

**AMENDMENT NUMBER 2008-007  
TO  
CITY OF OGDENSBURG EMPLOYEE'S HEALTH PLAN**

BY THIS AGREEMENT, the City of Ogdensburg Employee's Health Plan, (herein called the "Plan") is hereby amended as follows, effective as of 01/01/2011.

**NATURE OF AMENDMENT:** To amend the Plan to comply with the portion of the federal Patient Protection and Affordability Care Act that incorporates coverage of children to age 26; removal of Pre-Existing Conditions exclusion for Covered Persons under age 19; provides a 30-day notice for rescission of coverage for fraud/abuse; removal of the Lifetime limit; well child and well adult allowed services will follow guidelines from the US Preventive Services Task Force (ratings of "A" or "B"), Advisory Committee on Immunization Practices and Health Resources and Services Administration including allowing nutritional counseling to four visits per Calendar Year/per Covered Person, allowing smoking cessation counseling, allowing smoking cessation to the Prescription Drug Benefit Expense; and removal of the annual limits for routine adults over age 50 and transplant charges.

To amend the Plan to comply with federal law mandating parity of Mental Disorders and Substance Use Disorders with medical benefits.

To amend the Plan to allow Hospitalists and Physician Extenders if they have a contract with the Claims Administrator.

**Provisions Affected:**

**1. The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION Provisions, subsection Eligibility, Eligible Classes of Dependents is amended as follows:**

- (1) A covered Employee's spouse. The term "spouse" shall mean the person recognized as the covered Employee's husband or wife (of the opposite sex) under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.
- (2) The term "children" shall include biological children, step-children, adopted children, or children placed with a covered Active Employee in anticipation of adoption.
  - (a) *A covered Active Employee's children from birth to the limiting age of 26 years. The child does not need to be a full time student, dependent on the Employee, or living with the Employee.*

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- (b) If a covered Employee is the Legal Guardian of an unmarried child or children and under the age of 19, these children may be enrolled in this Plan as covered dependents.

The dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Federal law mandates that coverage will not terminate if the covered dependent child's failure to maintain full-time status at a postsecondary educational institution is due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating Physician certifies in writing that the child is suffering from a serious Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins.

To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (c) Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.
- (3) A covered dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country (*other than a dependent child*); or any person who is covered under the Plan as an Employee.

**2. The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION Provisions, subsection Pre-Existing Conditions is amended as follows:**

...

The Pre-Existing Condition does not apply to Pregnancy, to a *covered person who is under age 19*, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

A Pre-Existing Condition limitation can be applied to any individual after the end of the first 63-day period during all, of which the individual was not covered under any Creditable Coverage.

**3. The Section entitled ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION Provisions, subsection Termination of Coverage is amended as follows:**

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.**

**The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage (*will provide a 30-day notice*). The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or dependent's paid contributions.**

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the **Continuation Coverage Rights under COBRA**.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage (*will provide a 30-day notice*).

- (5) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a Lifetime limit on all benefits.

...

**When Dependent Coverage Terminates.** A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**):

- (1) The date the Plan or dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason, except death. (See **Continuation Coverage Rights under COBRA**.)
- (3) The date a covered spouse loses coverage due to loss of dependency status. (See the **Continuation Coverage Rights under COBRA**.)
- (4) On the first date that a dependent child ceases to be a dependent as defined by the Plan. (See the **Continuation Coverage Rights under COBRA**.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage (*will provide a 30-day notice*).
- (7) The earliest date the dependent has a claim that is denied in whole or in part because it meets or exceeds a Lifetime limit on all benefits.
- (8) Your dependents enrolled in your family coverage at the time of an Employee's or Retiree's death will maintain Plan enrollment eligibility until the end of the contribution paid period. The Human Resources Department can provide full details concerning Survivor Dependent eligibility and Plan participation costs. (See the **Continuation Coverage Rights under COBRA**.)

**4. The Section entitled SCHEDULE OF BENEFITS is amended as follows:**

Plan Features	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Maximum Benefit Amounts (Lifetime)	\$1,000,000.00 <i>As of 1/1/11, there will no longer be a Lifetime limit.</i>	

Preventative Care	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
<b>Well Child Care and Immunizations</b> (through age 18)	100% of Allowed Charge, no deductible applies  Includes labs, X-rays, exam, hearing and vision tests. <i>The Plan will follow the immunizations recommended by ACIP; and the screening recommendations for infants, children and adolescents provided by the Health Resources and Services Administration.</i>	
<b>Routine Newborn Care</b> (includes circumcision-if child is less than 30 days old)	100% of Allowed Charge, no deductible applies	
<b>Routine Adult Care</b>	100% of Allowed Charge, no deductible applies; \$50.00 yearly maximum. <i>As of 1/1/11, there will no longer be a yearly maximum.</i> Includes exam, x-rays, immunizations, and labs. <i>This Plan will follow the recommendations of the United States Preventive Services Task Force (ratings of "A" or "B") and the immunizations recommended by the ACIP.</i>	
<b>Bone Density Testing</b>	100% of Allowed Charge, no deductible applies <ul style="list-style-type: none"> <li>o Previously diagnosed as having osteoporosis or having a family history of osteoporosis;</li> <li>o With symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;</li> <li>o On a prescribed drug regimen posing a significant risk of osteoporosis;</li> <li>o With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or</li> <li>o With such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.</li> </ul>	
<b>Routine Mammography Screening</b>	100% of Allowed Charge, no deductible applies <ul style="list-style-type: none"> <li>o at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;</li> <li>o a single baseline mammogram for Covered Persons aged 35-39; and</li> <li>o age 40 or over for Covered Persons; cover once a year</li> </ul>	
<b>Routine Colonoscopy/Sigmoidoscopy</b>	100% of Allowed Charge, no deductible applies  <i>Age 50 and older. Routine frequency for persons at average risk when recommended by a Physician:</i> <ul style="list-style-type: none"> <li>o Sigmoidoscopy – once every five years; or</li> <li>o Barium enema (double contrast) - once every five years; or</li> <li>o Colonoscopy - once every ten years.</li> </ul>	
<b>Routine Prostate-Specific Antigen (PSA)</b>	100% of Allowed Charge, no deductible applies  <i>Limit – One per year from age 50 (from age 40 for men at high risk).</i>	
<b>Routine Annual GYN (age 18 and older)</b> • Exam	100% of Allowed Charge, no deductible applies  Maximum 2 per Calendar Year.	
• Pap Smear, Cytology Screening	100% of Allowed Charge, no deductible applies  Maximum 2 per Calendar Year.	

Preventative Care	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
<ul style="list-style-type: none"> <li><b>Other Routine Testing</b></li> </ul>	Not covered, unless recommended by the United States Preventive Services Task Force (ratings of "A" or "B") or the screening recommendations adolescents provided by the Health Resources and Services Administration.	
<b>Smoking Cessation Counseling</b>	100% of Allowed Charge, no deductible applies	
	----- Limited to two attempts per year. Each attempt includes a maximum of four intermediate or intensive sessions.	

Hospital and other Facilities Expense Benefits	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
<b>Inpatient Mental Disorder Care (facility charge)</b> <ul style="list-style-type: none"> <li>General Hospital or Private Proprietary Psychiatric Facility</li> <li>Hospital Mental Disorder Day/Night Care Center</li> </ul>	100% of Allowed Charge, no deductible applies	
<b>Inpatient Substance Use Disorder</b> <ul style="list-style-type: none"> <li>General Hospital or Certified Substance Use Disorder Facility Program</li> <li>Hospital Substance Use Disorder Day/Night Care Center</li> </ul>	100% of Allowed Charge, no deductible applies	

Medical/Surgical Services and Supplies	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
<b>Diabetic Education</b>	100% of Allowed Charge, no deductible applies	
<b>Dietary/Nutritional Counseling wellness (no underlying chronic condition required)</b>	100% of Allowed Charge, no deductible applies	
	----- Limited to four visits per Covered Person per Calendar Year. Services must be rendered by a certified nutritionist or certified or registered dietician.	
<b>Mental Disorders - Outpatient Treatment - Includes family therapy</b>	\$8.00 allowable at 100% Remainder at 80% of Allowed Charge, after deductible.	
<b>Substance Use Disorder – Outpatient Treatment Includes family therapy</b>	\$8.00 allowable at 100% Remainder at 80% of Allowed Charge, after deductible.	
<b>Transplants</b>	See benefit for type of service rendered ----- Transplant is <b>not</b> covered. Prescriptions, physician services and diagnostic tests are covered. Services will only be considered after one-year waiting period from date of transplant. Limited to \$15,000.00 per Calendar Year. As of 1/1/11, there will no longer be a Calendar Year Limit.	

**5. The Section entitled COMPREHENSIVE MEDICAL BENEFITS, subsection Preventive Care is amended as follows**

Covered Charges under **Medical Benefits** are payable for routine **Preventive Care** as described in the **Schedule of Benefits**. *The following is a list of the most common services. This list is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force; evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Health Resources and Services Administration; and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service.*

**Charges for Routine Well Child Care:**

- **Well Newborn Nursery/Physician Care:** The benefit is limited to the Allowed Charges made by a Physician for the first routine pediatric care while the newborn child is Hospital-confined. Charges for covered routine Physician care will be applied toward the Plan of the covered parent or if enrolled as a dependent in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.
- **Routine Well Child Care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits and immunizations. Coverage is intended to be consistent with the *above* clinical standards.

**6. The Section entitled COMPREHENSIVE MEDICAL BENEFITS, subsection Hospital and Other Facilities is amended as follows:**

***Diabetic Education***

*Diabetic self-management education and education relating to diet may be covered for a Covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational services will be covered when provided by:*

- (a) A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;*
- (b) A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient's area, the Plan may cover individual education;*
- (c) A professional Provider as described above may be covered for services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive services at home.*

**Dietary/Nutritional Counseling (for diagnosis other than Diabetes)**

*The Plan will cover wellness (no underlying chronic condition required) dietary/nutritional counseling up to the benefit maximums shown in the "Schedule of Benefits". Services must be rendered by certified nutritionist or certified and registered dietician. See the Summary of Benefits for limitations.*

**Mental Disorders.** Covered Charges for care, supplies and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the **Schedule of Benefits** for an approved plan of care. *For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.* Covered Charges for care, supplies and treatment of Mental Disorders for an approved plan of care will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

**Substance Use Disorder.** Covered Charges for care, supplies and treatment of Substance Use Disorder for an approved plan of care will be subject to the benefit payment maximums shown in the **Schedule of Benefits** for services by a certified alcohol or Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an approved plan of inpatient care. *For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.*

Inpatient detoxification is considered under this benefit. However, detoxification coverage is limited to no more than seven days in a Calendar Year. Expenses for Inpatient Substance Use Disorder (alcohol or drug use disorder) rehabilitation are covered separately from detoxification.

Physician's visits are limited to one treatment per day. Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

**7. The Section entitled COMPREHENSIVE MEDICAL BENEFITS, subsection Major Medical Benefits is amended as follows:**

**Mental Disorders – Outpatient Treatment**

Covered Charges for care, supplies and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the **Schedule of Benefits** for an approved plan of care. *For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.* Covered Charges for care, supplies and treatment of Mental Disorders for an approved plan of care will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

#### **Substance Use Disorder – Outpatient Treatment**

Covered Charges for care, supplies and treatment of Substance Use Disorder for an approved plan of care will be subject to the benefit payment maximums shown in the **Schedule of Benefits**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable. Covered Charges for care, supplies and treatment of Substance Use Disorder will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

#### **Transplants**

Organ transplant services will be covered, not including the transplant itself, under the Major Medical portion of the benefit program. The services would include applicable prescriptions, Physician services and diagnostic tests. The annual maximum is \$15,000.00. As of January 1, 2011 there no longer be an annual maximum. Such services would be considered after one year from the date of the transplant.

#### **8. The Section entitled DEFINED TERMS is amended to add or revise the following terms:**

**Advanced Physician Care Extender or Physician Extender** includes physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

**Hospitalist** is a Physician that assumes the care of a Hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a covered person who is under age 19, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

A Pre-Existing Condition limitation can be applied to any individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

**Substance Use Disorder** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Substance Use Disorder Facility** - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the outpatient treatment of *Substance Use Disorder* (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations for the outpatient treatment of *Substance Use Disorders*.

**9. The Section entitled PLAN EXCLUSIONS. is amended to revise the following exclusion:**

(26) **Hospital/Facility Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital, or Skilled Nursing Facility, or any inpatient facility where care is received and paid by the Hospital or facility for the service. **Exception:** *Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.*

**10. The Section entitled PRESCRIPTION DRUG BENEFITS, Covered Prescription Drugs, is amended to add the following verbiage:**

(5) *Smoking deterrent coverage is limited to:*

(a) **Patches** obtained with or without doctor's orders. Coverage is limited to a maximum therapy cycle of 10 weeks and one therapy cycle per Lifetime for each Covered Person; and

(b) **Zyban** or **Chantix**. Coverage is limited to a maximum therapy cycle of 12 weeks and one therapy cycle per Lifetime for each Covered Person. Coverage is limited to either Zyban or Chantix (not both).

**11. The Section entitled PRESCRIPTION DRUG BENEFITS, Exclusions, is amended to remove (19) Smoking Cessation.**

**12. The Section entitled COORDINATION OF BENEFITS, subsection Benefit Plan Payment Order has been amended to read:**

**Benefit plan.** This provision will coordinate the medical benefits of a benefit plan. *When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Plan will automatically follow the amended regulations.* The term benefit plan means this Plan or any one of the following plans.

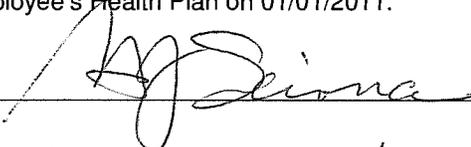
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**13. The Section entitled RESPONSIBILITIES FOR PLAN ADMINISTRATION, subsection Misrepresentation/Fraud is amended to add the following language:**

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim, *giving a 30-day notice*. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

\* \* \*

IN WITNESS WHEREOF this agreement has been executed on behalf of City of Ogdensburg Employee's Health Plan on 01/01/2011.

By 

Title City Manager / CEO / CAO

Date 11/10/10