

**AMENDMENT NUMBER 2008-008
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 revision of the appeal process.

Provisions Affected:

1. The Section entitled CLAIMS REVIEW PROCEDURES is amended to read:

Following is a description of how the Plan processes Claims for benefits in compliance with the federal Patient Protection and Affordable Care Act, as amended.

An Adverse Benefit Determination is defined as a Rescission, or a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in the Plan;*
- A determination that a benefit is not a covered benefit;*
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or*
- A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.*

A Rescission is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required contributions toward the cost of coverage. A Rescission does not include a retroactive elimination of coverage due to certain administrative record-keeping delays and certain cases where a Participant fails to timely notify the Plan of a change in eligibility (e.g. a divorce) and there has been no payment of the full COBRA premium.

A Final Adverse Determination is defined as the upholding of an Adverse Benefit Determination at the conclusion of the internal appeals process or an Adverse Benefit Determination with respect to which the internal appeals process has been deemed exhausted.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed with the Plan. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	24 hours
<i>Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:</i>	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
<i>Ongoing courses of treatment, notification of:</i>	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
<i>Insufficient information on the Claim:</i>	
Notification of	15 days

<i>Response by claimant</i>	<i>45 days</i>
<i>Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim</i>	<i>5 days</i>
<i>Ongoing courses of treatment:</i>	
<i>Reduction or termination before the end of the treatment</i>	<i>15 days</i>
<i>Request to extend course of treatment</i>	<i>15 days</i>
<i>Review of adverse benefit determination</i>	<i>30 days</i>
<i>Reduction or termination before the end of the treatment</i>	<i>15 days</i>
<i>Request to extend course of treatment</i>	<i>15 days</i>

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

<i>Notification to claimant of benefit determination</i>	<i>30 days</i>
<i>Extension due to matters beyond the control of the Plan</i>	<i>15 days</i>
<i>Extension due to insufficient information on the Claim</i>	<i>15 days</i>
<i>Response by claimant following notice of insufficient information</i>	<i>45 days</i>
<i>Review of adverse benefit determination</i>	<i>60 days</i>

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination or Final Adverse Determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The date of service, the health care provider, the diagnosis code, the treatment code, the corresponding meanings of these codes, and the claim amount, if applicable.
- (2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning.
- (3) Reference to the specific Plan provisions on which the determination was based and the Plan's standard, if any, that was used in denying the claim.

- (4) *A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.*
- (5) *A description of the Plan's internal appeals and external review procedures, including information about how to initiate an appeal, and the time limits applicable to such procedures.*
- (6) *A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.*
- (7) *The claimant will also be provided free of charge with any new or additional rationale or evidence considered, relied upon, or generated by the Plan, or at the direction of the Plan, in connection with the Claim with sufficient notice, assuming the Plan has received the information in a timely manner, so that the claimant has a reasonable opportunity to respond.*
- (8) *If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.*
- (9) *If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided upon request.*

Internal Appeals

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended. When a claimant receives an Adverse Benefit Determination, the claimant or an authorized representative acting on behalf of the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which an Adverse Benefit Determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) *was relied upon in making the benefit determination;*
- (2) *was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;*
- (3) *demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or*

- (4) *constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.*

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan or Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

External Appeals

(1) Your Right to an External Appeal

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended and applicable New York State Insurance Law, as amended (regardless of state of residence).

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not Medically Necessary, or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the state to conduct such appeals.

(2) Your Right to appeal a Determination that a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service is not Medically Necessary, you may appeal to an external appeal agent if you satisfy the following two criteria:

- *The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and*
- *You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree to waive any internal appeal.*

(3) Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following two criteria:

- *The service must otherwise be a Covered Service under the Plan; and*

- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

In addition, your attending Physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending Physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

(4) The External Appeal Process

If, through the Plan's internal appeal process, you have received a Final Adverse Determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an Experimental or Investigational treatment you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the Final Adverse Determination

issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You must then submit the completed application to the Claims Administrator at the address indicated on the application. If you satisfy the criteria for an external appeal, the Claims Administrator will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your Physician, or the Plan. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment the Plan will provide coverage subject to the other terms and conditions of the Plan. Please note that if the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

(5) Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the Claims Administrator. You may appoint a representative to assist you with your external

appeal request; however, the Claims Administrator may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law (regardless of state of residence), your completed request for appeal must be filed with the Plan within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover Experimental or Investigational treatments. However, the Plan shall cover an Experimental or Investigational treatment approved by an external appeal agent in accordance with the External Appeal Section of the Plan. If the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

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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 Mgr / CEO
Date 12/23/10