

**AMENDMENT NUMBER 2008-011
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 01/01/2012.

NATURE OF AMENDMENT: To amend the Plan to change the definition of allowed Mental Disorder Physicians. To amend the Plan to comply with the new External Appeal process per New York state guidelines.

Provisions Affected:

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

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 rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.*

2. 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 rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health*

facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.

3. The Section entitled CLAIMS REVIEW PROCEDURE, subsection External Appeals is amended to read:

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 *does not meet the Plan's requirements for Medically Necessity*, 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 *does not meet the Plan's requirements for Medically Necessity*, 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 **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan.

(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 **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to

matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan.

In addition, your attending Physician must certify that your 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 *four months* 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 *four months* 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; *or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health, or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay*, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours 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 \$25 for each external appeal, not to exceed \$75 in a single Plan Year. 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 four months 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 or the failure of the Plan to adhere to claim

processing requirements. 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 01/01/2012.

By Cheryl A. Cosmo

Title Acting City Manager

Date 1/17/12