

**AMENDMENT NUMBER 2008-013
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.

NATURE OF AMENDMENT:

Effective as of 01/01/2013: To amend the Plan to clarify benefits are in compliance with the federal Patient Protection and Affordable Care Act (PPACA) by including preventive fecal occult blood testing, allowing preventive services performed by Out-of-Network because an In-Network Provider could not be located, and clarifying the benefit for preventive drugs offered at no cost share.

Effective as of 01/01/2014: To amend the Plan to comply with the federal PPACA by removing Pre-Existing, include coverage of Routine Patient Costs associated with clinical trials, Out-of-Pocket limits will include deductible and copays, to indicate PPACA's Health Insurance Marketplace, and to include coverage of vitamin D2 D3 (as per the US Preventive Services Task Force). To amend the Plan to comply with the repeal of the Defense of Marriage Act (DOMA) by adding coverage for same-gender Spouses.

To amend the Plan to clarify language for Urgent Care Facility; this is not a change in benefits only a clarification. To amend the Plan to update the POMCO web address to www.MyPOMCO.com. To amend the Plan to update the appeal process; this is not a change in benefits, only a clarification.

Provisions Affected:

1. Section ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Eligibility, Eligible Classes of Dependents the following paragraphs only are amended to read as follows:

- (1) **A covered Employee's Spouse.** The term "Spouse" shall mean *the person recognized as the covered Employee's husband or wife under the laws of the state or other jurisdiction where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.*

If both *parents* are Employees, their children will be covered as dependents of *one parent*, but not of both.

2. Section ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Pre-Existing Conditions is removed.

3. Section ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Timely Enrollment is amended as follows:

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If a person enrolls prior to the 15th of the month, coverage will be effective the first of the next month. If a person enrolls after the 15th of the month coverage would not begin until the first of the next full month, which could be up to 45 days depending on receipt of enrollment.

If two Employees (*Spouses*) are covered under the Plan and the Employee covering any dependent children terminates coverage, the dependent coverage may be continued by the other covered Employee; no Waiting Period is required if coverage has been continuous.

4. Section ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Open Enrollment is amended as follows:

OPEN ENROLLMENT

At a time determined by the Plan Administrator, there will be an annual enrollment period. At that time, Covered Employees and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the Open Enrollment Period will become at a time determined by the Plan Administrator unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. *To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.*

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

Covered Retired Employees cannot add any additional dependents.

If a Retired Employee elected not to continue coverage under this Plan at the time of their retirement, they may not elect coverage at a later date for any reason.

5. Section ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsections Termination of Coverage, Continuation during Family and Medical Leave and Rehiring a Terminated Employee are amended as follows:

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

6. Section SCHEDULE OF BENEFITS, subsection Comprehensive Medical Benefits revise the following paragraphs only to read:

The Plan is a plan which contains a Network Provider Organization.

PPO name: POMCO Allied Network
 Address: 2425 James Street
 Syracuse, NY 13206
 Telephone: 888.887.6626

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. The Plan agrees to reimburse the Provider directly for Covered Services.

If a Covered Person is not able to locate an In-Network Provider for Preventive Care Services, there will be no cost sharing for the Out-of-Network Provider's charges for those covered Preventive Care Services.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request.

7. Section SCHEDULE OF BENEFITS, the following gridlines are added/ revised:

Plan Features	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Out-of-Pocket Limit <i>Including</i> Deductible, per Calendar Year PBA ,CSEA, and Library/Remington covered Employees and Retirees; and their dependents		\$460 per person
PSU and IAFF covered Employees and Retirees; and their dependents		\$410 per person

Preventative Care	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Colorectal Cancer Screening	100% of Allowed Charge, no deductible applies	
	Age 50 and older. Routine frequency for persons at average risk when recommended by a Physician: <ul style="list-style-type: none"> o Sigmoidoscopy – once every five years; or o Barium enema (double contrast) - once every five years; or o Colonoscopy – once every ten years; or o <i>Fecal occult blood.</i> 	

Hospital and other Facilities Expense Benefits	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Urgent Care Facility	100% of Allowed Charge, no deductible applies	
	<i>Includes all covered facility/Physician charges performed in the Urgent Care Facility.</i>	

Medical/Surgical Services and Supplies	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
<i>Clinical Trials (Excludes the Actual Clinical Trial)</i>	100% of Allowed Charges <hr/> <i>Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.</i>	

Any one retail Pharmacy prescription or refill is limited to a 30-day supply, unless otherwise specified. Any one mail order prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs have a quantity limit under the Plan. For additional information on medications that have quantity limits you may call ProAct Customer Service at 1.877.635.9545. *The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. Contact ProAct Customer Service Department toll-free at 1.877.635.9545 for details.*

8. Section COMPREHENSIVE MEDICAL BENEFITS, subsection Deductible, Deductible Amount and subsection Out-of-Pocket Limit are amended to read as follows:

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the **Schedule of Benefits**. *This amount will accrue toward the 100% maximum Out-of-Pocket payment.*

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the **Schedule of Benefits** is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

9. Section PREVENTIVE CARE, revise the following paragraphs only to read as follows:

PREVENTIVE CARE

Covered Charges under **Medical Benefits** are payable for routine **Preventive Care** as described in the **Schedule of Benefits**. *The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act.* 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 the first Plan Year after 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. *Ancillary charges associated with any preventive care service will be available at no cost share.*

- **Well Woman Preventive**

- **Contraceptive management.** The Plan will cover FDA-approved contraceptive methods including injectable drugs, implantable drugs, patches, emergency contraceptives, and contraceptive devices prescribed by a professional Provider.

FDA-approved injectable contraceptives, implantable contraceptives and contraceptive devices are covered **only** under the “Medical Benefits” section of the Plan. Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.

FDA-approved oral contraceptives, contraceptive patches, emergency contraceptives/*barrier contraceptives* (retail only) are covered **only** under the “Prescription Drug Benefits” section of the Plan.

Elective (female only) sterilization is covered under this benefit.

Benefits are not provided for abortifacient drugs or any drug or device obtainable without a prescription. Male contraceptive medicines or devices or male elective sterilization are not covered, regardless of intended use. **Exception:** Over-the-counter emergency contraceptives *and barrier contraceptives* will be covered at the retail Pharmacy level as shown in the “Prescription Drug Benefits” section of this document.

10. Section COMPREHENSIVE MEDICAL BENEFITS, subsection Hospital and Other Facilities, Inpatient Hospital care (3) and Urgent Care Facility are amended to read as follows:

Inpatient Hospital care. The medical services and supplies furnished by a Hospital or a Birthing Center.

- (3) **Coverage of Pregnancy.** The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. There is no coverage for a dependent child’s pregnancy, *except for prenatal care as mandated by federal law.*

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Urgent Care Facility. *As defined. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.*

11. Section COMPREHENSIVE MEDICAL BENEFITS, subsection Major Medical Benefits, add the following subsection to read as follows:

Clinical Trials

The Plan will allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. **Exception:** Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient.

Kidney Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copayment and/or Coinsurance). Additional visits are allowed up to 150% of the current Medicare allowed amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations.

Benefits are available for service or supplies related to outpatient kidney dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Maternity

The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your spouse. Expenses related to Pregnancy incurred by your dependent children are excluded, *except for prenatal care as mandated by federal law*. Coverage is not provided for expenses connected with elective abortion. The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth, cesarean section will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

12. Section DEFINED TERMS is amended to remove “Creditable Coverage”, “Genetic Information” and “Pre-Existing Condition”; to change “Allowed Charge”; and to add the following terms to read as follows:

Allowed Charge (or Allowed Expense, Allowed Fee) - The Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered non-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. *When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered outpatient renal dialysis services are payable up to 150% of the current Medicare allowable amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.*

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Approved Clinical Trial - *a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:*

- *Federally funded or approved by NIH, CDC, AHCRC, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;*
- *Study or trial conducted under FDA approved investigational new drug application;*
- *Drug trial exempt from FDA approved investigational new drug application;*
- *Or as amended by the federal Patient Protection and Affordable Care Act.*

Qualified Individual *is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.*

Routine Patient Costs *include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.*

13. Section PLAN EXCLUSIONS (7) and (18) are amended as follows:

- (7) **Birth control.** Services or supplies related to family planning, oral contraceptives or other birth control devices. Oral contraceptives are covered under the Prescription Drug Benefits. **Exception:** This Plan will follow the federal Affordable Care Act Women's Preventive Services provisions for women's contraceptive management as shown in the section entitled "Preventive Care". Oral contraceptives contraceptive patches, and over-the-counter emergency *and barrier* contraceptives (retail Pharmacy only) are covered **only** under the "Prescription Drug Benefits" section of the Plan.

- (18) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary, *unless as required by federal law.*

14. Section PRESCRIPTION DRUG BENEFITS, subsection Co-payments is amended to read as follows:

Copayments

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. **Exceptions:** Some Prescription Drugs have a quantity/dosage limit other than the 30-day and 90-day limit shown above.

Copayment is waived for Generic Drug Prescription Drugs that are mandated as covered under the "Preventive Care" provisions of the federal Patient Protection and Affordable Care Act. If a Generic Drug version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. Contact the ProAct Customer Service Department at 1.877.635.9545 for details on quantity limits and "Preventive Care" provisions under the Plan.

14. Section PRESCRIPTION DRUG BENEFITS, subsection Mandatory Generic Drug Substitution Program (only applies to IAFF, CSEA, and Library/Remington covered Employees and Retirees; and their dependents) is amended to add the following paragraph:

Exception: For preventive care drugs mandated as covered under the preventive care provisions of the federal Patient Protection and Affordable Care Act, if a Generic drug would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts. No penalty will apply.

15. Section PRESCRIPTION DRUG BENEFITS, subsection Covered Prescription Drugs (6) is amended to read as follows:

- (6) *The Plan will comply within one year of the effective date of all new recommendations or guideline changes as required under the federal Patient Protection and Affordable Care Act; the Plan will not cover any item or service that is no longer a recommended preventive service. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts for the following:*
- Aspirin when prescribed by a Physician, limited to males ages 45 years through 79 years to reduce risk of myocardial infarction and to females ages 45 years through 79 years to reduce risk of ischemic stroke.
 - Vitamin supplements when prescribed by a Physician for over-the-counter and prescription forms of folic acid for females to age 50 years who are planning or capable of Pregnancy; iron (ferrous sulphate) supplements to age one year for children who are at increased risk of iron deficiency anemia; and fluoride for children to age five years.

- FDA-approved *self-administered contraceptives when prescribed by a Physician for females with reproductive capacity (up to age 50)* to include Generic Drug oral contraceptives, patches, and emergency contraceptives. Covered Brand Name contraceptives are subject to the Brand Name Copayments shown in the Schedule of Benefits if a Generic Drug version of the drug is available *or would not be medically appropriate for the patient as determined by the attending Physician*. Over-the-counter emergency contraceptives *and barrier contraceptives* are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs
- *Vitamin D2 or D3 containing 1,000IU or less per dosage form or combination vitamin D products that also contain calcium (combination of two agents only for the combination) when prescribed by a Physician, limited to Covered Persons age 65 years or older.*

16. Section PRESCRIPTION DRUG BENEFITS, subsection Expenses Not Covered (2), (5) and (16) are amended to read as follows:

- (2) **Appetite suppressants/dietary/vitamin supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride. *Except for drugs/medicines specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.*
- (5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person, *unless as required by federal law.*
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin *or drugs as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.*

17. Section CLAIMS REVIEW PROCEDURE is amended as follows:

CLAIMS REVIEW PROCEDURE

Following is a description of how the Plan processes Claims for benefits. 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. A claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination".

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal". If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination". If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner

designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

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	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
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

Notification of Adverse Benefit Determination on Appeal	72 hours
Ongoing courses of treatment, notification of:	
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. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

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

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

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:

<i>Notification to claimant of benefit determination</i>	<i>15 days</i>
<i>Extension due to matters beyond the control of the Plan</i>	<i>15 days</i>
<i>Insufficient information on the Claim:</i>	
<i>Notification of</i>	<i>15 days</i>
<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>Notification of Adverse Benefit Determination on Appeal</i>	<i>15 days per benefit appeal</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 Adverse 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>Notification of Adverse Benefit Determination on Appeal</i>	<i>30 days per benefit appeal</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, and the claim amount, if applicable.
- (2) The specific reason or reasons for the adverse determination.
- (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. Submit all appeals to:

- (1) **Medical Benefits:** POMCO, Appeals Department, P.O. Box 6329, Syracuse, NY 13217.

- (2) **Prescription Drug Benefits:** ProAct Pharmacy Services, Inc., 29 East Main Street, Gouverneur, NY 13642.

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 does not meet the Plan's Medically Necessary requirements (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), 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 Medically Necessary requirements, 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 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).*

(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).*

Your attending Physician must also 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. If the Plan fails to adhere to claim processing requirements, you have four months from such failure 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 an 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.

18. Section CONTINUATION COORDINATION OF BENEFITS, subsection Benefit plan payment order (3) only is amended to read as:

- (3)** Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of

whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. *The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.*

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

19. Section CONTINUATION COVERAGE RIGHTS UNDER COBRA, only the following paragraphs are amended to read as:

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under City of Ogdensburg Employees' Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is City of Ogdensburg, 330 Ford Street, Ogdensburg, New York 13669, telephone 315.393.1860. COBRA continuation coverage for the Plan is administered by First Niagara Risk Management, 7481 Henry Clay Blvd., Liverpool, New York 13088, 315.461.1282. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

In addition to COBRA continuation of coverage, there may be other coverage options for Employees and their families:

- *When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.*
- *Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.*

Who can Become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee or a Dependent child of a Covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual

will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (2) Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A Covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or Dependent child of such a Covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or Dependent child was a beneficiary under the Plan.

The term "Covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

A same-sex spouse is covered as a Qualified Beneficiary under federal law as of September 16, 2013.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What Factors Should be Considered When Determining to Elect COBRA Continuation Coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. *Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Affordable Care Act.*

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a

plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the Election Period and How Long Must it Last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. *However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.*

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health Plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. *Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Affordable Care Act.*
- (5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

19. Section RESPONSIBILITIES FOR PLAN ADMINISTRATION, add the following subsection to read as:

FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only

when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), U.S. Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

* * *

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

By John M. Puntica
Title CITY MANAGER, Ogdensburg, NY
Date 11/26/13