

**AMENDMENT TO THE
SIOUX VALLEY HEALTH PLAN
OF MINNESOTA**

**LARGE & SMALL GROUP
CERTIFICATE OF COVERAGE**

The following is an amendment to your Sioux Valley Health Plan Group Certificate of Coverage dated August 2003. Please review this document carefully and keep it with your Certificate of Coverage for future reference. Deleted items have strike-through lines and new items are **in red print**. These Amendments are effective 01/01/04.

AMENDMENT #1	<p>Page ii, #7 “Member Responsibilities”</p> <p>“7. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating, to the degree possible, in understanding their health care problems including behavioral problems and developing mutually agreed-upon treatment goals.</p>
AMENDMENT #2	<p>Page ii, “Member Responsibilities” Add new paragraph:</p> <p>“#11. Members are responsible to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.”</p>
AMENDMENT #3	<p>Page 2, “Definitions” Under “Formulary” add new definition for:</p> <p>“2-Tier Formulary uses a copayment structure that reduces your out-of-pocket costs when using Generic Drugs and Formulary Brand Name Drugs. It does not provide for preferred medication as a way to control costs. When a prescription is filled, your copayment will be at one of these tiers:</p> <ul style="list-style-type: none"> • Tier 1: Generic Drugs (lowest copay) • Tier 2: All covered Brand Name Drugs (higher copay)”
AMENDMENT #4	<p>Page 3, “Definitions.” After “Hospitalization” insert:</p> <p>“Intensive Outpatient Program (IOP)” means weekly structured programs for education and counseling for alcohol, drug or gambling problems. Programs may be available in the evenings or weekends.”</p>

AMENDMENT #5	<p>Page 3, “Definitions” After “Non-Participating Provider” insert:</p> <p>“Partial Hospital Program” also known as <i>Day Treatment</i> for mental health and chemical dependency services means a group-oriented treatment setting based on an intermediate level of care usually held during the daytime hours generally providing twenty (20) or more hours of therapeutic activities per week.</p>
AMENDMENT #6	<p>Page 4, “Definitions” After “Spouse” insert:</p> <p>“Step Therapy Program” uses protocols that specify the order in which different drugs for a given condition are prescribed. If a member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. Step therapy requires the use of first-line alternatives before more expensive second-line drugs are covered by the pharmacy benefit.”</p>
AMENDMENT #7	<p>Page 5, Part II A. 4. “Late Entrant” Insert the following Statement:</p> <p>“4. The individual is a new dependent child of an eligible employee. The effective date will be the first of the month following the new enrollee request;”</p>
AMENDMENT #8	<p>Page 8, Part III A. 2. “Covered Services. Preconditions for Coverage.” Insert the following as the last sentence:</p> <p>“Members who live outside of the Plan’s service area must use the Plan’s contracted network of participating providers as indicated on the <i>Member Welcome Letter</i> enclosed with their Member Identification Card. Members who live outside the Plan’s service area will receive Identification Cards that display their network logo along with instructions on how to access this network. If Member chooses to go to a non-participating provider when access is available, claims will be paid at the out-of-network benefit level.</p> <p>Members are not required, but are strongly encouraged, to select a Primary Care Physician and use that physician to coordinate their Health Care Services.”</p>
AMENDMENT #9	<p>Page 8, Part III B. 1. “Services that Require Prior Authorization Include:”</p> <ul style="list-style-type: none"> • “Inpatient hospital admissions including admissions for medical, surgical, obstetric, neonatal intensive care nursery, mental health and chemical dependency services; • Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;”

AMENDMENT #10	<p>Page 8, B. 2. "Prescription Drugs that Require Prior Authorization" First sentence of the first paragraph is revised as follows:</p> <p>"To be covered by Sioux Valley Health Plan the following medications require prior authorization and a letter of medical necessity for a formulary exception."</p>
AMENDMENT #11	<p>Page 9, B. 2. "Prescription Drugs that Require Prior Authorization Include" Under "Injectible Medications" add:</p> <ul style="list-style-type: none"> • "Hepatitis C" <p>Also add new section for Step Therapy drugs that require Prior Authorization: "Step Therapy Medications:</p> <ul style="list-style-type: none"> • Zetia • Singulair • Vioxx"
AMENDMENT #12	<p>Page 10, Part III B. 5. "Authorization of Concurrent Review" Correction to the last paragraph is as follows:</p> <p>"...The Plan may provide an initial oral notification of the denial decision orally within seventy-two (72) hours of the request provided that an electronic or written notification is given no later than <i>three (3) calendar days</i> after the oral notification."</p>
AMENDMENT #13	<p>Page 11, Part III C. 2. "Out of Network Coverage" Insert the following statement:</p> <p>"Out of Network Coverage means Covered Services that do not fit the definition of In Network Coverage set forth above. All Out of Network services are subject to Reasonable Cost. Members who live outside of the Plan's service area must use the Plan's contracted network of participating providers as indicated on the Member Welcome Letter enclosed with their Member Identification Card. Members who live outside the Plan's service area will receive Identification Cards that display their network logo along with instructions on how to access this network. If Member chooses to go to a non-participating provider when access is available, claims will be paid at the out-of-network benefit level. Specifically, Out of Network Coverage means Covered Services that are received:..."</p>
AMENDMENT #14	<p>Page 11, Part III D. 7. "Chemical Dependency Services" Insert the following bullet points:</p> <ul style="list-style-type: none"> • Intensive Outpatient Programs (IOP) will apply towards Member's deductible/coinsurance benefit. • Every two (2) days of Partial Hospital Program (PHP)/Day Treatment counts towards one (1) day of inpatient services."
AMENDMENT #15	<p>Page 11, Part III D. 8. "Casts, Splints, Braces Crutches and Dressings" Revisions are as follows:</p> <p>"Casts, Splints, Braces Crutches and Dressings that are part of treatment received in a physician's office, emergency room, or as part of an approved hospital treatment for the diagnosis of fracture, dislocation, torn muscles and/or ligaments only."</p>
AMENDMENT #16	<p>Page 14, Part III D. 27. "Mental Health Services" Add the following statement at the beginning of the 1st paragraph: "Includes Partial Hospital Programs or Day Treatments."</p>
AMENDMENT #17	<p>Page 16, Part III D. 32 "Injectible Drugs that require Prior Authorization Include:" Add:</p> <ul style="list-style-type: none"> • "Hepatitis C"

Page 18, Part III D. 32. "Prescription Drug Services"
 Insert the following new information on *Step Therapy Programs* as the last paragraph under #32.

“Step Therapy Program

The step therapy program was developed to encourage the use of first-line alternatives before more expensive second-line medications are covered by the pharmacy benefit. If a member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by prior authorization. You can prior authorize by calling the Health Services Department at (800) 805-7938. The following step therapy programs are listed and their clinical criteria are as follows.

Zetia Step Therapy

1. If a member has tried one of the following drugs (may be brand or generic) or combination of drugs at the following dosage:

<u>Generic (Brand) Drug Name</u>	<u>Daily Dose</u>
Atorvastatin (Lipitor).....	≥ 40 mg
Fluvastatin (Lescol).....	≥ 40 mg
Lescol XL.....	≥ 80 mg
Lovastatin (Mevacor; generics).....	≥ 40 mg
Lovastatin ER (Altacor).....	≥ 40 mg
Niacin ER/Lovastatin (Advicor).....	≥ 2000 mg/40 mg
Pravastatin (Pravachol).....	≥ 40 mg
Simvastatin (Zocor).....	≥ 40 mg

2. The member has tried one of the drugs from the above list and can not tolerate the side effects.
3. The member is taking or will be taking a medication that has drug interactions with a drug from the above listing.
4. Children or adolescents <17 years of age must have tried a drug from the above listing but not at the doses listed.
5. Members with severe renal impairment of creatinine clearance =30 mL/minute.
6. Homozygous familial hypercholesterolemia.
7. Homozygous familial sitosterolemia.
8. Pregnant women.
9. Active liver disease or unexplained persistent elevations of serum transaminases.

Singulair Step Therapy

1. Authorization for Singulair is approved for members with Asthma.
2. For children < 5 years of age, exceptions can be made for Singulair authorization.
3. For members with *allergic rhinitis* Singulair is not covered.
4. For members with *chronic urticaria* should have tried one of the oral antihistamines (Zyrtec/D) or hydroxyzine.
5. For members with atopic dermatitis should have tried a prescription topical corticosteroid or a topical immunomodulator (Elidel, Protopic). If one of these drugs has been tried, then approve Singulair.
6. Infants with *acute respiratory syncytial virus (RSV) bronchiolitis*. Approve Singulair.

Vioxx Step Therapy

1. If a member has tried one (1) prescription strength NSAIDS (nonsteroidal anti-inflammatory) (may be generic or Brand) for the current condition, then authorization for a formulary single source COX-2 Inhibitor (Vioxx) may be given at the 3rd tier copay. Generic Naproxen 500mg will be offered to all members at \$0 copay.
2. Exceptions for formulary coverage at a 2nd tier copay can be made for members that meet one of the following criteria:
 - Age =65
 - Past history of a GI bleed, perforation, obstruction or on a Proton Pump Inhibitor (PPI) in the last 90 days.

**ATTACHMENT II
DRUG EXCLUSION LIST**

<p>AMENDMENT #18 (Continued)</p>	<ul style="list-style-type: none"> • Requires use of long-term (>1 month) oral corticosteroids therapy. • Currently taking warfarin (Coumadin® - DuPont Pharma) or dicumarol. • Diagnosis of rheumatoid arthritis. <p>3. Authorization for formulary Vioxx, may be given for patients with reduced platelets counts < 75,000.</p> <p>The following list of Step Therapy Drugs require Prior Authorization and a letter of medical necessity for a formulary exception. Please call the Health Services Department at 1-800-805-7938 or (605) 328-6807. The medications listed will be applied to your medical benefit with coinsurance and deductible applying.</p> <p>Step Therapy Drugs that require Prior Authorization include:</p> <ul style="list-style-type: none"> • Zetia • Singulair • Vioxx”
<p>AMENDMENT #19</p>	<p>Page 20, Part IV A. 24. “Any durable medical equipment....”</p> <p>Revisions are as follows:</p> <p>1st Bullet:</p> <ul style="list-style-type: none"> • “Orthopedic shoes; over the counter orthotics and appliances; <p>Add a bullet for:</p> <ul style="list-style-type: none"> • Over the Counter equipment, supplies and appliances.”
<p>AMENDMENT #20</p>	<p>Page 20, Part IV A. 34. f. “Organ Transplants”</p> <p>Revisions are as follows:</p> <p>“f. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan contracted, non-LifeTree Center of Excellence.</p> <p>g. Costs related to locating and/or screening organ donors.”</p>
<p>AMENDMENT #21</p>	<p>Page 21, Part IV B. 5. “Excluded Drugs and Supplies.”</p> <p>#5 is hereby deleted.</p> <p>“5. Prescriptions written by a dentist.”</p>
<p>AMENDMENT #22</p>	<p>Page 26, Part VII D. 1. “Complaint & Medical Review Determination Process. Informal Complaints:”</p> <p>Correction to Commissioner of Health Phone number in the 2nd paragraph:</p> <p>“At any time the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 282-5600.....”</p>

**ATTACHMENT II
DRUG EXCLUSION LIST**

<p>AMENDMENT #23</p>	<p>Page 29, Part VIII A. "Termination by the Subscriber" Revisions are as follows:</p> <p>"A. Voluntary Termination by the Subscriber In accordance with your employer's Human Resource Policy; You may be allowed to voluntarily terminate coverage for you and/or any Dependent(s) when the following events occur: at any time</p> <ul style="list-style-type: none"> • During your Employer's annual Open Enrollment period; • When your Employer makes changes to your existing Benefit Package(s); • Upon a marriage or divorce; or • Upon the birth or adoption of a dependent. <p>The Plan must receive a written request from....."</p>
<p>AMENDMENT #24</p>	<p>Page 29, Part VIII B. "Termination of Member Coverage" Revisions are as follows:</p> <p>"A Member, retiree, or dependent's coverage will automatically terminate at the earliest of the following events below. The Plan may terminate, cancel or refuse to renew a Member's coverage for any of the reasons listed below. Such action by the Plan is called "Disenrollment" of the Member.</p> <ol style="list-style-type: none"> 1. Payments. Failure to make any required Service Charge payments, Copays, Deductibles, or Coinsurance when due. A grace period of <i>thirty-one (31)</i> days, unless stated otherwise in this Certificate of Coverage, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period. 2. Employee Termination. The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s). 3. Group Termination. The date your Group terminates coverage. 4. Move Outside the Area. A Member establishes permanent residence outside the Service Area and outside the State of Minnesota. 5. Contract Termination. This contract terminates. 6. Eligibility. The last day of the month in which the Member is no longer eligible for coverage under this contract. 7. Retiree Termination. The last day of the month in which the retiree, or his or her dependents become eligible for Medicare. 8. Death. The date the Member dies. 9. Lifetime Maximum. When lifetime maximum benefits of your Plan have been met. 10. Armed Forces. The first of the month following the date the Member enters the armed forces of any country as a full-time Member. 11. Fraudulent Information. The date a Member's application form contains false information. 12. Use of ID Card by Another. The date a Member allows another individual to use his or her ID Card to obtain services."

ATTACHMENT II DRUG EXCLUSION LIST

AMENDMENT #25	<p>Page 36, Part X, Section B. 4b and 4c “Allowable Expense”</p> <p>b. If a person is covered by two or more plans (excluding Medicare, see Section E below) that compute the benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense;</p> <p>c. If a person is covered by two or more plans (excluding Medicare, see Section E below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;</p>
AMENDMENT #26	<p>Page 38, Part X, Section E. “Coordination of Benefits with Medicare”</p> <p>Insert the following as a new paragraph #2:</p> <p>“If a provider has accepted assignment of Medicare, the Plan determines allowable expenses based upon the amount allowed by Medicare. The Plan’s allowable expense is the <i>lesser</i> of the usual and customary amount or the Medicare allowable amount. The Plan pays the difference between what Medicare pays and the Plan’s allowable expense.”</p>
AMENDMENT #27	<p>Attachment II “Drug Exclusion List” is hereby deleted and replaced by the following “Attachment II”</p>

ATTACHMENT II DRUG EXCLUSION LIST

DRUG EXCLUSION LIST

The following drugs (and their generic equivalent, if available) are excluded because they can be obtained without a prescription as an OTC (over-the-counter) medication or due to Health Plan prescription benefit coverage. For a copy of the Plan Formulary you can contact our Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863 (TTY: (605) 328-6869) or you can view the formulary online at www.siouxvalley.org/HealthPlan.

Exception to formulary. The health plan will promptly grant an exception to the drug formulary/list of excluded drugs, including exceptions for anti-psychotic and other mental health drugs, for a Member when the health care provider prescribing the drug indicates to the health plan company that:

- (1) the formulary drug causes an adverse reaction in the patient;
- (2) the formulary drug is contraindicated for the patient;
- or
- (3) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

Antipsychotic drugs prescribed to treat emotional disturbance or mental illnesses is covered by the Plan regardless of whether the drug is in the Plan’s drug formulary, if the health care provider prescribing the drug certifies in writing to the health plan that the health care provider has considered all equivalent drugs in the health plan’s drug formulary and has determined that the drug prescribed will best treat the patient’s condition. The prescribing provider must indicate to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated. The Plan

will not provide coverage for drugs removed from the formulary for safety reasons. Antipsychotic drug exceptions to the formulary will not be subject to any special payment requirement different from drugs on the formulary and the Plan will not require written certification each time a prescription is refilled.

Continuing care.

Members receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to *one (1) year* without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan’s drug formulary changes or a Member changes health plans and the medication has been shown to effectively treat the patient’s condition.

In order to be eligible for this continuing care benefit:

- (1) the patient must have been treated with the drug for 90 days prior to a change in a health plan’s drug formulary or a change in the Member’s health plan;
- (2) the health care provider prescribing the drug indicates that the prescription must be dispensed as communicated; and
- (3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient’s condition.

The continuing care benefit shall be extended annually when the prescribing provider meets the criteria set forth above for *Antipsychotic Drugs*.

ATTACHMENT II DRUG EXCLUSION LIST

Excluded Drugs:

- Avage
- DESI Drugs
- Differin (over the age of 35)
- Immunological Agents
- Infertility Drugs (Refer to Injectable Program in *Part III C, #31*)
- Legend Vitamins
- Levitra
- Pigmenting/Anti-pigmenting Agents
- Prescription Vitamins
- Propecia
- Renova (over the age of 25)
- Vaniqa
- Axid – use OTC Axid AR
- Claritin/-D – use Claritin/-D OTC, Alavert, loratadine OTC
- Lamisil Solution - OTC Lamisil AT Solution
- Pepcid – use OTC Pepcid AC
- Prilosec – use Prilosec OTC
- Tagamet – use OTC Tagament HB
- Zantac – use OTC Zantac 75

**ATTACHMENT II
DRUG EXCLUSION LIST**

The following drugs (and their generic equivalent, if listed) are excluded because of Health Plan policy, as there are similar drugs in this category considered for coverage.

<u>Excluded Drug</u>	<u>Formulary Alternative</u>
Accolate	Singulair
Aciphex	generic omeprazole, Prevacid
Aerobid-M	Flovent, Pulmicort
Allegra/-D	OTC products, Zyrtec/-D
Alora	Climara, Estraderm, Vivelle, Esclim
Anaprox/DS (naproxen)	generic ibuprofen, naproxen sodium
Ansaid (flurbiprofen)	generic ibuprofen, naproxen sodium
Anzemet	Zofran
Atacand/HCT	Avapro/Avalide, Diovan/HCT
Axert	Amerge, Imitrex, Zomig, Frova, Maxalt, Relpax
Avinza	generics, Oxycontin
Avita	generic tretinoin, Differin
Azmacort	Flovent, Pulmicort
Beclovent	Flovent, Pulmicort
Beconase/AQ	Flonase, Nasacort/AQ, Nasonex
Benicar	Avapro, Diovan
Bextra	Vioxx
Cardene SR	Nifedipine ER, Norvasc
Cataflam (diclofenac potassium)	generic ibuprofen, naproxen sodium
Ceclor CD	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Cedax	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Celebrex	Vioxx
Clarinex	OTC products, Zyrtec
Cozaar	Avapro, Diovan
Dynabac	generic erythromycin, Biaxin, Zithromax
DynaCirc/CR	nifedipine ER, Norvasc
EC-Naprosyn (naproxen)	generic ibuprofen, naproxen sodium
Fempatch	Climara, Estraderm, Vivelle, Esclim
Flumadine	generic rimantadine, generic amantadine, Tamiflu
Fluoxetine 40mg strength	Use 2 x 20mg strength
Hyzaar	Avalide, Diovan HCT
Kadian	generics, Oxycontin
Kytril	Zofran

**ATTACHMENT II
DRUG EXCLUSION LIST**

<u>Excluded Drug</u>	<u>Formulary Alternative</u>
Lescol/XR	generic lovastatin, Lipitor, Zocor, Crestor
Lexxel	Tarka, Lotrel
Lorabid	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Luvox	generic fluvoxamine
Miacalcin	Actonel, Fosamax
Micardis/HCT	Avapro/Avalide, Diovan/HCT
MS Contin	generics, Oxycontin
Naprelan (naproxen)	generic ibuprofen, naproxen sodium
Nasalide	Flonase, Nasacort/AQ, Nasonex
Nasarel	Flonase, Nasacort/AQ, Nasonex
Nexium	generic omeprazole, Prevacid
Oramorph SR	generics, Oxycontin
Oxytrol	generic oxybutyninl, Detrol/LA, Ditropan XL
PCE	generic erythromycin, Biaxin, Zithromax
Plendil	nifedipine ER, Norvasc
Pravachol	generic lovastatin, Lipitor, Zocor, Crestor
Prilosec	generic omeprazole, Prevacid
Protonix	generic omeprazole, Prevacid
Prozac Weekly	generic fluoxetine
QVAR	Flovent, Pulmicort
Relenza	generic rimantadine, generic amantadine, Tamiflu
Retin-A/micro	generic tretinoin, Differin
Rhinocort/AQ	Nasacort/AQ, Flonase, Nasonex
Sarafem	generic fluoxetine
Serzone	generic nefazadone, generic mirtazipine, Effexor/XR, Wellbutrin SR/XL
Sonata	Ambien
Sular	nifedipine ER, Norvasc
Suprax	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Teveten	Avapro, Diovan
Tri-Nasal	Flonase, Nasacort/AQ, Nasonex
Vanceril	Flovent, Pulmicort
Vantin	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Voltaren/XR (diclofenac sodium)	generic ibuprofen, naproxen sodium
Zyflo	Singulair

ATTACHMENT II DRUG EXCLUSION LIST

Quantity Limit List

Quantity limits are designed to help promote appropriate medication use and enhance patient safety. Quantity limits are based on generally accepted pharmaceutical guidelines and FDA-approved manufacturer labeling. The following drugs do not require prior authorization but have a quantity limit:

- Amerge—9 tablets/month
- Anzemet—1 tablets/month
- Axert—6 tablets/month
- Diflucan—3 tablets/month
- Frova—9 tablets/month
- Imitrex—9 tablets/ 6 nasal spray or 1 kit for injections/month or 2 injections
- Kytril—2 tablets/month
- Maxalt—6 tablets/month
- Maxalt MLT—6 tablets/month
- Migranal—4 ampules/spray/month
- Stadol Nasal Spray—2 spray bottles
- Viagra—4 tablets/month
- Zofran—12 tablets/month
- Zomig—6 tablets for 2.5mg. and 3 tablets for 5mg./month
- Zomig ZMT—6 tablets for 2.5 mg. and 3 tablets for 5 mg./month
- Zyban – 6-month supply per calendar year

Coverage of drugs beyond the quantity limits requires prior authorization by the health plan and a letter of medical necessity from your provider.

**The Sioux Valley Health Plan policy is a 30-day prescription limit excluding maintenance medications.