SUMMARY OF MATERIAL MODIFICATIONS No. 2

This modification is made effective **July 1, 2011,** 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 be responsible for distribution.

_______ First Administrators, Inc. will provide a formal copy of the amendment to the Plan Administrator for distribution.

_______ First Administrators, Inc. will provide the Plan Administrator with ________ copies of the amendment for distribution.

_______ Other:____

The following **"Grandfathered Health Plan Disclosure"** is **added** following the **"Plan Specifications"** page of the current Summary Plan Description.

GRANDFATHERED HEALTH PLAN DISCLOSURE

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 essential 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. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

The following **"Dental Services Covered Under The Medical Plan"**, **"Hospice Care"**, **"Limited Wellness Benefits"** and **"Outpatient diagnostic x-ray and laboratory services"** are **replaced** and **"Bereavement Care"** is **added** in the **"Schedule of Benefits"** in the current Summary Plan Description.

MEDICAL BENEFITS	IN NETWORK	OUT OF NETWORK	GENERAL PLAN LIMITS
Bereavement Care	70%	60%	
Dental Services Covered Under The Medical Plan	70%	60%	
Hospice Care	70%	60%	
Limited Wellness Benefit	*100% up to $200 then 70%	60%	Deductible waived for in and out of network. *Limited to $200 in network maximum paid per calendar year. In network charges that exceed the calendar year maximum will be subject to coinsurance.
Outpatient diagnostic x-ray and laboratory services	70%	60%	Deductible waived for dependent child.

The following **"Lifetime Maximum"** is **removed** from the **"Schedule of Benefits"** page of the current Summary Plan Description.

~~MEDICAL PLAN'S MAXIMUM LIABILITY~~	
~~Lifetime Maximum~~	~~$2,000,000 except as limited herein~~

SUMMARY OF MATERIAL MODIFICATIONS No. 2

The following **replaces** the **"Dependent Unmarried Child Maximum Age"** section in the **"General Information"** section within the Summary Plan Description.

Dependent Child Maximum Age *See Article IX for definition of Dependent.*	Covered to age 26. ***Dependent full-time students who reach age 24 on or after July 1, 2007***: coverage will continue to age 29, with an option to purchase single continuation coverage for up to 36 additional months.

The following Bullet (F) is **removed** from the first paragraph and Bullet (E) is **removed** from the second paragraph in the **"S1.04 Termination of Coverage"** section within the Summary Plan Description.

~~F. the date the participant receives the lifetime maximum benefit, as specified in the Schedule of Benefits.~~

~~E. the date the dependent receives the lifetime maximum benefit, as specified in the Schedule of Benefits.~~

The last paragraph in **S1.03 "Late Enrollment"** is **replaced** in the current Summary Plan Description.

Late applicants, individuals over age 18 and not eligible for a special enrollment period, are subject to an 18 month exclusionary period. At the end of the 18 month exclusionary period late applicants are eligible to join the Plan with no Pre-Existing Condition Exclusion Period. A formal application, available from the participant's employer, must be completed to begin the 18 month exclusionary period.

The fifth paragraph in the **"Dependent Beneficiary"** section found in **S1.05 "Special Enrollment Periods"** is **replaced** in the current Summary Plan Description.

Enrollees over age 18, joining the Plan through a special enrollment period are subject to the Pre-Existing Condition Exclusion Period outlined in Section 1.09, including the right to demonstrate Creditable Coverage.

The first paragraph is **replaced** and the eighth paragraph is **removed** in **S1.09 "Pre-Existing Condition Exclusion Period"** in the current Summary Plan Description.

S1.09 PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants or dependents with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's or dependent's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's or dependent's date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information. This pre-existing condition exclusion period will not be applied to any participant or dependent under age 19 and never applies to pregnancy, regardless of whether the woman had previous coverage.

~~The pre-existing condition exclusion period never applies to pregnancy, regardless of whether the woman had previous coverage. In addition, a pre-existing condition exclusion period will not be applied to a newborn, an adopted child who is under age 18 at the time of the adoption, or a child placed for adoption who is under age 18 at the time of placement for adoption, if the child becomes covered under a group health plan or other creditable coverage within 30 days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of 63 or more consecutive days.~~

SUMMARY OF MATERIAL MODIFICATIONS No. 2

The following text **adds S1.10 "Fraud or Misrepresentation of Material Facts"** in the **"Coverage and Eligibility"** section within the current Summary Plan Description.

S1.10 FRAUD OR MISREPRESENTATION OF MATERIAL FACTS

Coverage will terminate immediately if a participant uses this Plan fraudulently or fraudulently misrepresents a material fact in his/her application.

If coverage is terminated for fraud or misrepresentation of a material fact, the Plan has the right to recover any/all claim payments and retains the right to pursue any/all other legal rights, including the right to bring a civil action.

The following text is **added** to **S5.03 "Other Covered Services"** within the current Summary Plan Description.

Bereavement services.

The following **removes "S5.14 Maximum Benefit"** in the current Summary Plan Description.

~~**S5.14 MAXIMUM BENEFIT**~~

~~The maximum lifetime benefit per covered person which applies across all plans or options sponsored by the employer for all eligible expenses under this Plan is as shown in the Schedule of Benefits.~~

The following **removes "S5.24 Bereavement Benefit"** in the current Summary Plan Description.

~~**S5.24 BEREAVEMENT BENEFIT in connection with hospice care**~~

~~Eligible bereavement service expenses of a participant or covered dependent by a family unit for bereavement will be covered, provided that on the day immediately prior to death, the terminally ill person was a participant or covered dependent and in a hospice care program covered by this Plan.~~

~~Bereavement services means supportive services provided after the death of the terminally ill person, by the members of the hospice team, in counseling sessions with the family unit.~~

~~Exclusions listed in this Plan apply to this benefit.~~

The following **replaces** bullets E and F in **"S5.30 Dental Services Covered Under Medical Benefits"** in the current Summary Plan Description.

E. Treatment of Temporomandibular Joint (TMJ) dysfunction including surgical treatment, appliance therapy, anesthesia, medications, x-ray, and laboratory tests when recommended by both a dentist and a medical doctor.

F. Orthognathic surgery if determined to be medically necessary. Treatment must be for a functional problem not a cosmetic problem.

The following **replaces "S5.31 Limited Wellness Benefit"** in the current Summary Plan Description.

S5.31 LIMITED WELLNESS BENEFIT

An annual routine physical examination for participants and covered dependents will be paid as stated in the Schedule of Benefits. Benefits include immunizations, physician fees, x-ray and laboratory fees.

SUMMARY OF MATERIAL MODIFICATIONS No. 2

The following **replaces** the first nine paragraphs in the **"Dependent"** definition in the **"Definitions"** section within the Summary Plan Description.

DEPENDENT

The term dependent means the spouse of the participant, if not divorced, and

A. natural children;
B. stepchildren;
C. legally adopted children;
D. foster children;

of the participant or spousefor whom an application for coverage hereunder has been submitted to the Plan as required..

When an application for coverage hereunder has been submitted to the Plan as required, for any participant's natural child, stepchild, or legally adopted child for whom the parent participant or his current spouse is required by court decree or Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage, such child shall remain a dependent under this Plan until he attains the age specified in the court decree or order.

"Stepchild" shall mean any natural or adopted child of any employee's current spouse, and any natural or adopted child of a former spouse of the employee living in the employee's home in a familial relationship if the natural parents of that natural or adopted child are both deceased.

"Adopted child" shall mean any child taken into the participant's family legally and for whom the participant is legally responsible.

"Foster child" shall mean a child whom the employee is raising as his/her own, who resides in the employee's home, who is chiefly dependent on the employee for support and for whom the employee has full parental responsibility and control. A foster child must have been placed in the employee's home by the appropriate governing authority.

In the event a child who is an unmarried dependent as defined herein is incapable of self-sustaining employment by reason of permanent handicapping mental or physical disability and chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he turns the age specified in the Schedule of Benefits, coverage will continue as a dependent until the participant, for any reason, discontinues his coverage hereunder; he is no longer considered an eligible participant; the Plan is canceled; or the disability no longer exists as determined by the Plan. Satisfactory evidence of such disability and dependency may be required by the Benefit Services Administrator. Such evidence must be received within 31 days of the dependent's normal termination date, with a request from the Plan participant for coverage to continue.

In the event a dependent child between the ages of 26 and 29 and a full-time student was married and after divorce meets all other criteria established by this Plan, such child may be covered under this Plan only after submitting a written request for late enrollment as required in Section 1.03 of the Plan.

Eligible dependents (see *Dependent Child Maximum Age* in the Schedule of Benefits) enrolled fulltime in an accredited college or university must submit proof of enrollment. The student must be considered fulltime as defined by the institution in which the dependent is enrolled. A letter from the registrar indicating proof of fulltime enrollment must be submitted every semester or quarter.

In the event an eligible dependent child, between the ages of 26 and 29, discontinues as a full-time student, he will no longer have coverage and will have the option to purchase individual coverage as stated in the Schedule of Benefits. If that dependent has completed the spring semester/quarter as a full-time student, he will have coverage through September 1 of the current year, and may elect continuation thereafter.

SUMMARY OF MATERIAL MODIFICATIONS No. 2

The following **"S10.14 Misrepresentation"** is **removed** in the current Summary Plan Description.

~~S10.15 MISREPRESENTATION~~

~~Any material misrepresentation on the part of the Plan Administrator or the participant in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.~~

CITY OF RAPID CITY

(Authorized Signature)	(Date)
(Printed Authorized Signature)	(Title)