No. CC120103-06

RESOLUTION TO AMEND
THE CITY OF RAPID CITY HEALTHCARE BENEFIT PLAN

PLAN AMENDMENT NO. 23

The **City of Rapid City** hereby amends its Healthcare Plan adopted July 1, 1990, restated March 1, 2002, with such amendment being effective retroactive to July 1, 2003 at 12:01 a.m. standard time.

The Plan shall be amended as follows:

Article III "Mandatory Cost Containment Program" shall be **replaced** with the following language:

D3.00 COST CONTAINMENT PROGRAMS

This Healthcare Benefit Plan includes mandatory procedures which require hospitalizations to be reviewed prior to admission to any hospital for any reason (Urgent Admissions please see section 3.02). **The Utilization Review Company's name and telephone number are listed on Page 4, Plan Specifications, of this booklet and on the front of your identification card.**

Utilization review is not required (but is recommended) for hospital admissions for childbirth if the length of stay for the mother and newborn child does not exceed 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Utilization review is required for maternity stays that exceed 48 hours for a vaginal delivery or 96 hours for cesarean delivery. (See Section 5.16 for details.)

Hospital utilization review does not guarantee benefits under this Plan. Utilization review merely means the length of stay requested is consistent with the diagnosis. Actual benefits provided under this Plan are determined based on the provisions of the Plan, including the patient's eligibility to receive benefits. Please call First Administrators, the Claims Administrator, at 1-605-343-2509 to determine benefits under this Plan.

D3.01 UTILIZATION REVIEW

Prospective Reviews

To be eligible for maximum benefits under this Plan, you are required to take a few simple steps before admission to a hospital. When your doctor suggests that hospitalization is necessary for you or a covered member of your family, you will need to follow the steps outlined below. Please remember that all hospital admissions must be authorized before you enter the hospital.

When your physician says that you or a covered member of your family must go into the hospital for a non-emergency (elective) procedure, you or your physician must call the Utilization Review Company. It is your responsibility to advise your doctor of your pre-admission review requirement and to provide him with adequate information to obtain the utilization review. For pre-scheduled admissions, you or your physician should secure a review from the Utilization Review Company as soon as possible and before you or your dependent actually enter the hospital. **It is your responsibility to see that the Utilization Review Company is notified.** You should be prepared to provide the following information when calling:

- name, address, social security number, and age of patient
- employee's name, social security number, and the name of his/her employer
- date of hospital admission if applicable
- admitting diagnosis, planned procedure or treatment and proposed length of stay
- insurance plan name and your policy or social security number
- name, address and telephone number of the attending physician and the hospital.

The Utilization Review Company will respond to your request within 15 days of your telephone call. The 15 day decision period may be extended one time, up to an additional 15 days if more time is needed to make the determination due to reasons beyond the Utilization Review Company's control. You will be

notified prior to the expiration of the initial 15 day period of the circumstances requiring an extension of time and the date by which a decision can be rendered. If the extension is necessary because additional information is needed from you, the notice will specifically describe the information needed and you will have 45 days from receipt of the notice to provide the information.

If a request is received that does not meet the filing procedures, the covered person or their authorized representative will be notified within 5 days of the proper procedures to be followed in obtaining a utilization review. Notification will be provided by telephone or if requested, in writing.

Urgent Care Reviews

In the case of urgent care for you or a covered member of your family, your doctor, the hospital, or a family member must telephone the Utilization Review Company within 48 hours of urgent care or on the first business day following weekend or holiday care.

The Utilization Review Company will respond to your urgent care request within 72 hours of your telephone call. The determination will be provided orally unless written notification is requested.

If additional information is needed to make a determination, you will be notified within 24 hours of the specific information needed. A determination will be made within 48 hours of receipt of the requested additional information. If the additional information is not received within 48 hours, the request may be denied.

Retrospective Reviews

If the Utilization Review Company reviews medical treatment or services after you have received them, a decision will be made within a reasonable period of time, but no later than 30 days after your request is received.

The Utilization Review Company may extend this 30-day period, only once, up to an additional 15 days if:

1. It is determined that an extension is necessary due to matters beyond their control; and
2. You are notified prior to the expiration of the initial 30-day period.

You will be informed of the circumstances requiring the extension and the date by which a determination can be rendered. If the extension is required because you failed to provide all the information necessary to reach a determination, the notice of extension will describe the required information still needed to complete the request. You will be given at least 45 days from the day you receive their request to provide the information.

Concurrent Reviews

The Utilization Review Company will monitor all hospital stays by being in contact with the physician until the patient is discharged from the hospital. This service is automatically provided to all patients who have been certified under the pre-admission utilization review program.

If a request to extend treatment beyond the initial period of time is received within 24 hours prior to the expiration of the certified period of time, the Utilization Review Company will respond to your request within 24 hours of the request. Treatment shall continue, without penalty, until the covered person is notified of the determination. If ongoing treatment benefits are reduced or terminated before the end of such treatment, the participant will be notified sufficiently in advance to give ample time to appeal the decision before the reduction or termination goes into effect. See Section 3.55 of this Plan for an explanation of the appeals procedure.

Counting Time Periods

Under prospective and retrospective reviews, time periods are counted starting on the day the Utilization Review Company receives your request. If the review periods are extended either 15 or 30 days, respectively, because you failed to provide the appropriate information, the time period within which the

Utilization Review Company is required to complete their review is suspended until the earlier of: when the Utilization Review Company receives the additional information from you; or the 45-day time period the Utilization Review Company allotted you to submit the requested information has expired.

If you fail to submit the requested information, the Utilization Review Company may deny your request for approval of a medical treatment or service.

D3.10 PREGNANCY REVIEW

As soon as you or an eligible, covered dependent (see Section 5.16) know you are expecting (**within the first trimester or soon thereafter**), call the Utilization Review Company. Specialized nurses will monitor your pregnancy through delivery. An informative book will be mailed to the expectant mother. If complications arise during your pregnancy, you will be assisted in receiving the most cost-effective, quality care necessary.

D3.50 PENALTY FOR NON-COMPLIANCE

All eligible charges relating to hospital confinement, including hospital, doctor and diagnostic x-ray and lab expenses may be reduced by twenty-five percent (25%) up to a maximum of two hundred fifty dollars ($250) for any single hospitalization if the Participant or Dependent fails to comply with the requirements of this pre-admission utilization review program.

Any amount not payable as a result of this twenty-five percent (25%) reduction shall not be covered under any other benefit provision of this Plan.

Following the required process to use the Utilization Review Company's services as outlined in this Article will assure that you receive maximum hospitalization benefits for any admissions that are medically necessary. If you have questions or need more information contact the Utilization Review Company or First Administrators at 1-605-343-2509.

D3.55 RIGHT OF APPEAL

You have the right to a full and fair review in case of an adverse benefit determination in response to a pre-admission utilization review request or to a request for continued stay in a facility. An adverse benefit determination is one that denies or reduces benefits. See Section 10.03 of this Plan for an explanation of the appeals procedure.

D3.60 EXTERNAL ASSISTANCE

You also have the right to contact the South Dakota Division of Insurance at any time for assistance at the following address:

South Dakota Division of Insurance
118 West Capitol Avenue
Pierre, South Dakota 57501-2000
Telephone: 1-605-773-3563

The following language shall be **added** to Section 4.02 "Prescription 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 26 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 the Pharmacy Benefit Manager 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.

The Pharmacy Benefit Manager will respond to a request for prior authorization within 72 hours for medically urgent situations and 15 days for non-medically urgent situations.

If your request for prior authorization is denied in whole or in part, you have the right to a full and fair review of the adverse determination.

You must appeal an adverse determination within 180 days of the Pharmacy Benefit Manager's decision. To appeal an adverse determination, call the Pharmacy Benefit Manager. For appeals involving medical urgency, you may request an expedited appeal. In an expedited appeal, information, including the decision, will be communicated by telephone, or if you request, in writing.

In a medically urgent situation, notification of the decision on the appeal will be provided within 72 hours of receipt of the appeal. For non-urgent situations, response to the appeal will be provided within 30 days of the request.

The following language shall be **added** to Article IV, *Special Provisions*:

D4.55 PRIOR APPROVAL

This Plan requires prior approval before you receive certain services, supplies, or procedures. You or your health care provider must request prior approval from the Claims Administrator. Prior approval determines whether a proposed treatment plan is an eligible expense under the Plan. Without prior approval for certain services, a proposed treatment plan may not be a covered benefit.

Following is a list of services for which prior approval is required.

Jaw Surgery. See Section 4.52.

Morbid Obesity Surgery. See Sections 8.31 and 9.35.

Organ Transplants, including Bone Marrow/Stem Cell Transfers. See Section 4.08.

Temporomandibular Joint Disorders (TMJ). See Section 4.52.

At your request, your health care provider will request prior approval by submitting the appropriate information. The Claims Administrator will determine if the requested service is a covered expense under the Plan from the written information provided by your health care provider.

After reviewing your request, the Claims Administrator will notify you and your health care provider of the decision within 72 hours if your request involves a medically urgent situation or within maximum of 15 days in a non-medically urgent situation, unless additional information is needed.

- If your request is approved, you know your Plan covers the specific services or procedures. **Please note:** An inpatient admission for the approved procedure will then require precertification, see Article III of this Plan for pre-certification requirements.

- If benefits are denied, you will receive written notice in which the reason(s) for denial will be listed. The notice will be mailed to the most current addresses the Claims Administrator has on record for you and your health care provider.

Certain factors may alter or impact whether you receive approval. These factors include benefit limitations, continued Plan participation, and the date you receive services.

If your request for prior approval is denied in whole or in part, you may appeal the adverse determination as explained in Section 10.03 of this Plan.

The following language shall be **added** to Article IV, *Special Provisions*:

D4.65 CONCURRENT CARE

If ongoing treatment benefits are reduced or terminated before the end of such treatment, the participant will be notified sufficiently in advance to give ample time to appeal the decision before the reduction or termination goes into effect. See Section 10.03 of this Plan for an explanation of the appeals procedure.

In Article VIII, *General Exclusions*, the following exclusion shall be **deleted** from the Plan:

D8.11 Illegal use of narcotics or use of hallucinogens in any form, unless prescribed by a physician.

The balance of Article VIII shall remain as previously adopted.

The following language shall be **added** to Article IX, *Definitions*:

D9.41 PROSPECTIVE REVIEW

Utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a healthcare plan's requirement that the health care service or course of treatment, in whole or in part, be approved prior to admission or the service.

D9.42 CONCURRENT REVIEW

Utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.

D9.43 RETROSPECTIVE REVIEW

Any review of a request for a benefit that is not a prospective review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment.

The balance of Article IX shall remain as previously adopted.

Section 10.03 "Application and Identification Card" shall be **replaced** with the following language:

D10.03 APPEALING A CLAIM

There may be an occasion when you do not agree with the decision to deny or reduce benefits. You may want to appeal the decision. The appeal process, summarized below, allows you or someone acting on your behalf to request a first level appeal, expedited appeal, standard review, or second level appeal/voluntary review of the decision.

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please send your appeal request to First Administrators, Inc., PO Box 8150, Rapid City, SD 57709-8150.

First Level Appeal

You have the right to a full and fair review in case of an adverse determination. An adverse determination is the denial, reduction, or termination of a benefit. Types of adverse determinations include, but are not limited to, determinations involving:

- Medical necessity;
- Appropriateness of service, including level or effectiveness of treatment;
- Place of service;
- Experimental or investigational treatment;
- Contract limitation;
- Eligibility for coverage; or
- Concurrent review not involving an urgent care request.

You or your authorized representative may request a first level appeal by submitting a written grievance within 180 days after the date you were notified of an adverse determination.

Send your written grievance for a first level review to:

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.
Appeals/Compliance Department
PO Box 8150
Rapid City, SD 57709-8150
Telephone Number: 1-605-343-2509

Within three working days of receiving your appeal request, you or your authorized representative will be sent a letter specifying the name of the person, address and phone number where the review will be conducted. You have a right to submit written comments, documents, records, and materials relating to the appeal as well as the right to receive, upon request and free of charge, copies of all relevant documentation used to make the initial determination.

The appeal will be conducted by someone not previously involved in your case and not by a subordinate of anyone previously involved. Appeals involving medical judgment will be reviewed by an appropriate medical expert. Only board-certified physicians will be consulted. The review will consider all pertinent documents, medical records, and additional information, regardless of whether the information was considered in the original decision, and will be independent of the original decision.

For first level appeals regarding a post-service issue, you or your authorized representative will be notified of the decision within 60 days after receipt of your grievance. For first level appeals regarding pre-service issues, you or your authorized representative will be notified of the decision within 30 days after receipt of your grievance. The decision of a first level appeal is subject to a second level appeal/voluntary review as outlined below.

Expedited Review

If your first level appeal involves a medically urgent situation or concurrent review urgent care request, you or your authorized representative may request an expedited review. An expedited review focuses on adverse determinations regarding imminent or ongoing services. Expedited review requests may be submitted by telephone or in writing (including facsimile). Written expedited review decisions are provided within 72 hours of receiving information required for an expedited review. A medically urgent situation is one involving a type of service where a delayed response could seriously jeopardize the life or health of the covered person seeking services or would subject the covered person to severe pain that cannot be managed without the service in question, or is medically urgent in the opinion of a physician with knowledge of the person's medical condition.

Requests for an expedited review must be submitted within 48 hours of an adverse determination. In the event the basis of the request for an expedited review is termination of benefits, your benefits will continue without liability in accordance with the terms of your eligible benefits until you are notified of the expedited review decision. If the expedited review decision results in the termination of benefits, your benefits will end at 11:59 p.m., standard time, on the termination date stated on the notification of termination of benefits.

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.
Appeals/Compliance Department
PO Box 8150
Rapid City, SD 57709-8150
Telephone Number: 1-605-343-2509

Standard Review

You also have the right to a full and fair review of a grievance not involving an adverse determination. This type of grievance may include, but is not limited to, issues involving:

- Availability, delivery, or quality of health services; or
- Claim processing or payment.

You or your authorized representative may request a standard review by submitting a written grievance within 180 days after the date you were notified of a decision not involving an adverse determination.

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.
Appeals/Compliance Department
PO Box 8150
Rapid City, SD 57709-8150
Telephone Number: 1-605-343-2509

Within three working days of receiving your standard review request, you or your authorized representative will be sent a letter specifying the name of unit, address and phone number where the review will be conducted. You have a right to submit written comments, documents, records, and materials relating to the appeal as well as the right to receive, upon request and free of charge, copies of all relevant documentation used to make the initial determination.

The standard review will be conducted by someone not previously involved in your case and not by a subordinate of anyone previously involved. The review will consider all pertinent documents, medical records, and additional information, regardless of whether the information was considered in the original decision, and will be independent of the original decision.

You or your authorized representative will be notified of the decision within 20 working days after receipt of your standard review request. The decision of a standard review is subject to a second level appeal/voluntary review as outlined below.

Second Level Appeal/Voluntary Review

If you are not satisfied with the resolution of a first level appeal or standard review, you or your authorized representative have the right to make an appeal to the review committee.

You or your authorized representative may request a second level appeal/voluntary review by submitting a written grievance within 60 days after the receipt of the first level appeal decision or standard review decision.

Send your written grievance for a second level appeal/voluntary review to:

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card to obtain the address where the appeal can be sent.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.
Appeals/Compliance Department
PO Box 8150
Rapid City, SD 57709-8150
Telephone Number: 1-605-343-2509

Upon receiving your request for a second level appeal/voluntary review you will be sent a letter notifying you of the date of the review committee meeting. In addition, you will also be advised of your rights to:

- Make a request within five working days of the receipt of the letter, to appear in person (or by conference call) before a review committee;
- Submit written comments, documents, records, and other materials relating to the appeal to the review committee;
- Receive, upon request and free of charge, copies of all relevant documentation used during the appeal;
- Present your case to the review committee;
- Ask questions of any representative on the review committee; and
- Be assisted or represented by an individual of you or your authorized representative's choice.

The review committee will convene within 45 days of receiving your request for second level appeal/voluntary review. The review committee consists of three individuals who were not previously involved in your case.

The review committee will issue a final decision and notify you by letter within five working days after its meeting.

If you or your authorized representative do not request the opportunity to appear in person before the review committee, the review committee will issue a decision within 45 days of your notice not to appear or within 45 days after your opportunity to request a personal appearance expires, whichever is earlier.

The information contained in this section (S10.03) is a summary of the appeal procedures. A copy of the complete appeal procedure is available, free of charge, to you or your authorized representative by calling:

The Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

The Claims Administrator at:

First Administrators, Inc.
Appeals/Compliance Department
PO Box 8150
Rapid City, SD 57709-8150
Telephone Number: 1-605-343-2509

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 57501-3563
Telephone: 1-605- 773-3563

Section 10.30 shall be **added** to Article X, *General Claim Information*:

D10.30 AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and with whom you want us to communicate with regard to specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Designated Representative Form. A Designated Representative Form can be obtained by calling the Claims Administrator. In a medically urgent situation, your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your health care provider a designated representative. You can revoke the designated representative at any time, and you can designate only one person as your representative at a time.

The following language shall be **added** to Article XI, *Dental Benefit*:

D11.15 REDUCTION OF BENEFITS

If your dental claim is denied in whole or in part, you may appeal the benefit reduction as explained in Section 10.03 of this Plan.

Passed this _____ day of _____, 2003.

THE CITY COUNCIL

_____
Jim Shaw, Mayor

_____
Finance Officer