a statement describing any voluntary appeal procedures offered by the plan and the participant's right to obtain information about such procedures, as well as the right to bring civil action as described in ERISA Section 502(a);

(e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request;

(f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request.

External Review

If the participant has exhausted his/her appeal process regarding a denial of benefits based on medical necessity, the participant's provider, acting on his/her behalf, may request an external review of our decision

If the participant authorized their provider to act on their behalf, this authorization must be in writing, signed by the participant, and include all the information required in our authorized representative form.

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102-0479

EXTERNAL REVIEW

You have the right to request an external review of a final adverse determination involving a covered service when the determination involved:

(a) Medical necessity;

(b) Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment;

(c) Experimental or investigational services or supplies;

(d) Continued stay or admission to a facility; or

(e) A rescission of coverage.

The Benefit Services Administrator shall complete a preliminary review of a request for external review to determine if the individual is or was covered under the plan at the time the service was incurred, whether the participant has exhausted the plan's internal appeal process, and whether the participant has provided all the information and forms required to process the external review.

(a) The Benefit Services Administrator will assign an independent review organization (IRO) to conduct the external review, with review assignments rotated among the available IROs.

(b) You will be advised of the name of the IRO and will then have 10 business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date the plan receives your request for an external review.

Expedited External Review:

An expedited external review process is available in these circumstances:

(a) The participant does not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if he/she has a medical condition for which the time frame for completing an internal appeal or for completing a standard external review would seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function.

(b) The participant may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, continued stay, or service for which the participant received emergency services, and has not been discharged from a facility.

(c) If the adverse benefit determination is that the service or treatment is experimental or investigational and the participant's treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, the participant may also have the right to request an expedited external review.

Assistance and Legal Action

You may contact the South Dakota Division of Insurance at any time for assistance with the appeal process at:

South Dakota Division of Insurance
445 E. Capitol Avenue
Pierre, SD 57501-3185
tel.: 605-773-3563

You may contact the customer service department at First Administrators, Inc. at the toll free number on your identification card.

You may not start legal action against us prior to the expiration of 60 days after receiving written notice of an adverse determination.

You shall not start legal action against us or the plan until you have exhausted the appeal process.

CITY OF RAPID CITY

_____ _____
(Authorized Signature) (Date)

_____ _____
(Printed Authorized Signature) (Title)