GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

Municipalities building a stable insurance future.

125 E. Court Street
Ithaca, NY 14850
607-274-5590
INFO: consortium@twcny.rr.com
www.tompkinscountyny.gov/hconsortium

Board of Directors Meeting
May 28, 2015 – 5:30 pm - Old Jail Conference Room
(free parking in County lots after 5:00 pm)

1. Call to Order

2. Approval of March 26, 2015 Minutes **(VOTE)** (5:30)

3. Changes to the Agenda

4. Chair's Report: (5:35) J. Drake
   a. Welcome Town of Willet

5. Executive Director's Report (5:40)
   a. Benefit Clerk's Appreciation Luncheon
   b. 2015 Education Retreat
   c. Report on Teleconference with DFS

6. Treasurer's Report 2014 and 1st qtr JURAT(5:50) R. Snyder

7. Report from Audit and Finance Committee (6:00) **VOTE** S. Thayer
   a. **Resolution:** Amendment to Resolution Nos. 018-2014 and 001-2015 - Amending Recertification Process Timeline
   b. **Resolution:** Acceptance of Medical Claims Audit Report (full report available upon request)

8. Report from MCA Review Committee (6:20) J. Fracchia
   a. MCA Recommendation to Participants **VOTE**

9. Report from Joint Committee on Plan Structure and Design (6:35) S. Weatherby
   a. **Resolution:** Resolution to Adopts the "Bronze Plan" **VOTE**

10. Excellus Utilization Report (6:45) B. Miller

11. Report from Owning Your Own Health Committee (7:00) M. Cook
    a. **Resolution:** Authorization to Hire Facilitator from Tompkins Cortland Community College to Guide the Consortium to Establish a Wellness Mission Statement, Vision Statement, Objectives, and Tag line **VOTE**

12. Resolution to Ethics Complaint **VOTE (7:10)**

13. Adjournment (7:20)

Next Meeting: July 23, 2015

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Draft 4/2/2015

Board of Directors
March 26, 2015
5:30 p.m.
Scott Heyman Conference Room

Municipal Representatives: 16
Judy Drake, Town of Ithaca; Rordan Hart, Village of Trumansburg; Scott Weatherby, 1st Labor representative (Chair, Joint Committee on Plan Structure and Design); Kathy Miller, Town of Lansing; Phil Vanwormer, 2nd Labor representative; Nancy Zahler, Town of Ulysses; Herb Masser, Town of Enfield; Steve Thayer, City of Ithaca; Mack Cook, City of Cortland; John Fracchia, Town of Caroline; Mary Ann Sumner, Town of Dryden (excused at 6:46 p.m.); Laura Shawley, Town of Danby; Deb Prato, Tompkins County (arrived at 5:42 p.m.); Genevieve A. Suits, Village of Homer (arrived at 5:37 p.m.); Betty Conger, Village of Groton (excused at 6:43 p.m.); Don Scheffler, Town of Groton

Excused: 1
Peter Salton, Village of Cayuga Heights

Absent: 1
Michael Murphy, Village of Dryden

Others in attendance:
Don Barber, Executive Director; Steve Locey, Locey & Cahill; Rick Snyder, Tompkins County Finance Director; Ashley Masucci, ProAct; Joe Mareane, Tompkins County Administrator; Beth Miller, Excellus; Margaret Gannon, CSEA Benefits Department

Call to Order

Ms. Drake, Chair, called the meeting to order at 5:30 p.m.

Approval of Minutes – January 22, 2015

It was MOVED by Ms. Sumner, seconded by Ms. Shawley, and unanimously adopted by voice vote by members present with Ms. Zahler abstaining, to approve the minutes of January 22, 2015 as submitted. MINUTES APPROVED.

Changes to the Agenda

A resolution was added to the agenda entitled Amendment to Resolution No. 018-2014 and Resolution No. 001-2015 – Termination of Insurance Coverage for Spouses and Dependents of Unverified Members (Recertification Plan) and Mr. Weatherby asked for a New Business item to be added.

Chair's Report

Ms. Drake reported Deb Prato who holds the Consortium's Officer position of Secretary will be leaving her position at the County; therefore, this position needs to be filled.

Motion No. 001-2015

It was MOVED by Ms. Shawley, seconded by Ms. Sumner, and unanimously adopted by voice vote by members present, to appoint Chuck Rankin to the position of Secretary. MOTION CARRIED.

It was also announced that there will be vacancies on the Appeals Committee due to Ms. Prato and Mr. Perine leaving the Board.

Motion No. 002-2015

It was MOVED by Mr. Hart, seconded by Ms. Miller, and unanimously adopted by voice vote by members present, to appoint Ms. Sumner and Mr. Vanwormer to the Appeals Committee. MOTION CARRIED.

Motion No. 003-2015

It was MOVED by Phil Vanwormer, seconded by Rordan Hart, and unanimously adopted by voice vote by members present, to appoint Kathy Miller to the Audit and Finance Committee for a term expiring December 31, 2015. MOTION CARRIED.

Ms. Drake said a communication was recently received from the New York State Department of Financial Services regarding the audit; Mr. Barber and Mr. Locey are in the process of reviewing the information and Mr. Barber will provide information in his report.

Executive Director's Report

Mr. Barber has been communicating with the New York State Department of Financial Services and expressed frustration over the short deadlines imposed in the Department's requests of the Consortium and the extended length of time it takes for the Department to respond to communication from the Consortium. He will continue to work with the Department to resolve issues relating the New York State Audit and amendments to the Municipal Cooperative Agreement.

Mr. Barber provided an update on the medical claims audit and reported BMI has completed its work and a draft report has been submitted to Excellus for review. That report should be included on the next Board of Directors agenda. He said there is good policy work being done by the Owning Your Own Health Committee. The Human Services Coalition recently held a meeting with the Worksite Wellness Coalition which is a made up of larger operating wellness programs groups including Cornell, Ithaca College, Cayuga Medical Center, the City of Ithaca, Tompkins County, and the Town of Dryden. He said as municipalities put together their wellness programs this is a great opportunity to collaborate with other municipalities and bigger organizations that have already been through this and encouraged others to participate as well.

Ms. Sumner said the Dryden Town Board was not initially enthused about a commitment to wellness; however, it is now being viewed as an incredible staff morale booster.

Mr. Barber said he has visited the Towns of Lansing, Dryden, and Homer to present the Orientation Manual and is scheduled to visit the Towns of Danby, Enfield, and Ulysses and will be contacting other municipalities to arrange a visit.

Ms. Prato arrived at this time.

Mr. Barber said he and Mr. Locey are working on the Consortium's first annual report and it should be complete by the end of next month. After that they will be working on planning

the June 12th Educational Retreat that will be focusing on building a benefit plan. He provided an update on the Dependent Recertification Process and said 11 municipalities have completed the work; the City of Ithaca and Tompkins County are close to resolving impact bargaining. Of the 545 contracts (1,000 covered lives) that have been audited 25 (4.5%) of contracts have ineligible dependents identified and two have been added. A resolution will be considered later in the meeting relating to this. Ms. Prato agreed to send Mr. Weatherby information on the terms agreed to with CSEA White and Blue Collar units.

Mr. Barber said he would like to put together a recognition event for benefit clerks in May because of the work they have been doing relative to the Consortium and particularly with the Recertification Process. There was consensus that he should move forward with this recognition event; a suggestion was made by Ms. Sumner that municipal officials be invited to attend.

Mr. Barber said since the last Board meeting he and the Executive Committee were invited to meet with the Cayuga Area Physicians Alliance to learn about the Clinical Integration Program that was introduced a couple of years ago. He said the program is being funded by performance goals that are agreed to between CAPA and Excellus and is not part of a premium or claim that would be made. They were very impressed with the program which includes communication, best practices, and individual practice goals which are the key aspects.

Mr. Barber reported he was invited to speak to a group of municipal leaders from Niagara County who are looking to apply for Article 47 certification. It looks like they have support from key players and are moving forward.

Consultant's Financial Report

Mr. Locey reported on the first two months of financial data and stated premium income is at $6.9 million; prescription drug rebates were slightly more than anticipated. In terms of expense $4.17 million was budgeted and there has been only $2.95 million which is 29% less than budget. He said for the first two months the Consortium has accumulated almost $2.3 million in net income but he anticipates expenses to even out to bring the budget closer to what was anticipated.

He briefly reviewed a memorandum that was distributed prior to the meeting on Incurred But Not Reported Claims Liability. He explained that of all the claims that were incurred in 2012 91.84% were paid in 2012, leaving slightly over 8% paid in subsequent years; in 2013 93.22% were incurred and slightly over 6% was paid in subsequent years. This shows that the Consortium is well below the 12% IBNR amount that is required by the State. The other document provided was related to the State's investigation on reserve components. In its report the State said it felt comfortable with 17% for medical and 5% for drug which equates to the 12%. Mr. Locey said these factors show that the Consortium's reserve component is conservative, prudent, and appropriate. He stated there is more than enough to cover liabilities and no reason to increase it at this time. Work continues on the 2014 year-end report that is due to the State by the end of April.

Pro Act 2014 Pharmacy Benefit Plan Review

Ms. Masucci provided the Board with a high-level Performance Summary on 2014 Prescription Plan Performance and Utilization. A summary of the information presented is below; the full report is available on the Consortium website. She said utilization was fairly consistent with 2013.

	Membership Utilization
• Eligible Member Months	5,064
• # of RX's Dispensed	77,534
• Approved Ingredient Cost*	$ 8,269,869.92
• Total Fill Fee	$ 100,405.62
• Total Cost	$ 8,370,275.54
• Total Member Paid	$ 625,325.62
• Total Paid by Plan	$ 7,741,286.29

Ms. Masucci noted one way to save on fill fees is to encourage members to fill prescriptions through mail order which has no fill fees.

	Membership Utilization Current	2013 Utilization
• # of Rx's PMPM	1.76	1.71
• Amount Paid PMPM	$127.40	$114.79
• % Generic Rx's	80%	78%
• Amount Paid/Generic Rx	$18.91	$17.92
• % Brand Rx's	20%	22%
• Amount Paid/Brand Rx*	$292.24	$245.70
• % Formulary Rx's	95%	94%
• Ingredient Cost/Rx	$77.12	$71.90
• Fill Fee/Rx	$0.94	$1.03
• Total Cost/Rx	$78.05	$72.93
• Member Paid/Rx	$5.83	$5.73
• Plan Cost	$72.19	$67.18

The increase is primarily due to the increase in the cost of specialty drugs.

Pharmacy Eligible Members and Demographics

• Average cost per Rx for 65+	$273
• Plan paid/Rx - Generic (Tier I)	$ 24.56; 91,944 prescriptions (19.65% of plan spend - $1,521,275.13)
• Plan paid/Rx - Tier II	$279.47; 11,394 prescriptions (41.14% of plan spend - $3,184,605.52)
• Plan paid/Rx - Tier III	$312.4; 3,427 prescriptions (13.83% of plan spend - $1,070,633.48)
• Plan paid/Rx - Specialty	$2,558.30; 768 prescriptions (25.38% of plan spend - $1,964,772.16)

Ms. Masucci presented information on specialty drugs and noted there has been a decrease of 3% in utilizing members and the prescription count has decreased by almost 5%; members cost towards specialty drugs has increased by 17%.

• # of Specialty Utilizers	108
• Rx Count	768
• Total Specialty Plan Spend	$1,964,772.16
• Total Specialty Ingredient Cost	$1,977,266.86
• Total Specialty Member Spend	$ 12,360.28

Ms. Sumner referred to the full report and said there is an interesting disparity in the prescription count numbers and asked if a three-month prescription counts as three prescriptions. Ms. Masucci said she believes it does but will follow-up and report back on this.

Re**port from the Audit and Finance Committee**

RESOLUTION NO. 003 – 2015 - ACCEPTANCE OF APPLICATION BY THE TOWN OF WILLET TO BECOME A PARTICIPANT IN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH CONSORTIUM

MOVED by Mr. Thayer, seconded by Mr. Hart, and unanimously adopted by voice vote by members present.

WHEREAS, by Resolution No. 005 of 2012 and amended by Resolution No. 27 of 2014 the Consortium Board of Directors adopted a policy outlining a process of applying for membership to the Consortium, and

WHEREAS, the Town of Willet has submitted an official resolution authorizing the Town of Willet to join the Consortium in accordance with the terms and conditions outlined in the Municipal Cooperative Agreement, and

WHEREAS, the Town of Willet has complied with membership process outlined in Resolution No. 005 of 2012 and amended by Resolution No. 027 of 2014 and has submitted copies of financial reports which have been reviewed and found acceptable by the Consortium's Treasurer, Chief Financial Officer and/or the Consortium's Auditor, now therefore be it

RESOLVED, That the Greater Tompkins County Municipal Health Insurance Consortium, accepts and welcomes the Town of Willet as the 17th municipal participant, with health insurance coverage beginning May 1, 2015,

RESOLVED, further, That the Board of Directors waives the requirement of payment of 5% of premium to the Surplus Reserve Account,

RESOLVED, further, That the Board of Directors determines that the terms of assessing the pro-rata share of any surplus or deficit to the applicant shall at the time the applicant leaves the Consortium or upon dissolution of the Consortium shall be based on their share of any deficit or being paid their share of any surplus that was generated during their years of participation. The Board of Directors would identify the surplus or deficit which exists on the date of entry and again on the date of withdrawal or dissolution and bill or pay the applicant accordingly.

* * * * * * * * *

RESOLUTION NO. 004- 2015 - AMENDMENT TO RESOLUTION NO. 018-2014 AND RESOLUTION NO. 001-2015 - TERMINATION OF INSURANCE COVERAGE FOR SPOUSES AND DEPENDENTS OF UNVERIFIED MEMBERS (RECERTIFICATION PLAN)

Mr. Thayer said the Committee felt that because of the discussions that have been taking place with the unions it would be appropriate to extend the timeline from May 1 to June 1st.

MOVED by Mr. Thayer, seconded by Ms. Suits, and unanimously adopted by voice vote by members present.

WHEREAS, the Audit and Finance Committee at its March 24, 2015 meeting reviewed the dependent re-certification process, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the 5th Resolved of resolution 018-2014 and the 6th Resolved of Resolution No. 001-2015 be changed to: "RESOLVED, further, That coverage for any dependent of an employee or retiree for which no verification information has been submitted will be terminated on **June 1, 2015** and the member will be invoiced for that coverage since January 1, 2011 and the employee/retiree and their spouse and/or dependents will not be eligible for COBRA;

The complete amended resolution to read as follows:

"WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium is a self-insured municipal cooperative health benefit plan operating pursuant to Article 47 of the New York State Health Insurance Law, and

WHEREAS, at GTCMHIC's inception all employees were transferred into the Consortium without verification that their spouse and/or dependents were still valid as defined by their benefit plan, and

WHEREAS, changes occur in employees lives with marriage, divorce, child birth, adoptions that may not become known to the health insurance provider, and

WHEREAS, Consortium Board Resolution No. 005-2014 approved forms and eligibility guidelines for ensuring that spouses and/or dependents of new hires after May 1, 2014, meet consistent requirements and provide consistent documentation to confirm that their relationship with the insured complies with the Consortium's eligibility guidelines, and

WHEREAS, The Greater Tompkins County Municipal Health Insurance Consortium has a responsibility to all employees and employers to ensure that the Plan covers only eligible spouses and/or dependents, and

WHEREAS, the Audit and Finance Committee has developed an internal process utilizing each municipalities benefit clerk to implement the recertification of spouses and/or dependents of all contracts that provides necessary information for verification of eligibility while safeguarding privacy, now therefore be it

RESOLVED, upon recommendation of the Finance and Audit Committee, the Board of Directors hereby approves the 2014/2015 Recertification Plan including forms and guidelines for verification of spouse and/or dependent status for all contracts, active and retired, of the Consortium,

RESOLVED, further, That the municipal partners will be instructed and expected to execute the same verification process for consistency of results and will report such results to the Consortium,

RESOLVED, further, That the verification process will begin on November 1, 2014 with an amnesty period until February 28, 2015 for those participants without the additional collective bargaining step for the removal of any ineligible spouse and/or dependents without penalty and therefore eligible for COBRA,

RESOLVED, further, That for those participants and contracts with the additional collective bargaining step, the amnesty period for those contracts covered by the impact bargaining process, the amnesty period will continue until two (2) months after the collective bargaining process on dependent certification has been ratified, and

RESOLVED, further That any ineligible covered lives discovered after February 28, 2015, **or two** months after impact bargaining ratification for those affected contracts maybe subject to reimbursement of premium paid by the employer since the change in status or January 1, 2011 whichever is later and the ineligible person will not be eligible for COBRA.

RESOLVED, further, That coverage for any dependent of an employee or retiree for which no verification information has been submitted will be terminated on **June 1, 2015** and the member will be invoiced for that coverage since January 1, 2011 and the employee/retiree and their spouse and/or dependents will not be eligible for COBRA,

RESOLVED, further, That the Recertification Plan provides an appeals process from May 1 through June 30, 2015 that will be administered by the Appeals Committee."

* * * * * * * * *

Mr. Thayer, Chair, reported the Committee began its review of the Bronze Metal Level Plan and expects the Committee will make a recommendation at its next meeting. Information on the Bronze Plan was circulated to Board members.

Report from the Joint Committee on Plan Structure and Design

Mr. Weatherby, Chair, reported the Committee did not meet in March; at its February meeting the Committee discussed the Bronze Metal Level Plan. Ms. Drake said there was quorum at that meeting and thanked Board members for their support encouraging members to attend. The Committee elected Phil Vanwormer to the second labor position on the Board.

Report from the Owning Your Own Health Committee

Mr. Cook, Chair, distributed a Wellness Vision Proposal that was prepared by Mr. Barber. He said the Committee is proposing the Board adopt a mission statement for the Consortium and presented the following for consideration: "A community that values and practices preventative health care of promoting health and preventing disease". He asked that members think about this and to provide him or Mr. Barber with feedback.

The Committee has been discussing a branding competition for the Consortium because it has become apparent over the last several months with several initiatives that perhaps members who look to the Consortium for insurance do not really know who the insurance company is as many think it may be their employer, Excellus, or Pro Act. The branding competition would spread the message of what the Consortium is and would be incentivized. The Committee is also developing a wellness team concept and will be looking to begin collaborating on wellness initiatives with the Joint Committee on Plan Structure and Design. He stressed this is a long-term endeavor but it will bear fruit at the end. He extended an invitation to all Board members to attend meetings.

MCA (Municipal Cooperative Agreement) Subcommittee

Mr. Fracchia, Chair, reported the Committee met on March 19th and made good progress. At the next meeting they will be discussing the growth of the Consortium and how to

deal with that. Another item that came up was what happens with municipalities that have different groups within them and situations where one group choses to opt out. He said the current MCA states that in that case the municipality is not permitted to continue in the Consortium. This item will be discussed at the next meeting.

Update on Excellus Data Breach

Ms. Miller distributed information on the Anthem Data Breach that occurred across the country and said letters have gone out notifying impacted members of the breach. She said anyone who receives a letter should follow the instructions contained in the letter or visit the BlueCross BlueShield website.

Code of Ethics Complaint

Mr. Weatherby reported he filed a Code of Ethics complaint against Mack Cook, Board member representing the City of Cortland. The complaint has been forwarded to Don Barber who has turned the matter over to John Powers, the Consortium Attorney. Mr. Cook requested a copy of the complaint from Mr. Barber. Ms. Drake said the Consortium's Code of Ethics states that the complaint will be investigated by the Consortium's attorney and that is taking place. Following Mr. Cook stating he was unaware of the complaint prior to this meeting, Mr. Masser said he believes an individual should be aware of a complaint before it is announced in a public meeting.

Unfinished Business

Ms. Prato requested an update on the Mental Health Act parity; Ms. Drake said Ms. Miller has information and this is being discussed by the Audit and Finance Committee. Ms. Prato also requested an update on the claims processing audit. Mr. Barber said Excellus and BMI have been communicating and a draft report has been put together by BMI and is currently being reviewed by Excellus. The report will be presented at the next Audit and Finance Committee meeting and a report should be available at the May 28th Board meeting.

Adjournment

On motion the meeting adjourned at 7:03 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk

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RESOLUTION NO. __- 2015 - AMENDMENT TO RESOLUTION NO. 018-2014 AND RESOLUTION NO. 001-2015 - AMENDING RECERTIFICATION PROCESS TIMELINE

(Changes to Resolution No. 1 of 2015 are in bold)

RESOLVED, upon recommendation of the Finance and Audit Committee, the Board of Directors hereby approves the 2014/2015 Recertification Plan including forms and guidelines for verification of spouse and/or dependent status for all contracts, active and retired, of the Consortium,

RESOLVED, further, That the municipal partners will be instructed and expected to execute the same verification process for consistency of results and will report such results to the Consortium,

RESOLVED, further, That the verification process will begin on November 1, 2014 with an amnesty period until February 28, 2015 for those participants without the additional collective bargaining step for the removal of any ineligible spouse and/or dependents without penalty and therefore eligible for COBRA,

RESOLVED, further, That for those participants and contracts with the additional collective bargaining step, the amnesty period for those contracts covered by the impact bargaining process, the amnesty period will continue until two (2) months after the collective bargaining process on dependent certification has been ratified, and

RESOLVED, further That any ineligible covered lives discovered after February 28, 2015, or two months after impact bargaining ratification for those affected contracts may be subject to reimbursement of premium paid by the employer since the change in status or January 1, 2011 whichever is later and the ineligible person will not be eligible for COBRA,

RESOLVED, further, That any dependent of an employee or retiree for which no verification information has been submitted will be terminated on ~~May~~ **November** 1, 2015 and the member will be invoiced for that coverage since January 1, 2011 and the employee/retiree and their spouse and/or dependents will not be eligible for COBRA,

RESOLVED, further, That the Recertification Plan provides an appeals process from May 1 through ~~June 30~~ **December 31**, 2015 that will be administered by the Appeals Committee."

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Resolution No._____ - 2015 – Acceptance of Medical Claims Audit Report

WHEREAS, the New York State Department of Financial Services, during its most recent audit recommended that the Consortium conduct periodic medical claims audits, and

WHEREAS, by Resolution No. 004 of 2014 the Board of Directors charged the Audit Committee with making a recommendation to select a qualified professional firm to perform a medical claims audit as part of their fiduciary responsibility to conduct periodic medical claims audits to ensure the medical claims are paid by Excellus are in accordance with the benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, and

WHEREAS, after a review of responses to a Request for Proposals the Audit Committee engaged the firm of BMI to perform an audit of the Consortium's medical claims, and

WHEREAS, BMI has completed the medical claims audit and presented the final report to the Audit and Finance Committee, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors accepts the final audit report presented by BMI on 2014 Medical Claims.

* * * * * * * * *

Health Care Claims Audit Report
May 2015

Prepared for

Greater Tompkins County Municipal Health Ins. Consortium

Administrator: Excellus BlueCross BlueShield

Prepared by

BMI Audit Services, LLC
202 South Michigan Street, Suite 200
South Bend, Indiana 46601
(800) 826-7041

www.bmiaudit.com

Audit Process Overview

This audit report has been prepared by BMI Audit Services, LLC (BMI) as a follow up to its health care claims audit of Greater Tompkins County Municipal Health Insurance Consortium's (Greater Tompkins) group medical plan administered by Excellus BlueCross BlueShield (Excellus) in Syracuse, NY.

Using our proprietary electronic auditing tools, we examined 100% of all paid claims records between 1/1/2012 and 12/31/2013. Based on exception reports created during our forensic analysis, our auditors used their judgment to select audit samples across a comprehensive base of benefit categories. Since the scope of our audit was to choose samples judgmentally rather than randomly, the results are not stated in statistical terms and cannot be statistically extrapolated over the entire claims population.

A total of 250 claims were examined against claim documentation. If, during the manual review, the claim was considered to be paid in error, we noted the determination in an audit spreadsheet along with any related claim amounts (related claims are those claims for the same patient with the same service/benefit issues). Excellus was provided a copy of the audit spreadsheet and accompanying patient histories to assist them in their reply to the findings.

A portion of the administrative issues we identified during our manual review have been confirmed by Excellus. We asserted additional errors during the audit; however, Excellus produced additional documentation that supported its payment decision in some cases. We have reported certain samples to be disputed findings characterized by continuing disagreement over the appropriateness of payment.

We have also identified benefit payments that cannot be confirmed as having been paid correctly or incorrectly; however, various administrative issues should be addressed to ensure that Excellus' systems, training, investigative techniques, and documentation practices are consistent with Greater Tompkins intent.

Outline of Audit Steps

In preparation for and during the audit, we followed a number of steps that are outlined in detail below:

- We held a conference call with Excellus to obtain a full and complete understanding of all policies and external audit requirements and to establish project milestones. We provided both Greater Tompkins and Excellus with a Claims Audit Manual that included data file layouts, audit scope, etc.

- Greater Tompkins provided Excellus with proper notification of the audit. BMI received all relevant SPD's and amendments that correspond to the audit period. We also contacted Excellus to review audit process and data needs. Excellus required all parties to sign its confidentiality agreement before any claims data was released.

- Excellus provided the claims data file with paid claims for the audit period 1/1/2012 to 12/31/2013. A utilization review of this claims file can be found in the report's exhibits section.

- We utilized our medical audit tools to analyze 100% of Greater Tompkins health care plan claims administered by Excellus during the audit period. This forensic analysis was performed following a review of Greater Tompkins' SPD.

- Of the 62 total categories of logic run against the entire claims file, 56 categories yielded potential errors. BMI auditors reviewed patient histories for each potential error flagged and we validated our findings in order to choose a more practical sample for further review.

- Our manual review eliminated all claims from a number of categories, based on the existence of appropriate modifiers, secondary diagnoses, subsequent care, etc. Below is a listing of the 24 category reports that our manual review eliminated from further scrutiny:

Anesthesia Indicator - Other	Modifier Cross-reference
Behavior Disorder	Multiple Procedures
Birth Control	Obesity
Chiropractic	Occupational Therapy
Dependent Pregnancy	Orthopedic Shoes
Enteral and Parenteral Therapy	Physical Therapy
Foot Care	Skilled Nursing Facility
Hearing	Sleep Disorders
Hearing Aids	Speech Therapy
Invalid Codes	Surgical Trays
Massage Therapy	TMJ
Maternity Indicator	Vision

- We selected 250 audit samples from the exception reports for further review. The claims we selected for audit came from the 32 categories below:

Abortion	Global Days
Add-on Codes	Immunizations
Age Indicator	Infertility
Ambulance - No Destination	Injectable Medications
Anesthesia Indicator - Colonoscopies/Upper GIs	Large Claim
Coordination of Benefits	Learning Disorder
Copay	Medical Necessity
Cosmetic	Orthoptics
Dental	Over the Counter
Dependent Eligibility	Paid After Termination
Diagnostic Scans	Potential Other Party Liability
Duplicate	Short Term Therapy
Durable Medical Equipment	Substance Abuse
End Stage Renal Disease	Timely Filing
Family Counseling	Unbundling
Genetic Testing	Upcoding

- BMI's audit team performed an audit of the selected claims that are administered at Excellus' Syracuse, NY location. Each audited claim was thoroughly reviewed and our findings were recorded into a spreadsheet. Excellus was provided an electronic copy of our findings and asked to reply expeditiously. Excellus' responses are provided verbatim in the exhibits section of this report.

- During this portion of the audit, Excellus' adjudication accuracy for each audit sample was evaluated relative to documentation of details including claimant eligibility, provider status, duplicate payment potential, covered service, limited service, excluded service, coordination of benefits potential, and other party liability potential.

- Testing for each sample included verification of the electronic data we received from Excellus, including the claim detail described above as well as the eligibility information relative to effective dates, termination dates, birthdate, relationship, and overage dependent status of the claimants. This information was also cross-checked with the information provided by the health care providers who submitted the claims being reviewed.

- Excellus responded in writing with its comments and either agreed with the audit findings or stated its support for payment of the claim(s) in question.

- Our audit report is divided into several categories of findings. These findings are based on our analysis of Excellus' administration, responses, SPD language, etc. We provide specific dollar amounts for each claim reviewed primarily to help quantify the importance of Greater Tompkins stating its intent with regards to benefit issues, language interpretation and administrator policies. All Excellus responses are published within this report and each audit sample is characterized as follows:

    - **Agreed to Findings** Error findings that BMI and Excellus agreed to.

    - **Disputed Findings** These are audit samples in which BMI and Excellus continue to disagree over the appropriateness of the payment.

    - **Unresolved Issues** Ongoing audit issues which require additional discussion between Greater Tompkins and Excellus to confirm correct payments are being made.

    - **No Error** An audit sample in which Excellus was able to present appropriate documentation or reasoning for claim payment.

Summary of Findings

Errors discovered during the on-site phase of the audit could be reimbursed to Greater Tompkins to the extent that the plan wishes. In some cases, employers are reluctant to pursue recoveries if such actions will result in those amounts being collected from plan participants. With post-audit assistance provided by BMI, Greater Tompkins should consider its own position in this matter. Trends we uncovered which could be detrimental to the long-term effectiveness of Excellus' administration of Greater Tompkins's plan are as follows:

- **Abortion –** Plan language provided to BMI for the audit excludes coverage for elective abortions. Excellus disputes this exclusion and there appears to be a conflict in plan language intent that should be discussed during post-audit conversations.

- **Add-on Codes -** Add-on codes are those procedure codes identified in the CPT Manual as ineligible unless billed with another primary procedure code. Excellus' claim payment system for these edits should identify the add-on procedure. Excellus agreed with our findings and should confirm that correct edits are in place going forward.

- **Age Indicator –** Certain CPT (procedure) codes are designated for specific age ranges and reimbursement is determined by the appropriate level of care for that service for that age. Excellus both agreed to and disputed findings but should review its internal edits for correct processing.

- **Anesthesia Indicator** – Some surgical procedures contain consideration for conscious sedation. If an independent provider other than the surgeon bills for anesthesia it is allowable only if there is documentation of a medical condition present indicating the need for separate anesthesia and monitoring. Excellus pays these without documentation of medical indications.

- **Coordination of Benefits (COB) –** On audit sample 46, Excellus agreed to a COB error but is still reviewing COB for additional paid claims in the patient's claim history. Excellus should complete its review and notify Greater Tompkins of its findings, including dollar amounts of any payments owed the plan by other insurance.

- **Copayments –** Excellus agreed to and disputed copayment errors and should confirm that its claim payment system is programmed according to the plan's intent.

- **Cosmetic** – Proper documentation of medical necessity should be examined to determine that potentially cosmetic procedures are not performed solely to improve the patient's appearance. Excellus should confirm that it has effective procedures in place to review charges for unlisted procedures and for services that require documentation of medical necessity (i.e. potentially cosmetic services) such as treatment of keloid scars, acne, skin tag removal, etc.

- **Dental –** Payment for dental services that are not covered by the medical plan were identified. Excellus disputed our findings, citing internal payment policies, but these internal policies conflict with the plan's written exclusion.

- **Diagnostic Scans –** Plan language provided to BMI for the audit is in conflict with Excellus administration of copayments for diagnostic scans (see audit samples 100 – 109). Greater Tompkins should review and confirm its intent. Impact reports should be run if applicable.

- **Duplicate / Durable Medical Equipment** – Excellus agreed to a duplicate and DME payment error and has confirmed actions to adjust payments with providers. No additional issues to report.

- **End Stage Renal Disease –** BMI reviewed audit sample 128 to confirm documentation of an established Medicare effective date for ESRD. Excellus was able to provide documentation to confirm its effective administration for this coordination of benefits issue.

- **Genetic Testing –** BMI questioned the medical necessity of covering genetic testing for a number of diagnoses (general pregnancy, diabetes, etc.) based on internal guidelines which is likely allowing payment for testing that is not medically necessary.

- **Global Days** – The global period is the number of days during which all necessary services normally furnished by a physician (and his/her practice) before, during, and after a surgery is applied industry-wide. Excellus disputed our findings, citing system updates implemented after the audit period. Excellus confirm that effective and industry standard systems are now in place to identify global days' services to minimize the plan's unnecessary expenses.

- **Immunizations –** Base on plan language, payments for immunizations for foreign travel (Yellow fever and typhoid) should not be covered. Excellus and Greater Tompkins should discuss to confirm the plan's intent is being met.

- **Infertility –** Payments for infertility related services excluded by the plan were identified. Excellus disputed our findings, stating that infertility related services are covered and that we were using an SPD with outdated verbiage. Discussion between Excellus and Greater Tompkins should occur to confirm the plan's intent was being met

- **Injectable Medications –** Payments for unclassified drugs, experimental drugs and drugs related to excluded services were identified. Excellus disputed our findings and further discussion should take place as to Excellus' process for payment of unclassified, experimental and excluded injectables.

- **Large Claim -** BMI auditors reviewed a number of large claims to confirm policies are in place for appropriate case management, authorizations, etc. Excellus and Greater Tompkins should discuss in more depth to confirm all are in agreement with current administrator policies.

- **Medical Necessity -** Excellus should confirm it has effective systems in place to review unlisted procedures.

- **Orthoptics –** Payments were made for excluded orthoptics training. Excellus agreed and has confirmed effective systems are in place to pay according to the plan's intent.

- **Paid After Termination –** Claims were reviewed and payments were confirmed for services rendered after member termination dates. Excellus should confirm it has procedures in place to retroactively recover these payments, as necessary, unless directed otherwise by the plan. Additionally, Greater Tompkins and Excellus should discuss an effective method of reducing potential lag times in receiving termination dates.

- **Potential Other Party Liability** – There are audit samples reviewed that represent potential other party liability and potential recovery. Excellus should complete the investigation of these claims and Greater Tompkins should be given regular activity updates. Additionally, Greater Tompkins should be notified when plan members are uncooperative to any Excellus investigation of a potential third party liability issue.

- **Short Term Therapy –** BMI auditors questioned the medical necessity of speech therapy services performed in the patient's home. Excellus disputed our findings, citing the fact that there is no visit limit in plan language, but they did not address the medical necessity issue.

- **Unbundling –** BMI reviews unbundling issues by utilizing edits approved for processing of Medicare claims, considered an industry standard. This helps to control improper coding that leads to inappropriate payment. Even when modifier 59 is submitted by the health care provider, a thorough review of medical records is necessary to properly adjudicate these claims. Greater Tompkins should discuss the issue with Excellus to confirm whether or not it is comfortable with Excellus' internal processing policies.

- **Upcoding –** Upcoding is the improper use of a billing code for a medical procedure that results in a higher payment to the medical provider than that warranted by the true procedure. There are claims we reviewed in which the provider billed for a higher level of service than is supported by the diagnoses submitted.

Operational Review

BMI's operational review covered a number of areas that contribute to the successful administration of the plan's medical claims. The categories reviewed by BMI were:

- Claims System
- Large Case Management
- Claims Control
- Claims Processing
- Coordination of Benefits
- Customer Service
- Data Storage/Security
- Eligibility
- Provider Information
- Quality Audits
- Subrogation

Excellus provided responses to questions asked by BMI and we have provided these responses in a separate exhibit in this report. On an ongoing basis, Greater Tompkins and Excellus should monitor mutual internal control objectives relative to operational standards. Based on our observations of actual operations, including system security and related controls, we were not alerted to any issue or concern as to Excellus' ability to comply with various controls and quality assurance policies.

See **the Operational Exhibit** for specific findings.

On-Site Findings

Agreed to Findings

Excellus agreed to 31 payment errors (with 34 related claim lines):

Category with Agreed to Findings	# of audit samples	Related Claim Lines	Total $ (incl. related)
Add-on Codes	4	3	$934.66
Age Indicator	6	0	$221.56
Coordination of Benefits	1	0	$24.97
Copay	7	1	$200.00
Dental	2	0	$300.00
Duplicate	1	0	$34.30
Durable Medical Equipment	1	0	$167.79
Injectable Medications	1	1	$800.00
Medical Necessity	5	0	$4,039.62
Orthoptics	2	29	$1,663.86
Timely Filing	1	0	$216.35
		Total amount of agreed to findings – audited claims:	$6,688.15
		Total amount of agreed to findings – related claims:	$1,914.96
		Total Agreed to Findings, Including Related:	**$8,603.11**

BMI's audit finding and Excellus' response can be found in the **Agreed to Findings Exhibit.** It is important to note that "related" claim payments are actual claim payments reported in the data we received, and are additional payments for the same patient for the same type of error as the claim for which a payment error was made.

Disputed Findings

BMI and Excellus disagree as to the appropriateness of payment on 77 audit samples (with 538 related claim lines). BMI asserts that these disputed findings indicate either corrective action or Greater Tompkins clarification may be needed to satisfy the intent of the plan:

Category with Disputed Findings	# of audit samples	Related Claim Lines	Total $ (incl. related)
Abortion	10	25	$9,268.15
Add-on Codes	1	0	$135.76
Age Indicator	3	0	$169.07
Anesthesia Indicator - Colonoscopies/Upper GIs	9	0	$4,898.75
Copay	4	86	$2,030.76
Cosmetic	3	29	$10,502.08
Dental	7	4	$8,126.94
Genetic Testing	4	0	$5,354.65
Global Days	8	4	$1,298.24
Immunizations	5	0	$1,076.05
Injectable Medications	6	1	$1,062.14
Short Term Therapy	2	126	$9,666.16
Timely Filing	1	0	$40.00
Unbundling	6	0	$4,620.36
Upcoding	8	263	$23,293.67
		Total amount of disputed findings – audited claims:	$44,795.67
		Total amount of disputed findings – related claims:	$36,747.11
		Total Disputed Findings, Including Related:	**$81,542.78**

BMI audit findings and Excellus responses for each of the audit samples deemed to be disputed findings by BMI can be found in the **Disputed Findings Exhibit.**

Unresolved Issues

There are 39 audit samples that remain unresolved until the plan can state its intent with regards to benefit issues, language interpretation, administrator policies, etc. It is our hope that these issues will be addressed after a thorough review of the report by Greater Tompkins and in conjunction with post-audit feedback from Excellus. Accordingly, this report should be used to initiate improvement on both sides such that Greater Tompkins effectively serves in its role as plan administrator:

Category with Unresolved Issues	# of audit samples	Related Claim Lines	Total $ (incl. related)
Coordination of Benefits	1	3	$16,783.40
Copay	7	83	$2,547.48
Diagnostic Scans	8	0	($80.00)
Infertility	11	1232	$145,098.50
Large Claim	5	0	$328,916.66
Paid After Termination	2	13	$561.76
Potential Other Party Liability	3	51	$55,631.80
Short Term Therapy	2	42	$3,040.00
		Total amount of unresolved issues – audited claims:	$351,499.09
		Total amount of unresolved issues – related claims:	$201,000.51
		Total Unresolved Issues, Including Related:	**$552,499.60**

Audit comments and Excellus responses for the audit samples we deemed to be unresolved can be found in the **Unresolved Issues Exhibit.**

No Error Findings

There were 106 audit samples reviewed that BMI and Excellus agreed were paid correctly. On-site review findings of the audit samples we deemed as no error can be found in the **No Errors Exhibit**.

Plan Design Analysis

Using the experience our audit staff has gained through the examination of thousands of Summary Plan Descriptions (SPDs) for self-insured clients, we have run a Plan Design Analysis that offers potential savings available to Greater Tompkins by making a few modest changes to the current plan language:

Plan Design Analysis			
Plan Benefit Category	**Current Plan Description**	**Potential Plan Language Revisions**	**Potential Plan Savings (Audit Period)**
Anesthesia Indicator	The plan is silent on this issue.	An increase in claim submission for anesthesiology services rendered during a colonoscopy or upper GI procedures continues. Conscious sedation provided during a procedure by the physician is included; however, separate allowance for services rendered by an anesthesiologist should not be allowed unless a co-morbid condition exists (diabetes, heart condition, etc.). The plan should consider adding specific language stating that based on AMA guidelines for CPT coding, separate additional general anesthesia for scopic procedures will not be allowed without documentation of medical indication necessitating services.	$43,066
Chiropractic	The plan is silent on this issue.	Add language to limit benefit to 15 visits per calendar year.	$536,087
Cosmetic	Minor skin surgery is not addressed in the SPD. That allows many potentially cosmetic services to be paid without review, based on internal admin. guidelines.	The plan should consider specific language that limits minor skin surgery to medically necessary services and add language stating minor skin surgery such as wart removal, removal of benign growths, skin tags, etc. will not be covered without documentation of medical necessity.	$17,692
Dependent Pregnancy	The plan is silent on this issue.	Add language excluding benefits for routine pregnancy services for dependent children.	$556,393
Genetic Testing	No specific language in the SPD to limit this benefit.	Add language to restrict benefits to only those at risk of inheritable disease.	$281,318
Massage Therapy	The plan is silent on this issue.	Add language to exclude benefits for massage therapy.	$5,080
Occupational Therapy (OT)	The plan does not have a visit limitation for OT. The PPO Plan combines PT, OT and ST to a limit of 45 visits per year.	Add language to all plans to limit OT benefit to 15 visits per calendar year.	$10,168
Physical Therapy (PT)	The plan does not have a visit limitation for PT. The PPO Plan combines PT, OT and ST to a limit of 45 visits per year.	Add language to all plans to limit PT benefit to 15 visits per calendar year.	$310,629
Speech Therapy (ST)	The plan does not have a visit limitation for ST. The PPO Plan combines PT, OT and ST to a limit of 45 visits per year.	Add language to all plans to limit ST benefit to 15 visits per calendar year.	$1,457
Sleep Studies	The plan is silent on this issue.	Add language that limits benefit for sleep studies to $3,000 limit per calendar year.	$286,617
TMJ	The plan is silent on this issue.	Add language that limits benefit for TMJ to $5,000 limit per calendar year.	$12,061
		Total, Potential Plan Savings:	**$2,060,568**

Auditor Recommendations

Greater Tompkins should use the findings of this audit as a means of reducing its exposure to benefits being paid that either conflict with specific plan exclusions or do not meet the plan's intent. Excellus has made business decisions in some cases that may not reflect Greater Tompkins's preferred approach and these issues should be discussed and agreed upon:

- Greater Tompkins personnel should thoroughly review the report and work with Excellus and BMI post-audit to ensure that identified errors are reimbursed and/or corrected.

- A discussion should take place between Greater Tompkins, Excellus and BMI to review areas where plan language exclusions may have not been effectively followed. Examples include plan language which excludes and/or limits benefits for abortions, dental services, genetic testing, immunizations, infertility, etc.

- Greater Tompkins should request clarification from Excellus on several claim processing policies::

    - Excellus policies on updating its payment system to effectively flag and deny/edit claims with inappropriate age-related codes, gender specific codes, unbundling, Upcoding, etc.
    - Excellus policies on flagging and reviewing claims with unlisted procedure codes.
    - Excellus policies on identifying, investigating and reporting potential other party liability claims.
    - Policies regarding internal policies that conflict with specific plan language.
    - Excellus policies on pursuing refunds for ineligible claims, if necessary.

- Clarifications of the plan's intent should be included in future Summary Plan Descriptions.

- Excellus should share with Greater Tompkins the results of any financial impact reports run across Greater Tompkins's claim population, based on the audit findings found in this audit report.

- Greater Tompkins should review BMI's Plan Design Analysis (page 12) and consider making changes to its plan language to consistently reflect intent and to limit plan exposure for services in which current plan language allows unlimited coverage or is silent on intent. This analysis is not intended to question the accuracy of Excellus' administration on the issues raised. We are, however, providing examples of potential savings if plan language for certain services is modified to match that of companies of similar size and health care spending levels. It should be used as another tool for controlling health care costs.

Conclusion

Based on our review, we identified claim handling decisions during the course of this audit that likely have caused Greater Tompkins to incur unintended plan expenses. It is important that Excellus confirms current and accurate systems are in place to effectively administer claims according to the plan's specific intent with regard to specific exclusions and/or limitations.

It is also important to note, however, that Excellus appears to have effective processes and training procedures for minimizing such human error as long as the intent of the plan is being followed. We reviewed claims in a number of categories that commonly contain claim issues and found no concerns to report on (routine foot care, obesity, speech therapy, etc.).

Overall, Excellus appears to have effective processes and training procedures for minimizing such human error as long as the system edits / denial flags mentioned within this report are confirmed to be effective. Once the issues discussed in the report are resolved, it is likely that Excellus would be performing in a satisfactory manner in terms of benefit payment and processing accuracy, and within industry standards.

EXHIBITS

- **Summary of Audit Findings**
- **Agreed to Findings**
- **Disputed Findings**
- **Unresolved Issues**
- **Summary of No Errors**
- **Operational Questionnaire**
- **Excellus Response to Draft Report**

Immunizations – Audit item 144, 145, 146, 147, 148 – Disagree.
Excellus maintains that these immunizations are covered. There is no evidence that the patient does or does not have other risk factors present, based on medical, occupational, lifestyle, etc. Tompkins can work with Excellus and group consultants if further clarification is needed.

Injectable Medications – Audit item 160, 161, 162, 163, 165, 166 – Disagree.
Excellus considers Avastin if it is administered in the physician's office or outpatient setting. Avastin is not appropriate for home infusion or self-administration. This is a medical benefit and is not covered if the member brings a prescription to a retail pharmacy. Providers may buy and bill the drug to the Health Plan or may arrange to have the drug shipped to their office. All claims were billed and processed under the medical plan appropriately.

Large Claim – Audit item 168, 169, 170, 171, 173 – Disagree.
Utilization Management reviews pre-cert requirements prior to services being rendered. All claims were pre-certified, and the stay is within the dates approved. This is appropriate to support medical necessity.

Vision Screening – Audit item 231 – Disagree
In regards to the vision screening specifically, this claim was processed on our retired legacy system. Claim processed according to the edits in place on the previous system.

Unbundling – Audit item 235, 236, 237, 238, 239, 240 – Disagree.
Excellus decides what codes to implement using Claim check software and ultimately Excellus determines the edits and payments coded to the system. According to internal business practice these claims paid correctly.

Up coding – Audit item 241, 242, 243, 244, 245, 246, 248, 249 – Disagree.
Excellus decides what codes to implement using Claim check software and ultimately Excellus determines the edits and payments coded to the system. According to internal business practice these claims paid correctly.

Summary

Overall, the audit performed by BMI was for medical appropriateness through the use of BMI's software to review medical procedures and diagnoses. The claims were reviewed judgmentally without the review of actual medical record documentation. In several cases conclusions were made based solely upon the CPT code or diagnosis for determination of the appropriate payment of the claim benefit. There are many other components that are integrated into the claim processing system. For example, Claim Check edits software, Excellus medical policies, and internal claim pends or suspends. The one-dimensional aspect of audit software does not always merge easily with the complexities of a claim processing system.

We will continue to work diligently with our Sales team to address any issues requested by the account and/or consultant as a result of this audit. Should there be any questions or related follow-up to our response, please direct those questions to Cathy Haunfelner, Director Audit & Performance Review at cathy.haunfelner@excellus.com or 315-671-6600. We thank you for your consideration.

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM
Municipalities building a stable insurance future.

125 E. Court Street
Ithaca, NY 14850
607-274-5590
INFO: consortium@twcny.rr.com
www.tompkinscountyny.gov/hconsortium

2015 AMENDMENT TO THE

MUNICIPAL COOPERATION AGREEMENT

THIS AGREEMENT (the "Agreement") made effective as of 1st day of October 2010 (the "Effective Date"), and as amended herein, by and among each of the signatory municipal corporations hereto (collectively, the "Participants").

W H E R E A S:

1. Article 5-G of the New York General Municipal Law (the "General Municipal Law") authorizes municipal corporations to enter into cooperative agreements for the performance of those functions or activities in which they could engage individually;

2. Sections 92-a and 119-o of the General Municipal Law authorize municipalities to purchase a single health insurance policy, enter into group health plans, and establish a joint body to administer a health plan;

3. Article 47 of the New York Insurance Law (the "Insurance Law" or "N.Y. Ins. Law"), and the rules and regulations of the New York State Superintendent of Financial Services ~~Insurance~~ (the "Superintendent") set forth certain requirements for governing self-insured municipal cooperative health insurance plans;

4. Section 4702(f) of the Insurance Law defines the term "municipal corporation" to include a county, city, town, village, school district, board of cooperative educational services, public library (as defined in Section 253 of the New York State Education Law) and district (as defined in Section 119-n of the General Municipal Law); and

5. The Participants have determined to their individual satisfaction that furnishing the health benefits (including, but not limited to, medical, surgical, hospital, prescription drug, dental, and/or vision) for their eligible officers, eligible employees (as defined by the Internal Revenue Code of 1986, as amended, and the Internal Revenue Service rules and regulations), eligible retirees, and the eligible dependents of eligible officers, employees and retirees (collectively, the "Enrollees") (such definition does not include independent contractors and/or consultants) through a municipal cooperative is in their best interests as it is more cost- effective and efficient. Eligibility requirements shall be determined by each Participant's collective bargaining agreements and/or their personnel policies and procedures.

NOW, THEREFORE, the parties agree as follows:

A. PARTICIPANTS.

1. The Participants hereby designate themselves under this Agreement as the Greater Tompkins County Municipal Health Insurance Consortium (the "Consortium") for the purpose of providing health benefits (medical, surgical, hospital, prescription drug, dental, and/or vision) to those Enrollees that each Participant individually elects to include in the Greater Tompkins County

Municipal Health Insurance Consortium Medical Plan(s) (the "Plan(s)").

2. The following Participants shall comprise the ~~initial~~ current membership of the Consortium (a) County of Tompkins; (b) City of Ithaca; (c) Town of Enfield; (d) Town of Caroline; (e) Town of Ithaca; (f) Town of Danby; (g) Town of Dryden; (h) Town of Ulysses; (i) Village of Cayuga Heights; (j) Village of Groton; (k) Village of Dryden; (l) Village of Trumansburg; (m) Town of Groton; (n) Town of Lansing; (o) City of Cortland; (p) Village of Homer; (q) Town of Willet. ~~The following Participants shall comprise the current membership of the Consortium (a) County of Tompkins; (b) City of Ithaca; (c) Town of Enfield; (d) Town of Caroline; (e) Town of Ithaca; (f) Town of Danby; (g) Town of Dryden; (h) Town of Ulysses; (i) Village of Cayuga Heights; (j) Village of Groton; (k) Village of Dryden; (l) Village of Trumansburg; (m) Town of Groton.~~ Membership in the Consortium may be offered to any municipal corporation within the geographical boundaries of ~~County of Tompkins~~ the Counties of Tompkins, Cayuga, Chemung, Cortland, Tioga, Schuyler, and Seneca, provided however that, in the sole discretion of the Board (as defined below), the applicant provides satisfactory proof of its financial responsibility and is of the same type of municipal corporation as the initial Participants. Notwithstanding anything to contrary set forth in this Agreement, admission of new Participants shall not require amendment of this Section A(2). Membership shall be subject to the terms and conditions set forth in this Agreement, any amendments hereto and applicable law.

3. Participation in the Plan(s) by some, but not all, collective bargaining units or employee groups of a Participant is not encouraged and shall not be permitted absent prior Board approval. Further, after obtaining approval, any Participant which negotiates an alternative health insurance plan offering other than the plan offerings of the Consortium with a collective bargaining unit or employee group may be subject to a risk charge as determined by the Board.

4. Initial membership of additional participants shall become effective as soon as practical but preferably on the first day of the Plan Year following the adoption by the Board of the resolution to accept a municipal corporation as a Participant. Such municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon entry.

5. The Board, by a two-thirds (2/3) vote of the entire Board, may elect to permit additional municipal corporations ~~not~~ located within the geographical ~~or political~~ boundaries ~~of the County of Tompkins~~ set forth in Paragraph A(2) to become Participants subject to satisfactory proof, as determined by the Board, of such municipal corporation's financial responsibility. Such municipal corporations must agree to continue as a Participant for a minimum of three (3) years upon entry.

6. A municipal corporation that was previously a Participant, but is no longer a Participant, and which is otherwise eligible for membership in the Consortium, may apply for re-entry after a minimum of three (3) years has passed since it was last a Participant. Such re-entry shall be subject to the approval of two-thirds (2/3) of the entire Board. This re-entry waiting period may be waived by the approval of two-thirds (2/3) of the entire Board. In order to re- enter the Consortium, a municipal corporation employer must have satisfied in full all of its outstanding financial obligations to the Consortium. A municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon re-entry.

B. PARTICIPANT LIABILITY.

1. The Participants shall share in the costs of, and assume the liabilities for benefits (including medical, surgical, and hospital) provided under the Plan(s) to covered officers, employees, retirees, and their dependents. Each Participant shall pay on demand such Participant's share of any assessment or additional contribution ordered by the governing Board of the municipal cooperative health benefit plan, as set forth in Section L(4) of this Agreement or as ordered by the Superintendent or under Article 47 (forty-seven) of the New York State Insurance Law. The pro rata share shall be based on the Participant's relative "premium" contribution to the Plan(s) as a percentage of the aggregate "premium" contribution to the Plan(s), as is appropriate based on the nature of the assessment or contribution.

2. New Participants (each a "New Participant") who enter the Consortium may, at the discretion of the Board of Directors, be assessed a fee for additional financial costs above and beyond the premium contributions to the Plan(s). Any such additional financial obligations and any related terms and conditions associated with membership in the Consortium shall be determined by the Board, and shall be disclosed to the New Participant prior to its admission.

3. Each Participant shall be liable, on a pro rata basis, for any additional assessment required in the event the Consortium funding falls below those levels required by the Insurance law as follows:

a. In the event the Consortium does not have admitted assets (as defined in Insurance Law § 107) at least equal to the aggregate of its liabilities, reserves and minimum surplus required by the Insurance Law, the Board shall, within thirty (30) days, order an assessment (an "Assessment Order") for the amount that will provide sufficient funds to remove such impairment and collect from each Participant a pro-rata share of such assessed amount.

b. Each Participant that participated in the Consortium at any time during the two (2) year period prior to the issuing of an Assessment Order by the Board shall, if notified of such Assessment Order, pay its pro rata share of such assessment within ninety (90) days after the issuance of such Assessment Order. This provision shall survive termination of the Agreement of withdrawal of a Participant.

c. For purposes of this Section B(3), a Participant's pro-rata share of any assessment shall be determined by applying the ratio of the total assessment to the total contributions or premium equivalents earned during the period covered by the assessment on all Participants subject to the assessment to the contribution or premium equivalent earned during such period attributable to such Participant.

C. BOARD OF DIRECTORS.

1. The governing board of the Consortium, responsible for management, control and administration of the Consortium and the Plan(s), shall be referred to as the "Board of Directors" (the "Board"). The voting members of the Board shall be composed of one representative of each Participant and representatives of the Joint Committee on Plan Structure and Design (as set forth in Section C(11)), who shall have the authority to vote on any official action taken by the Board (each a "Director"). Each Director, except the representatives of the Joint Committee on Plan Structure and Design, shall be designated in writing by the governing body of the Participant.

2. If a Director designated by a Participant cannot fulfill his/her obligations, for any reason, as set forth herein, and the Participant desires to designate a new Director, it must notify the

Consortium's Chairperson in writing of its selection of a new designee to represent the Participant as a Director.

3. Directors shall receive no remuneration from the Consortium for their service and shall serve a term from January 1 through December 31 (the "Plan Year").

4. No Director may represent more than one Participant.

5. No Director, or any member of a Director's immediate family shall be an owner, officer, director, partner, or employee of any contractor or agency retained by the Consortium, including any third party contract administrator.

6. Except as otherwise provided in Section D of the Agreement, each Director shall be entitled to one vote. A majority of the entire Board, not simply those present, is required for the Board to take any official action, unless otherwise specified in this Agreement. The "entire Board", as used herein and elsewhere in this Agreement, shall mean the total number of Directors when there are no vacancies.

While physical presence is strongly encouraged, Directors who cannot be physically present at any meeting may attend remotely utilizing appropriate technology that allows for real time audio and visual participation and voting in the meeting as it progresses.

7. Each Participant may designate in writing an alternate Director to attend the Board's meeting when its Director cannot attend. The alternate Director may participate in the discussions at the Board meeting and will, if so designated in writing by the Participant, be authorized to exercise the Participant's voting authority. Only alternate Directors with voting authority shall be counted toward a quorum. The Joint Committee on Plan Structure and Design may designate alternate Directors as set forth in Section C(11).

8. A majority of the Directors of the Board shall constitute a quorum. A quorum is a simple majority (more than half) of the entire Board. A quorum is required for the Board to conduct any business. This quorum requirement is independent of the voting requirements set forth in Section C(6). The Board shall meet on a regular basis, but not less than on a quarterly basis at a time and place within the State of New York determined by a vote of the Board. The Board shall hold an annual meeting (the "Annual Meeting") between October 3rd and October 15th of each Plan Year.

9. Special meetings of the Board may be called at any time by the Chairperson or by any two (2) Directors. Whenever practicable, the person or persons calling such special meeting shall give at least three (3) day notice to all of the other Directors. Such notice shall set forth the time and place of the special meeting as well as a detailed agenda of the matters proposed to be acted upon. In the event three (3) day's notice cannot be given, each Director shall be given such notice as is practicable under the circumstances.

10. In the event that a special meeting is impractical due to the nature and/or urgency of any action which, in the opinion of the Chairperson, is necessary or advisable to be taken on behalf of the Consortium, the Chairperson may send proposals regarding said actions via electronic communication ~~facsimile~~ to each and all of the Directors. The Directors may then electronically communicate ~~fax~~ their approval or disapproval of said actions to the Chairperson. Upon receipt by the Chairperson of the requisite number of written approvals, the Chairperson may act on behalf of the Board in reliance upon such approvals. Any actions taken by the Chairperson pursuant to this paragraph shall be ratified at the next scheduled meeting of the Board.

11. The Chair of the Joint Committee on Plan Structure and Design and any At-Large Labor Representatives (as defined in Section K) (collectively the "Labor Representatives") shall serve as Directors and shall have the same rights and obligations as all other Directors. The Joint Committee on Plan Structure and Design may designate in writing alternate Directors to attend the Board's meetings when the Labor Representatives cannot attend. The alternate Director may, if designated in writing, be authorized to exercise the Labor Representatives' voting authority.

D. WEIGHTED VOTING.

1. Except as otherwise provided in this Agreement, any two or more Directors, acting jointly, may require a weighted vote on any matter that may come before the Board. In such event, the voting procedure set forth in this Section D shall apply in lieu of any other voting procedures set forth in this Agreement. Such weighted voting procedures shall apply solely with respect to the matter then before the Board.

2. For purposes of this Section D, each Director shall receive votes as follows:

a. each Director representing a Participant with five hundred (500) or fewer Enrollees shall be entitled to one (1) vote.

b. each Director representing a Participant with more than five hundred (500) Enrollees shall be entitled to a number of votes equaling the total number of votes assigned under subsection 2(a) above minus the number of Labor Representative votes, divided evenly by the number of Participants eligible under this subsection 2(b) and rounded down to the nearest whole number.

c. the Labor Representatives shall be entitled to one (1) vote each.

3. Attached as Addendum "A" to this Agreement is an example of the application of the voting formula contained in subparagraph "2" of this Section.

4. Notwithstanding anything to the contrary contained in this Agreement, any action taken pursuant to this Section D shall require the approval of two-thirds (2/3) of the total number of votes, if all votes had been cast.

E. ACTIONS BY THE BOARD.

Subject to the voting and quorum requirements set forth in this Agreement, the Board is authorized and/or required to take action on the following matters:

1. To fill any vacancy in any of the officers of the Consortium.

2. To fix the frequency, time and place of regular Board meetings.

3. In accordance with N.Y. Ins. Law § 4705(d)(5), to approve an annual budget for the Consortium, which shall be prepared and approved prior to October 15th of each year, and determine the annual premium equivalent rates to be paid by each Participant for each Enrollee classification in the Plan on the basis of a community rating methodology in accordance with N.Y. Ins. Law § 4705(d)(5)(b) and filed with and approved by the Superintendent.

4. To audit receipts and disbursements of the Consortium and provide for independent audits, and periodic financial and operational reports to Participants in accordance with N.Y. Ins.

Law § 4705(e)(1).

5. To establish a joint fund or funds to finance all Consortium expenditures, including claims, reserves, surplus, administration, stop-loss insurance and other expenses in accordance with N.Y. Ins. Law § 4705(d)(4).

6. To select and approve the benefits provided by the Plan(s) including the plan document(s), insurance certificate(s), and/or summary plan description(s) in accordance with N.Y. Ins. Law § 4709, a copy of the Plan(s) effective on the date of this Agreement is incorporated by reference into this Agreement.

7. To ~~annually select~~have a plan consultant (the "Plan Consultant) contract in place for the upcoming Plan Year, prior to October 1st of each year.

8. To review, consider and act on any recommendations made by the Plan Consultant.

9. To establish administrative guidelines for the efficient operation of the Plan.

10. To establish financial regulations for the entry of new Participants into the Consortium consistent with all applicable legal requirements and this Agreement.

11. In accordance with N.Y. Ins. Law § 4705(d)(2), may ~~to~~ contract with third parties, if appropriate, which may include one or more Participants, for the furnishing of all goods and services reasonably needed in the efficient operation and administration of the Consortium, including, without limitation, accounting services, legal counsel, contract administration services, consulting services, purchase of insurances and actuarial services. Provided, however (a) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts, as required in Section 92-a(6) of the General Municipal Law; (b) payment for contracted services shall be made only after such services are rendered; (c) no Director or any member of such Director's immediate family shall be an owner, officer, director, partner or employee of any contract administrator retained by the Consortium; and (d) all such agreements shall otherwise comply with the requirements of Section 92-a(6) of the General Municipal Law.

12. To purchase stop-loss insurance on behalf of the Consortium and determine each year the insurance carrier or carriers who are to provide the stop- loss insurance coverage during the next Plan Year, as required by N.Y. Ins. Law §§ 4707 and 4705(d)(3).

13. To determine and notify each Participant prior to October 15th of each Plan Year of the monthly premium equivalent for each enrollee classification during the next Plan Year commencing the following January 1st.

14. To designate the banks or trust companies in which joint funds, including reserve funds, are to be deposited and which shall be located in this state, duly chartered under federal law or the laws of this state and insured by the Federal Deposit Insurance Corporation, or any successor thereto.

15. To designate annually a treasurer (the "Treasurer") who may or may not be a Director and who shall be the treasurer, or equivalent financial officer, for one of the Participants. The Treasurer's duties shall be determined by the Chief Fiscal Officer to whom he/she will report.

16. To designate one governing Board member ~~an Officer or Director~~ to retain custody of all reports, statements, and other documents of the Consortium, in accordance with N.Y. Ins. Law § 4705(c)(2), and who shall also take minutes of each Board meeting which, if appropriate, shall

be acted upon by the Board in a subsequent meeting.

16. In accordance with N.Y. Ins. Law § 4705(e)(1), to choose the certified public accountant and the actuary to provide the reports required by this Agreement and any applicable law.

17. To designate an attorney-in-fact to receive summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Consortium. The Board designates John G. Powers, Esq. as the Consortium's initial attorney-in-fact.

18. To take all necessary action to ensure that the Consortium obtains and maintains a Certificate of Authority in accordance with the Insurance Law.

19. To take all necessary action to ensure the Consortium is operated and administered in accordance with the laws of the State of New York.

20. To take any other action authorized by law and deemed necessary to accomplish the purposes of this Agreement.

F. EXECUTIVE COMMITTEE.

1. The Executive Committee of the Consortium shall consist of the Chairperson, the Vice-Chairperson, the Secretary, and the Chief Fiscal Officer of the Consortium. The Secretary shall be the governing board member who holds all records in accordance with Article E, Section 16.

2. The Executive Committee may meet at any time between meetings of the Board, at the discretion of the Chairperson. The Executive Committee shall make recommendations to the Board.

3. The Executive Committee shall manage the Consortium between meetings of the Board, subject to such approval by the Board as may be required by this Agreement.

G. OFFICERS.

1. At the Annual Meeting, the Board shall elect from its Directors a Chairperson, Vice Chairperson, Chief Fiscal Officer, and Secretary, who shall serve for a term of one (1) year or until their successors are elected and qualified. Any vacancy in an officer's position shall be filled at the next meeting of the Board.

2. Officers of the Consortium and employees of any third party vendor, including without limitation the officers and employees of any Participant, who assist or participate in the operation of the Consortium, shall not be deemed employees of the Consortium. Each third party vendor shall provide for all necessary services and materials pursuant to annual contracts with the Consortium. The officers of the Consortium shall serve without compensation from the Consortium, but may be reimbursed for reasonable out-of-pocket expenses incurred in connection with the performance of such officers' duties.

3. Officers shall serve at the pleasure of the Board and may be removed or replaced upon a two-thirds (2/3) vote of the entire Board. This provision shall not be subject to the weighted voting alternative set forth in Section D.

H. CHAIRPERSON; VICE CHAIRPERSON; SECRETARY.

1. The Chairperson shall be the chief executive officer of the Consortium.

2. The Chairperson, or in the absence of the Chairperson, the Vice Chairperson, shall preside at all meetings of the Board.

3. In the absence of the Chairperson, the Vice Chairperson shall perform all duties related to that office.

4. The Secretary shall retain custody of all reports, statements, and other documents of the Consortium and ensure that minutes of each Board meeting are taken and transcribed which shall be acted on by the Board at a subsequent meeting, as appropriate.

I. PLAN ADMINISTRATOR.

The Board, by a two-thirds (2/3) vote of the entire Board, may annually designate an administrator and/or insurance company of the Plan (the "Plan Administrator") and the other provider(s) who are deemed by the Board to be qualified to receive, investigate, and recommend or make payment of claims, provided that the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services and/or insurance contracts and payment for such contracted services shall be made only after such services are rendered or are reasonably expected to be rendered. All such contracts shall conform to the requirements of Section 92-a(6) of the General Municipal Law.

J. CHIEF FISCAL OFFICER.

1. The Chief Fiscal Officer shall act as the chief financial administrator of the Consortium and disbursing agent for all payments made by the Consortium, and shall have custody of all monies either received or expended by the Consortium. The Chief Fiscal Officer shall be a fiscal officer of a Participant. The Chief Fiscal Officer shall receive no remuneration from the Consortium. The Plan shall reimburse the Participant that employs the Chief Fiscal Officer for reasonable and necessary out-of-pocket expenses incurred by the Chief Fiscal Officer in connection with the performance of his or her duties that relate to the Consortium.

2. All monies collected by the Chief Fiscal Officer relating to the Consortium, shall be maintained and administered as a common fund. The Chief Fiscal Officer shall, notwithstanding the provisions of the General Municipal Law, make payment in accordance with procedures developed by the Board and as deemed acceptable to the Superintendent.

3. The Chief Fiscal Officer shall be bonded for all monies received from the Participants. The amount of such bond shall be established annually by the Consortium in such monies and principal amount as may be required by the Superintendent.

4. All monies collected from the Participants by the Chief Fiscal Officer in connection with the Consortium shall be deposited in accordance with the policies of the Participant which regularly employs the Chief Fiscal Officer and shall be subject to the provisions of law governing the deposit of municipal funds.

5. The Chief Fiscal Officer may invest moneys not required for immediate expenditure in the types of investments specified in the General Municipal Law for temporary investments or as

otherwise expressly permitted by the Superintendent.

6. The Chief Fiscal Officer shall account for the Consortium's reserve funds separate and apart from all other funds of the Consortium, and such accounting shall show:

a. the purpose, source, date and amount of each sum paid into the fund;

b. the interest earned by such funds;

c. capital gains or losses resulting from the sale of investments of the Plan's reserve funds;

d. the order, purpose, date and amount of each payment from the reserve fund; and

e. the assets of the fund, indicating cash balance and schedule of investments.

7. The Chief Fiscal Officer shall cause to be prepared and shall furnish to the Board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of Enrollees, the Board's consultants, and to the Superintendent:

a. an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan;

b. an annual report and quarterly reports describing the Consortium's current financial status; and

c. an annual independent actuarial opinion on the financial soundness of the Consortium, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

8. Within ninety (90) days after the end of each Plan Year, the Chief Fiscal Officer shall furnish to the Board a detailed report of the operations and condition of the Consortium's reserve funds.

K. JOINT COMMITTEE ON PLAN STRUCTURE AND DESIGN.

1. There shall be a Joint Committee on Plan Structure and Design (the "Joint Committee"), which shall consist of (a) a representative of each collective bargaining unit that is the exclusive collective bargaining representative of any Enrollee or group of Enrollees covered by the Plan(s) (the "Union Members"); and (b) a representative of each Participant (the "Management Members"). Management Members may, but are not required to be, Directors.

2. The Joint Committee shall review all prospective Board actions in connection with the benefit structure and design of the Plan(s), and shall develop findings and recommendations with respect to such matters. The Chair of the Joint Committee shall report such findings and recommendations to the Board at any regular or special meeting of the Board.

3. The Joint Committee shall select (a) from among the Union Members, an individual who shall serve as Chair of the Joint Committee; and (b) from among the Management Members, an individual who shall serve as Vice Chair of the Joint Committee. The Joint Committee shall establish its own parliamentary rules and procedures.

4. Each eligible union shall establish such procedures by which its representative to the Joint Committee is chosen and such representative shall be designated in writing to the Chairperson of the Board and the Chair of the Joint Committee.

5. The Union Members on the Joint Committee on Plan Structure and Design shall select from among the Union Members an individual to serve as an additional at-large voting Labor Member on the Board of Directors of the Consortium. If the number of municipal members on the Consortium rises to seventeen (17), the union members of the Joint Committee on Plan Structure and Design shall select from among the Union Members an additional at-large voting Labor Member on the Board of Directors of the Consortium. The at-large voting Labor Member(s) along with the Joint Committee Chair shall collectively be the "Labor Representatives" as defined in Section C(11) of this Agreement. If the number of municipal members on the Consortium rises to twenty-three (23), the Union Members may select from among their members a third At-Large Labor Representative to serve as a Director. Thereafter, for every increase of five (5) additional municipal members added to the Consortium Union Members may select from among their members one (1) At-large Labor Representative to serve as Director. Attached hereto as Addendum "B" is a table illustrating the addition of At-Large Labor Representatives as set forth in this Section. Any At-Large Labor Representative designated according to this section shall have the same rights and obligations as all other Directors.

L. PREMIUM CALCULATIONS/PAYMENT.

1. The annual premium equivalent rates shall be established and approved by a majority of the entire Board. The method used for the development of the premium equivalent rates may be changed from time to time by the approval of two-thirds (2/3) of the entire Board, subject to review and approval by the Superintendent. The premium equivalent rates shall consist of such rates and categories of benefits as is set forth in the Plan[s] that is determined and approved by the Board consistent with New York law.

2. The Consortium shall maintain reserves and stop-loss insurance to the level and extent required by the Insurance Law and as directed by the Superintendent.

3. Each Participant's monthly premium equivalent, by enrollee classification, shall be paid by the first day of each calendar month during the Plan Year. A late payment charge of one percent (1%) of the monthly installment then due will be charged by the Board for any payment not received by the first of each month, or the next business day when the first falls on a Saturday, Sunday, legal holiday or day observed as a legal holiday by the Participants.

The Consortium may waive the first penalty once per Plan Year for each Participant, but will strictly enforce the penalty thereafter. A repeated failure to make timely payments, including any applicable penalties, may be used by the Board as an adequate justification for the expulsion of the Participant from the Consortium.

4. The Board shall assess Participants for additional contributions, if actual and anticipated losses due to benefits paid out, administrative expenses, and reserve and surplus requirements exceed the amount in the joint funds, as set forth in Section B(3) above.

5. The Board, in its sole discretion, may refund amounts in excess of reserves and surplus, or retain such excess amounts and apply these amounts as an offset to amounts projected to be paid under the next Plan Year's budget.

M. EMPLOYEE CONTRIBUTIONS.

If any Participant requires an Enrollee's contribution for benefits provided by the Consortium, the Participant shall collect such contributions at such time and in such amounts as it requires. However, the failure of a Participant to receive the Enrollee contribution on time shall not diminish or delay the payment of the Participant's monthly premium equivalent to the Consortium, as set forth in this Agreement.

N. ADDITIONAL BENEFITS.

Any Participant choosing to provide more benefits, coverages, or enrollment eligibility other than that provided under the Plan(s), will do so at its sole expense. This Agreement shall not be deemed to diminish such Participant's benefits, coverages or enrollment eligibility, the additional benefits and the payment for such additional benefits, shall not be part of the Plan(s) and shall be administered solely by and at the expense of the Participant.

O. REPORTING.

The Board, through its officers, agents, or delegatees, shall ensure that the follow reports are prepared and submitted:

1. Annually after the close of the Plan Year, not later than one-hundred twenty (120) days after the close of the Plan Year, the Board shall file a report with the Superintendent showing the financial condition and affairs of the Consortium, including an annual independent financial audit statement and independent actuarial opinion, as of the end of the preceding plan year.

2. Annually after the close of the Plan Year, the Board shall have prepared a statement and independent actuarial opinion on the financial soundness of the Plan, including the contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

3. The Board shall file reports with the Superintendent describing the Consortium's then current financial status within forty-five (45) days of the end of each quarter during the Plan year.

4. The Board shall provide the annual report to all Participants and all unions, which are the exclusive collective bargaining representatives of Enrollees, which shall be made available for review to all Enrollees.

5. The Board shall submit to the Superintendent a report describing any material changes in any information originally provided in the Certificate of Authority. Such reports, in addition to the reports described above, shall be in such form, and containing such additional content, as may be required by the Superintendent.

P. WITHDRAWAL OF PARTICIPANT.

1. Withdrawal of a Participant from the Consortium shall be effective only once

annually on the last day of the Plan Year.

2. Notice of intention of a Participant to withdraw must be given in writing to the Chairperson prior to October 3rd of each Plan Year. Failure to give such notice shall automatically extend the Participant's membership and obligations under the Agreement for another Plan Year, unless the Board shall consent to an earlier withdrawal by a two-thirds (2/3) vote.

3. Any withdrawing Participant shall be responsible for its pro rata share of any Plan deficit that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The withdrawing Participant shall be entitled to any pro rata share of surplus that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The Consortium surplus or deficit shall be based on the sum of actual expenses and the estimated liability of the Consortium as determined by the Board. These expenses and liabilities will be determined one (1) year after the end of the Plan Year in which the Participant last participated.

4. The surplus or deficit shall include recognition and offset of any claims, expenses, assets and/or penalties incurred at the time of withdrawal, but not yet paid. Such pro rata share shall be based on the Participant's relative premium contribution to the Consortium as a percentage of the aggregate premium contributions to the Consortium during the period of participation. This percentage amount may then be applied to the surplus or deficit which existed on the date of the Participant's withdrawal from the Consortium. Any pro rata surplus amount due the Participant shall be paid to the Participant one year after the effective date of the withdrawal. Any pro rata deficit amount shall be billed to the Participant by the Consortium one year after the effective date of the withdrawal and shall be due and payable within thirty (30) days after the date of such bill.

Q. DISSOLUTION; RENEWAL; EXPULSION.

1. The Board at any time, by a two-thirds (2/3) vote of the entire Board, may determine that the Consortium shall be dissolved and terminated. If such determination is made, the Consortium shall be dissolved ninety (90) days after written notice to the Participants.

a. Upon determination to dissolve the Consortium, the Board shall provide notice of its determination to the Superintendent. The Board shall develop and submit to the Superintendent for approval a plan for winding-up the Consortium's affairs in an orderly manner designed to result in timely payment of all benefits.

b. Upon termination of this Agreement, or the Consortium, each Participant shall be responsible for its pro rata share of any deficit or shall be entitled to any pro rata share of surplus that exists, after the affairs of the Consortium are closed. No part of any funds of the Consortium shall be subject to the claims of general creditors of any Participant until all Consortium benefits and other Consortium obligations have been satisfied. The Consortium's surplus or deficit shall be based on actual expenses. These expenses will be determined one year after the end of the Plan Year in which this Agreement or the Consortium terminates.

c. Any surplus or deficit shall include recognition of any claims/expenses incurred at the time of termination, but not yet paid. Such pro rata share shall be based on each Participant's relative premium contribution to the Plan as a percentage of the aggregate premium contributions to the Plan during the period of participation. This percentage amount would then be applied to the surplus or deficit which exists at the time of termination.

2. The continuation of the Consortium under the terms and conditions of the Agreement, or any amendments or restatements thereto, shall be subject to Board review on the fifth (5^{th}) anniversary of the Effective Date and on each fifth (5^{th}) anniversary date thereafter (each a "Review Date").

a. At the annual meeting a year prior to the Review Date, the Board shall include as an agenda item a reminder of the Participants' coming obligation to review the terms and conditions of the Agreement.

b. During the calendar year preceding the Review Date, each Participant shall be responsible for independently conducting a review of the terms and conditions of the Agreement and submitting to the Board of Directors a written resolution containing any objection to the existing terms and conditions or any proposed modification or amendment to the existing Agreement, such written resolution shall be submitted to the Board on or before March 1^{st} preceding the Review Date. Failure to submit any such resolution shall be deemed as each Participant's agreement and authorization to the continuation of the Consortium until the next Review Date under the existing terms and conditions of the Agreement.

c. As soon as practicable after March 1^{st}, the Board shall circulate to all Participants copies of all resolutions submitted by the Participants. Subject to Section S hereof, any resolutions relating to the modification, amendment, or objection to the Agreement submitted prior to each Review Date shall be considered and voted on by the Participants at a special meeting called for such purpose. Such special meeting shall be held on or before July 1^{st} preceding the Review Date.

d. Notwithstanding the foregoing or Section T hereof, if at the Annual Meeting following any scheduled Review Date the Board votes on and approves the budget and annual assessment for the next year, the Participants shall be deemed to have approved the continuation of the Consortium under the existing Agreement until the next Review Date.

3. The Participants acknowledge that it may be necessary in certain extraordinary circumstances to expel a Participant from the Consortium. In the event the Board determines that:

a. a Participant has acted inconsistently with the provisions of the Agreement in a way that threatens the financial well-being or legal validity of the Consortium; or

b. a Participant has acted fraudulently or has otherwise acted in bad faith with regards to the Consortium, or toward any individual Participant concerning matters relating to the Consortium, the Board may vote to conditionally terminate said Participant's membership in the Consortium. Upon such a finding by the affirmative vote of seventy-five percent (75%) of the Participants, the offending Participant shall be given sixty (60) days to correct or cure the alleged wrongdoing to the satisfaction of the Board. Upon the expiration of said sixty (60) day period, an absent satisfactory cure, ~~to~~ the Board may expel the Participant by an affirmative vote of seventy-five percent (75%) of the Participants (exclusive of the Participant under consideration). This section shall not be subject to the weighted voting provision provided in Section D. Any liabilities associated with the Participant's departure from the Consortium under this provision shall be determined by the procedures set forth in Section P of this

Agreement.

R. REPRESENTATIONS AND WARRANTIES OF PARTICIPANTS.

Each Participant by its approval of the terms and conditions of this Agreement hereby represents and warrants to each of the other Participants as follows:

1. The Participant understands and acknowledges that its participation in the Consortium under the terms and conditions of this Agreement is strictly voluntary and may be terminated as set forth herein, at the discretion of the Participant.

2. The Participant understands and acknowledges that the duly authorized decisions of the Board constitute the collective will of each of the Participants as to those matters within the scope of the Agreement.

3. The Participant understands and acknowledges that the decisions of the Board made in the best interests of the Consortium may on occasion temporarily disadvantage one or more of the individual Participants.

4. The Participant represents and warrants that its designated Director or authorized representative understands the terms and conditions of this Agreement and is suitably experienced to understand the principles upon which this Consortium operates.

5. The Participant understands and acknowledges that all Directors, or their authorized representatives, are responsible for attending all scheduled meetings. Provided that the quorum rules are satisfied, non-attendance at any scheduled meeting is deemed acquiescence by the absent Participant to any duly authorized Board-approved action at the meeting. However, a Participant that was absent from a meeting will not be presumed to have acquiesced in a particular action taken at the meeting if, within fifteen (15) calendar days after learning of such action, the Participant delivers written notice to the Chairperson that it dissents from such action. The Participant shall also notify the other members of the Board of such dissent. The Chairperson shall direct the Secretary to file the notice with the minutes of the Board.

6. The Participant understands and acknowledges that, absent bad faith or fraud, any Participant's vote approving any Board action renders that Board action immune from later challenge by that Participant.

S. RECORDS.

The Board shall have the custody of all records and documents, including financial records, associated with the operation of the Consortium. Each Participant may request records and documents relative to their participation in the Consortium by providing a written request to the Chairperson and Chief Fiscal Officer. The Consortium shall respond to each request no later than thirty (30) days after its receipt thereof, and shall include all information which can be provided under applicable law.

T. CHANGES TO AGREEMENT.

Any change or amendment to this Agreement shall require the unanimous approval of the

Participants, as authorized by their respective legislative bodies.

U. CONFIDENTIALITY.

Nothing contained in this Agreement shall be construed to waive any right that a covered person possesses under the Plan with respect to the confidentiality of medical records and that such rights will only be waived upon the written consent of such covered person.

V. ALTERNATIVE DISPUTE RESOLUTION ("ADR").

1. General. The Participants acknowledge and agree that given their budgeting and fiscal constraints, it is imperative that any disputes arising out of the operation of the Consortium be limited and that any disputes which may arise be addressed as quickly as possible. Accordingly, the Participants agree that the procedures set forth in this Section V are intended to be the exclusive means through which disputes shall be resolved. The Participants also acknowledge and agree that by executing this Agreement each Participant is limiting its right to seek redress for certain types of disputes as hereinafter provided.

2. Disputes subject to ADR. Any dispute by any Participant, Board Member, or Committee Person arising out of or relating to a contention that:

a. the Board, the Board's designated agents, a Committee person, or any Participant has failed to adhere to the terms and conditions of this Agreement or any duly-passed resolution of the Board or any duly-passed resolution of the Board;

b. the Board, the Board's designated agents, a Committee person, or any Participant has acted in bad faith or fraudulently in undertaking any duty or action under the Agreement; or

c. any other dispute otherwise arising out of or relating to: (i) the terms or conditions of this Agreement; (ii) any duly-passed decision, resolution, or policy by the Board of Directors; or (iii) otherwise requiring the interpretation of this Agreement shall be resolved exclusively through the ADR procedure set forth in paragraph (3) below.

3. ADR Procedure. Any dispute subject to ADR, as described in subparagraph (2), shall be resolved exclusively by the following procedure:

a. Board Consideration: Within ninety (90) days of the occurrence of any dispute, the objecting party (the "Claimant") shall submit a written notice of the dispute to the Chairperson specifying in detail the nature of the dispute, the parties claimed to have been involved, the specific conduct claimed, the basis under the Agreement for the Participant's objection, the specific injury or damages claimed to have been caused by the objectionable conduct to the extent then ascertainable, and the requested action or resolution of the dispute. A dispute shall be deemed to have occurred on the date the objecting party knew or reasonably should have known of the basis for the dispute.

(i) Within sixty (60) days of the submission of the written notice, the Executive Committee shall, as necessary, request further information from the Claimant, collect such other information from any other interested party or source, form a recommendation as to whether the Claimant has a valid objection or claim, and if so, recommend a fair resolution of said claim. During such period, each party shall provide the other with any reasonably requested information within such party's control. The Executive Committee

shall present its recommendation to the Board in writing, including any underlying facts, conclusions or support upon which it is based, within such sixty (60) day period.

(ii) Within sixty (60) days of the submission of the Executive Committee's recommended resolution of the dispute, the Board shall convene in a special meeting to consider the dispute and the recommended resolution. The Claimant and the Executive Committee shall each be entitled to present any argument or material it deems pertinent to the matter before the Board. The Board shall hold discussion and/or debate as appropriate on the dispute and may question the Claimant and/or the Executive Committee on their respective submissions. Pursuant to its regular procedures, the Board shall vote on whether the Claimant has a valid claim, and if so, what the fair resolution should be. The weighted voting procedure set forth in Section D shall not apply to this provision. The Board's determination shall be deemed final subject to the Claimant's right to arbitrate as set forth below.

b. Arbitration. The Claimant may challenge any Board decision under subparagraph (V)(3)(a)(ii) by filing a demand for arbitration with the American Arbitration Association within thirty (30) days of the Board's vote (a "Demand"). In the event a Claimant shall fail to file a Demand within thirty (30) days, the Board's decision shall automatically be deemed final and conclusive. In the event the Participant files a timely Demand, the arbitrator or arbitration panel may consider the claim:

provided however;

(i) in no event may the arbitrator review any action taken by the Board that occurred three (3) or more years prior to when the Chairperson received notice of the claim; and

(ii) in no event may the arbitrator award damages for any period that precedes the date the Chairperson received notice of the claim by more than twenty-four (24) months.

c. The Participants agree that the procedure set forth in this Section V shall constitute their exclusive remedy for disputes within the scope of this Section.

W. MISCELLANEOUS PROVISIONS.

1. This instrument constitutes the entire Agreement of the Participants with respect to the subject matter hereof, and contains the sole statement of the operating rules of the Consortium. This instrument supersedes any previous Agreement, whether oral or written.

2. Each Participant will perform all other acts and execute and deliver all other documents as may be necessary or appropriate to carry out the intended purposes of this Agreement.

3. If any article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion of this Agreement shall for any reason be held or adjudged to be invalid or illegal or unenforceable by any court of competent jurisdiction, such article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion so adjudged invalid, illegal or unenforceable shall be deemed separate, distinct and independent and the remainder of this Agreement shall be and remain

in full force and effect and shall not be invalidated or rendered illegal or unenforceable or otherwise affected by such holding or adjudication.

4. This Agreement shall be governed by and construed in accordance with the laws of the State of New York. Any claims made under Section V(3)(b) except to the extent otherwise limited therein, shall be governed by New York substantive law.

5. All notices to any party hereunder shall be in writing, signed by the party giving it, shall be sufficiently given or served if sent by registered or certified mail, return receipt requested, hand delivery, or overnight courier service addressed to the parties at the address designated by each party in writing. Notice shall be deemed given when transmitted.

6. This Agreement may be executed in two or more counterparts each of which shall be deemed to be an original but all of which shall constitute the same Agreement and shall become binding upon the undersigned upon delivery to the Chairperson of an executed copy of this Agreement together with a certified copy of the resolution of the legislative body approving this Agreement and authorizing its execution.

7. The provisions of Section V shall survive termination of this Agreement, withdrawal or expulsion of a Participant, and/or dissolution of the Consortium.

8. Article and section headings in this Agreement are included for reference only and shall not constitute part of this Agreement.

9. No findings or recommendations made by the Joint Committee on Plan Structure and Design or by the Chair of the Joint Committee shall be considered a waiver of any bargaining rights under any contract, law, rule, statute, or regulation.

X. APPROVAL, RATIFICATION, AND EXECUTION.

1. As a condition precedent to execution of this Municipal Cooperative Agreement and membership in the Consortium, each eligible municipal corporation desiring to be a Participant shall obtain legislative approval of the terms and conditions of this Agreement by the municipality's governing body.

2. Prior to execution of this Agreement by a Participant, the Participant shall provide the Chairperson with the resolution approving the municipality's participation in this Consortium and expressly approving the terms and conditions of this Municipal Cooperative Agreement. ~~Each presented resolution shall be attached to and considered a part of this Agreement~~. Each presented resolution shall be maintained on file with the Consortium.

3. By executing this Agreement, each signatory warrants that he/she has complied with the approval and ratification requirements herein and is otherwise properly authorized to bind the participating municipal corporation to the terms and conditions of this Agreement.

[Signature Pages Follow]

IN WITNESS WHEREOF, the undersigned has caused this Amended Agreement to be executed as of the date adopted by the Board of Directors of the Greater Tompkins County Municipal Health Insurance Consortium and subsequently adopted by all participating municipalities.

Addendum "A"

Example of Weighted Voting Formula under Section D(2)

If 11 Participants have 500 or fewer enrollees each and 2 Participants have more than 500 enrollees each, under subparagraph "a" the 11 each get 1 vote. Under subparagraph "b" the 2 large Participants get 4 votes each, which is calculated by taking the total number of votes under subparagraph "a" [11] subtracting the number of Labor Representative votes [2], dividing by the number of eligible Participants under subsection "b" [2], and rounding the result [4.5] down to the nearest whole number [4]. The Labor Representative shall have 1 vote, irrespective of the votes available to the Participants.

Addendum "B"

Illustration of At-Large Labor Representative Calculation

Total Number of Participants	Total Number of At-Large Labor Representatives
< 17	1
17-22	2
23-27	3
28-32	4
33-37	5
38-42	6

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www.tompkinscountyny.gov/hconsortium

RESOLUTION NO. _____2015 - RESOLUTION TO ADOPT THE "BRONZE PLAN"

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (Consortium) is a self-insured municipal cooperative health benefit plan operating pursuant to a Certificate of Authority issued on October 1, 2010 in accordance with the provisions of Article 47 of the New York State Health Insurance Law, and

WHEREAS, the Consortium's consultant, Locey and Cahill, LLC and medical claims administrator, Excellus BlueCross BlueShield, have collaboratively developed the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" which is consistent with and meets the standards for Bronze level benefit plans as defined by the Patient Protection and Affordable Care Act, and

WHEREAS the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" will have an Actuarial Value as defined by the Patient Protection and Affordable Care Act equal to an overall plan benefit for the average participant of 60%, and

WHEREAS, the Joint Committee on Plan Structure and Design and the Audit and Finance Committee have reviewed the details of the "GTCMHIC Standard Bronze Plan" and supports the addition of this Plan to the Consortiums menu of plan offerings, and

WHEREAS, the addition of this Plan or other metal level Plans of coverage will not diminish, alter, or eliminate any current medical or prescription drug plans offered by the Consortium, and

WHEREAS, comparable benefit plans are available to the Consortium's Participating Municipalities either through the Patient Protection and Affordable Care Act Health Insurance Exchange or ~~on~~ the private health insurance marketplace, and

WHEREAS, several Participating Municipalities in the Consortium are seeking plan designs consistent with the metal levels of coverage as defined by the Patient Protection and Affordable Care Act, now therefore be it

RESOLVED, on recommendation of the Joint Committee on Plan Structure and Design and the Audit and Finance Committees, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors adopts the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" for inclusion in the Greater Tompkins County Municipal Health Insurance Consortium's available benefit plan menu to be effective as soon as practicable,

RESOLVED, further, the Consortium Board of Directors requires that Said Actuarial Value be calculated annually by the rating and underwriting department at Excellus BlueCross BlueShield or an independent actuarial firm using the Actuarial Value Calculator developed by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) which was implemented in accordance with the Patient Protection and Affordable Care Act. If such calculator is no longer available or in use, the Consortium will have an independent Actuary develop the Actuarial Value of the health insurance plan on an annual basis. In either case, it is the intent that the result will represent an empirical estimate of the Actuarial Value calculated in a

manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population and that said Actuarial Value will be equal to or greater than 60% within an acceptable deviation of + or – 2%,

RESOLVED, further, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors directs the Executive Director to coordinate the development of procedures necessary to coordinate the logistics of making changes to the "Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan" which will occur no more frequently than once annually on January 1st of the year in question and that those procedures will become effective when approved by the Consortium Board of Directors.

* * * * * * * * *

Plan Benefit and Cost Sharing Highlights		Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Cost Sharing		**In-Network**	**Out-of-Network**
Deductible	Individual	$3,500 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
	Family	$7,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
Out-of-Pocket Maximum **(Medical Plan Coinsurance and Copayments)**	Individual	$6,350 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
	Family	$12,700 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
Out-of-Pocket Maximum **(Rx Plan Copayments)**	Individual	Combined with Medical - See Note	Not Applicable
	Family	Combined with Medical - See Note	Not Applicable
Annual Maximum		Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited
Preventive Health Care Services		**In-Network**	**Out-of-Network**
Well Child Visits and Immunizations		Covered In Full	Covered In Full
Adult Routine Physical Exams (1 Per Year)		Covered In Full	40% After Deductible
Adult Immunizations		Covered In Full	40% After Deductible
Routine Gynecological Exams		Covered In Full	40% After Deductible
Cervical Cytology Preventive		Covered In Full	40% After Deductible
Prostrate Cancer Screenings		Covered In Full	40% After Deductible
Mammography Preventive Facility and Professional		Covered In Full	40% After Deductible
Bone Density Testing Facility and Professional		20% After Deductible	40% After Deductible
Colonoscopy Screening Facility and Professional		Covered In Full	40% After Deductible
Family Planning Services		Covered In Full	40% After Deductible
Pre/Post Natal Care		Covered In Full	40% After Deductible
Inpatient Facility Benefits		**In-Network**	**Out-of-Network**

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Hospital Benefits (unlimited days)	20% After Deductible	40% After Deductible
Mental Health Care	20% After Deductible	40% After Deductible
Mental Health Residential Care	20% After Deductible	40% After Deductible
Substance Use Detoxification	20% After Deductible	40% After Deductible
Substance Use Residential Care	20% After Deductible	40% After Deductible
Skilled Nursing Facility (Limited to 45 Days Per Year In and Out-of Network)	20% After Deductible	40% After Deductible
Inpatient Physical Rehabilitation (Limited to 60 Days Per Year In and Out-of-Network)	20% After Deductible	40% After Deductible
Maternity Care	20% After Deductible	40% After Deductible
Routine Newborn Nursery Care	Covered In Full	40% After Deductible
Prosthetics - Implanted Devices	20% After Deductible	40% After Deductible

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Mastectomy	20% After Deductible	40% After Deductible
Observation Stay	20% After Deductible	40% After Deductible
Inpatient Professional Services	**In-Network**	**Out-of-Network**
Inpatient Hospital Surgery	20% After Deductible	40% After Deductible
Anesthesia	20% After Deductible	40% After Deductible
In-Hospital Physician Visits and Consults	20% After Deductible	40% After Deductible
Outpatient Facility Services	**In-Network**	**Out-of-Network**
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	20% After Deductible	40% After Deductible
Pre-Admission / Pre-Operative Testing	20% After Deductible	40% After Deductible
Diagnostic and Routine X-Rays	20% After Deductible	40% After Deductible
Advanced Imaging Services	20% After Deductible	40% After Deductible
Diagnostic and Routine Laboratory and Pathology	20% After Deductible	40% After Deductible
Diagnostic Testing	20% After Deductible	40% After Deductible
Radiation Therapy	20% After Deductible	40% After Deductible
Chemotherapy	20% After Deductible	40% After Deductible
Infusion Therapy	20% After Deductible	40% After Deductible
Dialysis	20% After Deductible	40% After Deductible
Injectable Drugs	20% After Deductible	40% After Deductible
Mental Health Care	20% After Deductible	40% After Deductible
Substance Use Care	20% After Deductible	40% After Deductible
Substance Use Family Counseling	20% After Deductible	40% After Deductible
Autism Applied Behavior Analysis	20% After Deductible	40% After Deductible
Pulmonary Rehabilitation	20% After Deductible	40% After Deductible
Cardiac Rehabilitation	20% After Deductible	40% After Deductible
Home Care and Hospice Care	**In-Network**	**Out-of-Network**

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Home Care (Limited to 40 Visits Per Year)	20% After $50 Deductible	25% After $50 Deductible
Hospice Care Inpatient	20% After Deductible	40% After Deductible
Hospice Care Outpatient	20% After Deductible	40% After Deductible
Family Bereavement (Limited to 5 Visits Per Year)	20% After Deductible	40% After Deductible
Outpatient and Office Professional Services	**In-Network**	**Out-of-Network**
Outpatient Hospital and Ambulatory Surgery	20% After Deductible	40% After Deductible
Office Surgery	20% After Deductible	40% After Deductible
Diagnostic X-Ray	20% After Deductible	40% After Deductible
Routine X-Ray	20% After Deductible	40% After Deductible
Advanced Imaging Services	20% After Deductible	40% After Deductible
Diagnostic Laboratory and Pathology	20% After Deductible	40% After Deductible

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Routine Laboratory and Pathology	20% After Deductible	40% After Deductible
Radiation Therapy	20% After Deductible	40% After Deductible
Chemotherapy	20% After Deductible	40% After Deductible
Infusion Therapy	20% After Deductible	40% After Deductible
Dialysis	20% After Deductible	40% After Deductible
Injectable Drugs	20% After Deductible	40% After Deductible
Mental Health Care	20% After Deductible	40% After Deductible
Substance Use Treatment	20% After Deductible	40% After Deductible
Maternity Care	20% After Deductible	40% After Deductible
Autism Applied Behavior Analysis	20% After Deductible	40% After Deductible
Additional (Second) Surgical Opinion	20% After Deductible	40% After Deductible
Second Medical Opinion for Cancer	20% After Deductible	40% After Deductible
Pulmonary Rehabilitation	20% After Deductible	40% After Deductible
Office Visits - Diagnostic	20% After Deductible	40% After Deductible
Medications Administration in Office	20% After Deductible	40% After Deductible
Eye Exams Diagnostic	20% After Deductible	40% After Deductible
Hearing Evaluation Diagnostic	20% After Deductible	40% After Deductible
Chiropractic Care	20% After Deductible	40% After Deductible
Allergy Testing	20% After Deductible	40% After Deductible
Allergy Treatment including Serum	Covered In Full	40% After Deductible
Hearing Evaluation Routine	Not Covered	40% After Deductible
Adult Hearing Aids	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit	Not Applicable	Not Applicable
Pediatric Hearing Aid	Not Covered	Not Covered
Cochlear Implants	20% After Deductible	40% After Deductible

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Rehab and Habilitation Services - Outpatient Facility	**In-Network**	**Out-of-Network**
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Rehab and Habilitation Services - Professional Services	**In-Network**	**Out-of-Network**
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	20% After Deductible	40% After Deductible
Other Benefits	**In-Network**	**Out-of-Network**
Treatment of Diabetes Insulin and Supplies	20% After Deductible	40% After Deductible
Diabetic Education	20% After Deductible	40% After Deductible
Diabetic Equipment	20% After Deductible	40% After Deductible
Autism Assistive Communication Device	20% After Deductible	40% After Deductible
Autologous Blood Banking	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% After Deductible	40% After Deductible
Mastectomy Prosthesis	20% After Deductible	40% After Deductible
Orthotics	20% After Deductible	40% After Deductible
Foot Orthotics	20% After Deductible	40% After Deductible
Prosthetic - External Benefit	20% After Deductible	40% After Deductible
Prosthetic - Wigs External Benefit	Not Covered	Not Covered
Medical Supplies	20% After Deductible	40% After Deductible
Acupuncture	20% After Deductible	40% After Deductible
Private Duty Nursing	Not Covered	Not Covered
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room Care - Facility (waived if admitted to hospital)	20% After Deductible	20% After Deductible
Emergency Room Care - Professional	Covered In Full	Covered In Full

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Ambulance - Pre-Hospital Emergency Services Transportation (Ground)	20% After Deductible	20% After Deductible
Air Ambulance	20% After Deductible	20% After Deductible
Water Ambulance	Not Covered	Not Covered
Urgent Care Center - Facility	20% After Deductible	40% After Deductible
Urgent Care Center - Professional Services	Covered In Full	40% After Deductible
Urgent Care Office Visit	20% After Deductible	40% After Deductible
Vision Benefits	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam (1 Per Year)	Not Covered	Not Covered
Adult Eyewear	Not Covered	Not Covered
Pediatric Routine Vision Exam (1 Per Year Children Less Than 19 Years Old)	Not Covered	Not Covered
Pediatric Eyewear	Not Covered	Not Covered

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventive and Routine	Not Covered	Not Covered
Pediatric Dental - Emergency Care	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered
Prescription Drug Benefits	**In-Network**	**Out-of-Network**
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $5	Not Covered
	Tier 2 $35	Not Covered
	Tier 3 $70	Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $10	Not Covered
	Tier 2 $70	Not Covered
	Tier 3 $140	Not Covered
$0 Generics for Children Less Than 19 Years of Age	Applicable	Not Covered
MAC Penalty (Mandatory Generic Substitution)	Applicable	Not Covered
Step Therapy	Applicable	Not Covered
Prior Authorization	Applicable	Not Covered
Generic Oral Contraceptives - Covered In Full	Applicable	Not Covered
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable
Monthly Premium Rates	**Individual**	**Subscriber and Spouse**
	#REF!	***Not Applicable***
2015 Fiscal Year	**Subscriber and Children**	**Family**

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
	Not Applicable	*#REF!*
Wellness Plan Included	*YES*	
Health Savings Account Eligible	*YES*	

*** The benefits outlined above are a summary of the benefits for the 2015 Fiscal Year and are subject to change to keep the overall benefit equal to an ACA Bronze**

*** Please refer to the actual insurance certificate or plan document for a detailed description of what is covered under this health insurance plan.**

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RESOLUTION NO. ____ - 2015 - AUTHORIZATION TO HIRE FACILITATOR FROM TOMPKINS CORTLAND COMMUNITY COLLEGE TO GUIDE THE CONSORTIUM TO ESTABLISH A WELLNESS MISSION STATEMENT, VISION STATEMENT, OBJECTIVES, AND TAG LINE

WHEREAS, in 2013 the Consortium established a committee called the Owning Your Own Health (OYOH) Committee to review the merits of incorporating a wellness component into the Consortium's recommended programming, and

WHEREAS, the OYOH Committee is comprised of Consortium members, community experts, and representatives from Excellus, ProAct, and Cayuga Area Preferred to include a wide range of perspectives and expertise, and

WHEREAS, the OYOH has reviewed several methods of establishing budget-conscious programs targeted to reduce costs and maintain and develop healthy insureds, and

WHEREAS, the OYOH Committee wishes to offer a formal directive to the Consortium Board of Directors by establishing a wellness mission statement, vision statement, objectives, and a tag line, and hire a facilitator from Tompkins Cortland Community College to solidify those benchmarks, now therefore be it

RESOLVED, on recommendation of the Owning Your Own Health Committee, That the Board of Directors authorizes the retention of a facilitator to develop a Consortium mission statement that incorporates wellness, a vision statement for the Owning Your Own Health Committee containing goals and measureable objectives, and a tagline,

RESOLVED, further, That the Chair of the Board of Directors is hereby authorized to sign an agreement with Tompkins Cortland Community College for an amount not to exceed $1,300 to facilitate the Committee's requests listed above.

* * * * * * * * *

:

TO: GTCMHIC Board Of Directors May 22, 2015
FROM: GTCMHIC Executive Committee
SUBJECT: **RECOMMENDED RESOLUTION re: Ethics Complaint of Scott Weatherby dated 3/23/ 2015**

This is the written recommendation of the Executive Committee of the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC" or the "Consortium") pursuant to Article V(3)(a)(ii) of the GTCMHIC Municipal Cooperative Agreement ("MCA") regarding a report of an alleged violation of the GTCMHIC Code of Ethics made on March 23, 2015 by Scott Weatherby against Mack Cook, both directors of the GTCMHIC.

Pursuant to Article V(3)(a)(ii) of the MCA, this memorandum is only a recommendation, which will be subject to deliberation and vote by the entire Board at the next scheduled Board meeting in the manner set forth in the alternative dispute resolution procedure contained within Article V.

Relevant Procedural Background

1. On February 2, 2014, the GTCMHIC Board of Directors adopted a "Code of Ethics and Conflict of Interest Policy" (hereinafter the "Ethics Policy") The Ethics Policy, among other things, sets forth certain expectations regarding the conduct of Directors in undertaking their responsibilities to the GTCMHIC. The Ethics policy indicates that individuals may "report" perceived violations of this policy to the GTCMHIC. (ATTACHED HERETO AS EXHIBIT "A.")

2. On or about March 23, 2015, Mr. Weatherby sent a letter to Don Barber, Executive Director of the GTCMHIC, alleging that certain conduct undertaken and statements made by fellow director Mack Cook constituted violations of the GTCMHIC Code of Ethics. The letter requested an investigation and asked that certain actions be taken to remedy the perceived violations. Included with the letter were two articles from the Cortland Standard News: *Unions threaten city's place in health care group*, dated 1/22/15 and *City gets extension on insurance data*, dated 1/23/15. (ATTACHED HERETO AS EXHIBIT "B.")

3. On March 27, 2015, Mr. Weatherby sent an e-mail to Mr. Barber and John G. Powers, outside counsel for GTCMHIC, providing further information and clarification regarding the nature of his complaint. (ATTACHED HERETO AS EXHIBIT "C.")

4. On March 27, 2015, Mr. Cook corresponded with Mr. Powers, indicating that he was represented in this matter by attorney Mary Louise Conrow of the law firm Coughlin & Gerhart LLP. (ATTACHED HERETO AS EXHIBIT "D.")

5. On April 3, 2015, counsel to the Consortium provided written guidance to the GTCMHIC Executive Committee and the parties regarding the procedural process and method of

resolution of the dispute regarding Mr. Weatherby's claim. (ATTACHED HERETO AS EXHIBIT "E.")

6. On April 30, 2015, Ms. Conrow sent a letter to the Executive Committee of GTCMHIC in response to Mr. Weatherby's claimed violation of the Ethics Policy setting forth Mr. Cook's response and various defenses to the claim. (ATTACHED HERETO AS EXHIBIT "F.")

7. The Executive Committee deliberated about this matter on May 5, 2015, and reached the following recommendation regarding what it views as a fair and appropriate resolution of the claim.

The above referenced events and attached documents constitute the entire record for this matter.

Findings

Mr. Weatherby takes the position that Mr. Cook has violated the Code of Ethics based on: (1) certain statements made to him by Mr. Cook, including specifically statements made to him on December 19, 2013 during a verbal disagreement that occurred after a Consortium meeting; (2) his perception, based on statements of opinion attributed to Mr. Cook in two articles in the Cortland Standard News, that those articles cast his union in a negative light; and (3) the demeanor displayed by Mr. Cook with respect to Mr. Weatherby, and his union, that he contends is not constructive and is otherwise unprofessional.

Mr. Cook contends that: (1) the statements Mr. Weatherby complains of were made outside the confines of the GTCMHIC meeting and as such are not subject to the Code of Ethics; (2) the statements Mr. Weatherby complains of did not concern GTCMHIC business, but rather concerned the specific business of the municipality that he represents, and that as such he did not violate the Code of Ethics; and (3) Mr. Weatherby himself may have committed a violation of the Code of Ethics by failing to remain neutral in a matter between a participating government and its bargaining unit regarding outside employment issues.

Having considered Mr. Weatherby's complaint and Mr. Cook's response, and having reviewed the Code of Ethics, the Executive Committee finds that none of the *objectively measurable* ethics requirements stated in the Code of Ethics have been violated. Further, the Committee recognizes the absolute right of public officials to provide their opinions to the media regarding matters of public concern. The Executive Committee also noted that the specific newspaper comments that offended Mr. Weatherby were not direct quotes of Mr. Cook, but rather a reporter's synopsis of the information they had received. And that Mr. Cook, or any Director, has no control over what is printed by independent media. To this end, the Committee finds nothing actionable regarding the portion of Mr. Weatherby's report as it relates to the newspaper articles.

Finally, with respect to the *subjective* requirements of the Code, the Executive Committee recognizes that there can exist the potential for interpersonal conflicts and differences of opinion regarding policy determinations. In this regard, we do not find that Mr. Weatherby's complaints regarding Mr. Cook's statements and demeanor constitute a *clear* violation of the

Consortium's Code of Ethics, or, at best, his complaints reveal his subjective dissatisfaction with the tone, content and demeanor of his interaction with Mr. Cook. The Committee submits that the Ethics Policy may not be the appropriate vehicle to air this particular type of disagreement, recognizing that adversarial discussions are to be expected whenever group decision making is required, especially in an Article 47 consortium where labor and management are statutorily required to collaborate.

However, the Committee believes that *all* Directors should endeavor to treat each other as colleagues, exercise civility to each other in all interactions, including adversarial ones, and provide each other mutual respect even in face of disagreement. To the extent that Mr. Weatherby's and Mr. Cook's conversations fell below that standard, they should consider themselves admonished.

Recommendation

Therefore, as to the recommended resolution of the present matter before the Board, the Executive Committee recommends that the Board adopt a resolution reminding all Board Directors, and Committee members, that they are to treat each other in a respectful, courteous, and civil manner with respect to all consortium activities.

Further Procedure

Under the relevant dispute resolution procedure set forth in Article V of the MCA, the Board will consider the dispute and the recommendation contained herein at the next scheduled Board meeting on May 28, 2015. The interested parties will be provided the opportunity, if they wish, to briefly address the Board regarding this matter. The Board will then deliberate pursuant to its regular procedures and will vote on the appropriate resolution of this matter.