RESOLUTION TO AMEND
THE CITY OF RAPID CITY HEALTHCARE BENEFIT PLAN

PLAN AMENDMENT NO. 16

The **City of Rapid City** hereby amends its Healthcare Plan adopted July 1, 1990, restated April 1, 2000, with such amendment being effective October 1, 2001 at 12:01 a.m. standard time.

The Plan shall be amended as follows:

In the Schedule of Benefits Optional Items that May Save You Money section, the Providers language of the TLC Advantage Network section shall be **replaced** with the following language:

Preferred Provider Networks:

- Providers — Various discounts applied to eligible claims submitted by participating providers. Provider list is available, as a separate document, at no charge from employer.

The balance of the Schedule of Benefits shall remain as previously adopted.

The first two paragraphs of Section 4.06 "Pre-Existing Conditions" shall be **replaced** with the following language:

> In the event medical advice, diagnosis, care, or treatment was recommended for or received by the participant or dependent covered under this Plan in the 90 days prior to his eligibility date, coverage for the allowable condition that was treated shall begin after a period of 12 consecutive months after the eligibility date, with or without medical treatment for the Pre-Existing Condition. **Eligibility date** is defined as the earlier of the first day of coverage in the Plan or the first day of the waiting period.

The balance of Section 4.06 shall remain as previously adopted.

Section 4.15 "Continuation of Benefits" shall be **replaced** with the following language:

D4.15 CONTINUATION OF COVERAGE UNDER FEDERAL LAW - COBRA

This Plan is in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as then constituted and later amended. This Act allows terminated employees and qualified beneficiaries to continue with the group coverage under certain conditions. COBRA continuation coverage is not available to any participant except as required by the rules under the Internal Revenue Code. The health care continuation requirements of COBRA were added as parallel provisions to the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act and the Internal Revenue Code.

If coverage under this Plan would otherwise cease due to the termination of employment, you and your covered dependents may continue with this Plan for a period of eighteen (18) months, provided your employment ends for any reason other than "gross misconduct." You may also continue coverage if the number of hours you work is reduced below the minimum required for participation in this Plan.

If you elect COBRA coverage, it will begin on the date following your termination under this Plan, subject to COBRA guidelines specified in this Plan, and it ends on that calendar date eighteen (18) months later.

Disability Extension

If you or a dependent are disabled, there are guidelines and circumstances under which you may qualify for an extended period of continuation coverage:

1. you or your dependent must file with, and be certified as disabled by, the Social Security Administration for a disability which exists at any time during the first sixty (60) days of COBRA continuation of coverage. This certification must be in writing and must be received from the Social Security Administration prior to the end of the original eighteen (18) months of continuation of coverage and provided to the Plan Administrators;
2. you and/or your dependent will then be eligible for an extension of an additional eleven (11) months, for a total COBRA continuation of coverage period of twenty-nine (29) months;
3. you must notify the Plan Administrator within sixty (60) days after the day of your Social Security disability certification and prior to the end of the original eighteen (18) months of continuation coverage.
4. 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 thirty (30) days following recovery. **Example:** If disability ends June 10, you will be covered through the month of July (7/31).

Length of COBRA for Dependents

A spouse or dependent child may continue with this Plan for a period of thirty-six (36) months if coverage would otherwise cease due to the occurrence of one of the following qualifying events:

1. the employee and his/her spouse have become divorced or legally separated;
2. the employee has started receiving benefits under Medicare (Title XVIII of the Social Security Act). When this is the original qualifying event, the period of continuation coverage begins on the date the employee becomes entitled to Medicare;
3. a dependent child(ren) is no longer considered dependent by this Plan's eligibility rules; or
4. if your group covers retired employees and a proceeding is commenced under federal bankruptcy law regarding the employer from which the covered employee retired, the retiree may be eligible to continue coverage throughout his or her life. Following the retiree's death, eligible dependents may be eligible to continue coverage for up to 36 months if the retiree's death is after the coverage loss due to the former employer's bankruptcy, and indefinitely if the retiree's death is before the coverage loss due to the former employer's bankruptcy.
5. The dependent's COBRA coverage ends on that calendar date thirty-six (36) months after the date of the qualifying event.

In the event of the employee's death, the spouse or dependent child(ren) may continue coverage with this Plan beyond the thirty-six (36) month period as determined by the criteria established by the City of Rapid City.

Election Period

You must notify your employer within sixty (60) days if you become divorced or legally separated, when a dependent child ceases to be an eligible dependent as defined by this Plan. The COBRA election period will not end before the date that is sixty (60) days after the later of:

1. the date that the qualified beneficiary would lose coverage due to the qualifying event; or
2. the date the qualified beneficiary is sent notice of his or her right to elect COBRA continuation of coverage.

An election is considered to be made on the date it is sent to the employer or the Plan Administrator.

This COBRA continuation coverage may be extended when certain multiple qualifying events occur.

Multiple Qualifying Events

Multiple qualifying events occur when an 18-month qualifying event is followed by a 36-month qualifying event, except for the filing of a bankruptcy proceeding or a termination following a reduction in hours of employment. If this happens, the original 18-month period is extended for your dependents to thirty-six (36) months *from the date of the first event.* The extension applies to individuals who were qualified beneficiaries under this Plan as of the first qualifying event *and* were covered under this Plan at the time of the second qualifying event. For participants on COBRA continuation coverage, newborn dependent children and newly acquired adopted children, or a child placed for adoption, under the age of 19 are considered qualified beneficiaries for this provision, if they are born to or adopted by, or been placed for adoption with the covered employee during the original 18-month continuation coverage period.

For example, a married employee terminated employment, and the employee and spouse lost their coverage. Both elected COBRA continuation coverage. If another event (such as death, divorce) were to occur during the 18-month period, the 18-month period would be extended to thirty-six (36) months for the spouse, counted from the termination of employment. f the employee's spouse was not covered under this Plan at the time of the first event (termination of employment) but was added later (if permitted under the terms of this Plan), he or she would *not* be entitled to the extension to thirty-six (36) months because of the second event. Similarly, if the employee had been single at the time of the first event and married at the time of the second event, the spouse's coverage would not be extended, and, in fact, could be terminated after the second event. However, if there is a covered newborn dependent, newly acquired adopted child, or a child placed for adoption, as qualified beneficiaries, they would be entitled to the extension to thirty-six (36) months.

This rule is simply designed to extend an 18-month period to thirty-six (36) months in cases where the second event would have resulted in a 36-month continuation coverage period if the second event had occurred first.

COBRA and Medicare

If an active, covered employee becomes entitled to Medicare, all qualified beneficiaries are eligible for up to thirty-six (36) months of COBRA coverage *from the date of Medicare entitlement.* If a covered employee COBRA participant becomes entitled to Medicare during the period of continuation coverage, that entitlement is a qualifying event, and all qualified beneficiaries other than the employee are eligible for up to thirty-six (36) months of COBRA coverage *from the date of the original qualifying event.*

COBRA and Pre-Existing Conditions

Individuals who have elected to continue coverage under COBRA may continue their COBRA coverage, in addition to a new group benefit plan with entitlement after the COBRA election date, if the new Plan contains an enforceable limitation on pre-existing conditions. The coverage may be retained for the time period during which benefits would be denied or limited under the pre-existing clause or until the occurrence of an event which would terminate COBRA continuation coverage, whichever happens sooner.

COBRA Premiums

The cost of the continuation coverage will be approximately equal to the "applicable premium" (plus an administration fee) that is provided to other employees and/or beneficiaries under the group benefit Plan whose coverage continues to be maintained by the employer. If you are disabled, the law allows this Plan to charge up to 150% of the applicable premium during the extended eleven (11) months of

coverage. The 150% premium for disabled qualified beneficiaries can also be charged to any qualified beneficiary receiving extended coverage as a result of the disability. You will be required to pay applicable premiums on a monthly basis.

Termination Events

The COBRA continuation period for you and the qualified beneficiaries will end on the earliest of the following dates:

1. the date your maximum allowable coverage period under COBRA is exhausted;
2. the date the Plan Administrator or employer ceases to provide any group health plan (including successor plans) for all employees;
3. the first day (including grace periods, if applicable) on which timely payment is not made;
4. the day such individuals become covered under any other benefit plan maintained by an employer if entitlement to the other benefit plan is after the COBRA election date (unless the group benefit plan contains an enforceable pre-existing condition provision as previously explained); or
5. the date such individuals become entitled to Medicare when Medicare entitlement follows the COBRA election date.
6. In the case of Social Security disability certification, the COBRA continuation period will end the first of the month beginning more than thirty (30) days after such individuals are no longer certified disabled by the Social Security Administration, or sooner, if for any of the reasons stated in (1) through (5) above.

Section 4.16 shall be **added** to the Plan as follows:

D4.16 RETIREE COVERAGE

A continuation of benefits may be purchased by surviving spouses and children due to death, or participants under the retirement option, and meeting the criteria established by the City of Rapid City.

The first paragraph in Section 9.27 "Qualified Medical Child Support Order (QMCSO)" shall be **replaced** with the following language:

As required by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), this Plan will recognize QMCSOs by providing benefits for Plan participant's children, who are the subjects of such orders, without regard to Plan limitations requiring that participants have custody of the children or that the children are designated as the participant's dependents for tax purposes. A QMCSO is a judgment, decree or order issued by a court, domestic relations magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act (for Medicaid purposes). A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect. A medical child support order must have the following elements to be considered a QMCSO:

The balance of Section 9.27 shall remain as previously adopted.

The title and first paragraph of Section 10.11 "Subrogation" shall be **replaced** with the following language:

D10.11 RIGHT OF SUBROGATION AND REIMBURSEMENT

In the event of any payment of benefits under this Plan on behalf of a participant or dependent, the Plan shall be subrogated to all of the participant's or dependent's rights of recovery of those benefits against any responsible party, its insurance company or other employee benefit plan. The participant or dependent agrees that any payment or payments under the Plan for such benefits shall be made on the condition and with the understanding that the Plan will be reimbursed first when recovery is made.

The participant or the dependent must agree that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims incurred as the result of the illness or injury, regardless of whether the participant or dependent is made whole. **The participant or the dependent agrees to cooperate with the Plan and do whatever is necessary to secure those rights including, but not limited to, signing a subrogation receipt consistent with the provisions of this paragraph in favor of the Plan in exchange for the Plan's payment of benefits.** The participant or dependent further agrees to cooperate and sign all additional documents reasonably necessary for the Plan to enforce its subrogation receipt. The participant or dependent further agrees to do nothing which would prejudice those rights including, but not limited to, signing any release or waiver of those rights without obtaining the prior written consent or written approval of the Plan Administrator. The Plan will not be responsible for the participant's or the dependent's attorney fees or any other costs unless the Plan has previously agreed in writing to pay such fees or costs. It is further agreed that in the event the participant or dependent fails to take the necessary legal action to recover from the responsible party, the Plan shall have the option to do so and may proceed in its name or the name of the participant or dependent against the responsible party and shall be entitled to the recovery of the amount of benefits paid under the Plan and the expenses, including reasonable attorney fees, incurred for such recovery. In the event the Plan recovers an amount greater than the benefit paid, the excess, reduced by the expenses of recovery, including reasonable attorney fees, will be paid to the participant. The Plan shall have the right, with prior notice to, but without the consent of the participant or dependent, to compromise the amount of its claim if, in its reasonable opinion, it is appropriate to do so.

The balance of Section 10.11 shall remain as previously adopted.

The first paragraph of Section 10.25 "Funding" shall be **replaced** with the following language:

This is a partially self-funded group healthcare plan. Contributions made to this Plan are used to pay claims and associated expenses of this Plan. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) the each covered Participant.

If your employer is unable to fund this Plan, you may be financially responsible for any incurred and unpaid claims. The Claims Administrator assumes no financial liability.

Section 10.26 shall be **added** to the Plan as follows:

D10.26 <u>RELEASE OF INFORMATION</u>

The Claims Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Claims Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

Section 10.27 shall be **added** to the Plan as follows:

D10.27 <u>NONDISCRIMINATION STATEMENT</u>

In addition, this Plan may not discriminate against you based on: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in

the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable cost-sharing amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

Passed this _______ day of __________________, 2001.

THE CITY COUNCIL

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Jerry Munson, Mayor

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Finance Officer