RESOLUTION TO AMEND
THE CITY OF RAPID CITY HEALTHCARE BENEFIT PLAN

PLAN AMENDMENT NO. 21

The **City of Rapid City** hereby amends its Healthcare Plan adopted July 1, 1990, restated March 1, 2002, with such amendment being effective January 1, 2004 at 12:01 a.m. standard time.

The Plan shall be amended as follows:

The following language shall be **deleted** from the *Schedule of Benefits*:

> ***Your deductible will be reduced 15% when you use the TLC Advantage Medical Care Network. The 15% reduction does not apply to prescriptions or the $50 co-pay per Hospital emergency room visit.***

In the *Schedule of Benefits*, the Deductible and Coinsurance Percentage shall be **replaced** with the following language:

	IN NETWORK SERVICES	**OUT OF NETWORK SERVICES**
Individual Deductible	$300 per person per calendar year, plus $50 co-pay per Hospital emergency room visit.	
Family Deductible	$600 per family per calendar year, plus $50 co-pay per Hospital emergency room visit.	
Coinsurance Percentage - The percentage the Plan pays of the first $5,000 per individual or $10,000 per family of eligible expenses per calendar year after satisfying the deductible, then 100% thereafter to the end of the calendar year unless otherwise specified.	70%	60%

> ***Note:*** *The deductible and coinsurance are integrated for both in and out of network services.*
> *The In-Network coinsurance percentage will apply to "Emergency Medical Services" if the person is unable, due to his or her condition, to receive treatment from a participating provider. See Article IX for definition of Emergency Care.*

The following language shall be **added** to the *Schedule of Benefits*:

Office Visits *(Includes Chiropractic Care*)	$20 co-pay per visit, then subject to deductible and coinsurance. X-ray and lab charges are not subject to the $20 co-pay.

In the *Schedule of Benefits*, the Prescription Drugs benefit shall be **replaced** with the following language:

Prescription Drugs *See Section 4.02.*	25% co-pay per prescription.

> ****Note:*** *Co-pays do not accumulate toward satisfaction of the deductible or coinsurance limit.*

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

Section 4.02 “Prescription Drugs” shall be **replaced** with the following language:

The Maximum Allowable Fee will be paid less a 25 percent co-pay per prescription to participating pharmacies and/or drug stores. Participants must present the proper identification and sign a receipt for each prescription received from a participating pharmacy, and pay the applicable co-pay before the prescription is received. Retail prescription drugs may be filled up to a 30 day supply per prescription. Maintenance medication prescriptions may be filled up to a 90 day supply when prescribed by a physician.

When a generic equivalent is available and you purchase the brand name drug you will have to pay the difference in price between the maximum allowable fee for the generic drug and the average wholesale cost for the brand name drug, in addition to the co-pay.

Generic drugs should be used whenever there is a generic equivalent for the drug you are taking. A generic equivalent means a prescription drug available from more than one drug manufacturer which has the same active therapeutic ingredient as a brand or trade name prescription drug.

Maintenance prescriptions refer to a drug treatment appropriate to control a specific ongoing condition. The drug may be required for a long time, even a lifetime. When practitioners write prescriptions, they indicate whether refills are allowed and, if so, how many. You may not receive benefits for a refill if:

- Sufficient time has not elapsed since the last prescription was filled. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner;
- The refill is to replace medications that have been lost, stolen, or used inappropriately;
- The refill is in excess of the number authorized by the practitioner; or
- The refill is limited by state law.

Items Covered:

A. Drugs or medicines authorized to be distributed by prescription;

B. Oral and injectable contraceptives (which may be a three month supply);

C. Compounded medication of which at least one ingredient is a prescription legend drug;

D. Insulin and insulin needles/syringes, test strips and tablets, and lancets;

E. Prenatal vitamins;

F. Smoking cessation products requiring a prescription.

Items NOT Covered:

A. Drugs or medicines, except for insulin, which are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;

B. Prescription drugs which may be properly received without charge under local, state, or federal governmental programs, including Worker's Compensation or similar laws;

C. Refilling of a prescription in excess of the number specified by the Physician, or any refill dispensed after one year from the date of order of the Physician;

D. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use (see Section 5.03 for coverage for diabetic supplies);

E. Drugs labeled: "Caution--limited by federal law to investigational use," or experimental drugs, even though a charge is made.

F. Vitamins, except prenatal vitamins;

G. Infertility drugs with no other approved indication;

H. Drugs for cosmetic purposes, such as Minoxidil (Rogaine), Eflornithine (Vaniqa), and Tretinoin (Retin A). Retin A for non-cosmetic purposes requires prior authorization for covered persons over age 35;

I. Drugs for weight loss and appetite suppressants.

Refer to the Exclusions Section of this Plan for additional limitations.

The Maximum Allowable Fee means the lesser of the normal cash price or an amount established as our maximum allowable fee for the same drug. The maximum allowable fee is determined as follows:

> The maximum allowable fee is developed from the average wholesale price (AWP), less a percentage of the price, plus a fixed dispensing fee or from the maximum allowable cost (MAC), where applicable, plus a fixed dispensing fee. The AWP is an industry-wide standard based on national surveys of drug pricing for brand name drugs. The MAC is an industry-wide standard based on national surveys of drug pricing for generic drugs.

Prior authorization may be required for some drugs. Prior authorization allows a drug that is not normally covered by the Plan to be covered if it is part of a specific treatment plan for an illness or injury.

Examples of drugs that may require prior authorization:

1. Retin A, if you are over 35 years of age,
2. Oral contraceptives for purposes other than contraception, if your plan does not cover them,
3. Gonadoptropin-releasing hormone (GnRH) analogs
4. Viagra and similar drugs used for sexual dysfunction

This list is not all inclusive and could change at any time.

To obtain prior authorization, you or your health care provider must request the prior authorization by calling or writing to the Benefit Services Administrator with the following information:

- name and age of patient;
- participant's name, group number, and identification number;
- name of drug and dosage;
- The reason the drug should be covered, and
- The length of time the drug should be covered.

Exclusion D8.04 shall **replaced** with the following language:

D8.04 Charges for or in connection with any injury or illness arising out of or in the course of any occupational activity wherein the participant is required, by state law, to be covered by worker's compensation insurance.

Section 9.35 “Morbid Obesity” shall be **replaced** with the following language:

The term “Morbid Obesity” shall mean all of the following are true:

A. You have been considered morbidly obese by your treating physician for at least five years and have been recommended by the treating physician for the procedure;
B. Your body mass index (BMI) is 43 or greater; and
C. Have participated in documented non-surgical methods of weight loss that have been supervised by a physician for at least three years without success; and
D. Prior to the procedure participated in psychological evaluation and educational counseling session(s) about the procedure;
E. You have two or more of the following documented medical conditions or have documented evidence of two or more of the following in your family history:
    1. Hypertension requiring medication
    2. Cardiovascular disease
    3. Congestive heart failure
    4. Cardiomyopathy
    5. Atherosclerosis
    6. Dyslipidemia, hypercholesterolemia, hypertriglyceridemia
    7. Insulin dependent diabetes
    8. Sleep apnea
    9. Osteoarthritis of weight bearing joints

Surgical treatment for morbid obesity must be provided by an in network physician at an in network facility.

Surgical and non-surgical treatment of morbid obesity are eligible expenses under the Plan only when the covered person meets the guidelines outlined above.

The following definition shall be **added** to Article IX “Definitions”:

D9.37 EMERGENCY CARE

The term “Emergency Care” shall mean emergency service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result in:

A. Placing the patient’s health in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

The balance of Article IX shall remain as previously adopted.

Passed this _____ day of _____, 2003.

THE CITY COUNCIL

_____
Jim Shaw, Mayor

_____
Finance Officer