Greater Tompkins County Municipal Health Insurance Consortium
408 East Upland Road, Suite 2 • Ithaca, New York 14850 • (607) 274-5590
healthconsortium.net • consortium@tompkins-co.org

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

AGENDA
Operations Committee
February 1, 2024 – 1:30 P.M.
GTCMHIC Conference Room - 408 East Upland Road, Ithaca

1. Call to Order — L. Granger

2. Changes to the Agenda (1:35)

3. Approval of October 23, 2023 Minutes

4. Benefit Specialist Report (1:40) — K. Rodrigues
- a. Update (Please see Executive Director December Report)
- b. PBM Transition
- c. MAPD – Aetna Contract Update
- d. CAA Reporting- Due May 2024
- e. SPD 2023 and 2024 Update with LBS
- f. Contraceptive Supply Limits
- g. Spring Benefit Clerk Update
- h. Four Tier Project Update
- i. Update Appeal Procedure

5. Resolutions (2:00)
- a. Resolution: Amendment to Resolution No. 031-2023 - Creation of 2024 Committee Structure and Appointments of Committee Members - Appointment of Valerie Saul to Operations
- b. Resolution: Dissolution of the "Owning Your Own Health Committee" for the Greater Tompkins County Municipal Health Insurance Consortium

6. Business Continuity and Cyber Security Attestation (2:15) — T. Apalovich
- a. Foxpointe Consultative Services
- b. Policy and Procedure Update
- c. Annual Review

7. Future Discussion Topics (2:25)
- a. Cybersecurity Annual Attestation

8. Adjournment (2:30)

Next Meeting: April 4, 2024

Greater Tompkins County Municipal Health Insurance Consortium
Operations Committee
October 23, 2023 – 1:00 p.m.
Zoom Remote or Aurora Room, Town of Ithaca Building

Present: Laura Granger*, Committee Chair; Schelley Michell-Nunn (arrived 1:04p); Judith (Judy) Drake, Committee Vice Chair; Brian Weinstein*, Labor; Ruby Pulliam; Janine Bond*; Sunday Earle*; Rita McCarthy*; Mark Emerson*
Excused:
Absent: LuAnn King, Ed Fairbrother
Staff/Guests: Elin Dowd, Executive Director; Teri Apalovich, Finance Manager; Kylie Rodrigues, Benefits Specialist; Lynne Sheldon, Clerk of the Board; Sarah Thomas, Tompkins County (arrived 1:19p)

* = Via Zoom remote

Call to Order

Ms. Granger, Chair, called the meeting to order at 1:00 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of July 24, 2023 Minutes

It was MOVED by Ms. Pulliam, seconded by Ms. Drake, and unanimously adopted by voice vote by members present and seen members via online, to approve the minutes as corrected of July 24, 2023. MINUTES APPROVED.

Executive Director Report Update

Ms. Dowd said that the Consortium is hoping to have the ability to start moving into the new office in Cayuga Heights after the furniture arrives around November 6th and hopes to be fully moved and hosting meetings by the 15th of November.

a. **Department of Fiscal Services (DFS)/Audit Recommendations:** Ms. Dowd said the auditors started their audit of the Consortium at the beginning of this year and it is still on-going. She said there have been many claim questions for both Excellus and ProAct. Ms. Dowd added most of the financial technical governance recommendations have been minimal such as: No Officer should be on the Audit Committee, and the Chief Financial Officer cannot chair the Audit Committee; Request to update the Consortium's records retention policy; and adopting additional cybersecurity programing.

   Ms. Dowd said DFS has billed the Consortium through the end of March, with an average of approximately $15K per month. She expects that amount to increase as DFS continues to bill for more items.

b. **Cyber Security Update with Foxpointe Solutions Proposal**: Ms. Dowd said the Consortium is working with the Tompkins County Information Technology (TC-IT)

Department as DFS recommends the Consortium to name an individual as the Information Security Officer. DFS would like cyber security programs in place to protect administrative staff from accessing HIPAA information, a safe filing system, and protection if one of the Consortium's vendors had a cyber-attack, questioning whether the Consortium would still be able to conduct business. Ms. Dowd said TC-IT does not have the manpower to provide the Consortium with an Information Security Officer, therefore, the Consortium has received a quote from Foxpointe Solutions to perform as the Consortium's Virtual Information Security Officer. Ms. Dowd said that Tompkins County may have a shared need for the services which may be beneficial as they and the Consortium could possibly share the financial aspect.

c. **Strategic Planning Updates**: Ms. Dowd said the Consortium hired Segal Consulting in 2022 to look at the Consortium's premium equivalent rate study. Locey & Cahill has continued using research data from Segal Consulting to report if the Consortium moved into a 4-tiered system, how would this move impact the Consortium and the insured. Locey & Cahill presented their analysis last week to the Executive Committee reporting there were several ways, but the options would not be easy to implement. For example, if the Consortium set a lower rate for a single plus one coverage, the family coverage premiums would have to be increased as well. She said Locey & Cahill has been asked by the Consortium to compare with the open market and how would rates compare to Excellus BCBS and/or New York State plans. These results will be discussed at the next Executive Committee meeting.

d. **PBM Transition Update:** Ms. Dowd reported Consortium staff meets with Excellus BCBS weekly to discuss the pharmacy benefit manager transition. Consortium staff is working with Excellus to confirm all the Consortium's plan descriptions to make sure that when plans are set up in their system, they are being set up correctly. Excellus BCBS has placed the Consortium in a "black out period" where the Consortium cannot do any data entry for new enrollments, as Excellus BCBS is currently setting up the new accounts. Letters to members have started to go out explaining that they will be getting a new pharmacy benefit manager. These letters will also include notifications if drugs will be increasing in tier levels, causing a negative price impact, and/or if one's pharmacy is out of network. New Excellus BCBS insurance cards identifying the new pharmacy benefit manager will also be sent out via US Mail in December. Ms. Michell-Nunn inquired what will happen with prior authorizations. Ms. Rodrigues responded if an individual has a prior authorization currently, it will roll to Excellus BCBS using the same ProAct expiration date, so individuals are not having to obtain brand new authorizations at the start of a new year. Ms. Rodrigues also explained that if an individual is on a medication that currently does not have a ProAct preauthorization, whereas Excellus BCBS requires one, Excellus BCBS will allow a 3-month extension to members so that they may pick up their medication. They will then receive a letter from Excellus BCBS stating they have picked up a medication that now requires pre-authorization, and to please reach out to their physician to send in that documentation.

e. **Update to Operations 2024 Meeting Schedule/Time:** Ms. Dowd reported that the Consortium has made a slight change to the 2024 meeting days/times.

The Operations Committee meeting will be moved to the first Thursday of the month (no longer on Monday) and will now be held quarterly. The time of the meeting will also be moved from 1:00PM to 1:30PM.

Resolutions:

Resolution: Amendment to Resolution No. 032-2022 that Amended Resolution No. 011-2020 - "Authorization by the Board of Directors to Remove Benefit Plans from the Consortium's Menu of Benefit Plan Offerings" By Restricting Plan Enrollment:

Ms. Dowd shared that the Consortium has been cleaning up the group coding system, and consolidating, and eliminating plans that the Consortium is administering. The Consortium is asking the Operations Committee to approve elimination of plans that have no individuals attached to for coverage, or plans that no municipality would like to return to. Ms. Rodrigues explained that these plans affect very few municipalities and participants, and eliminating them will really help the Consortium with not having to create benefit summaries, summary of benefits, and plan structures.

RESOLUTION NO. XXX - 2023 – AMENDMENT TO RESOLUTION NO. 032- 2022 THAT AMENDED RESOLUTION NO. 011-2020 "AUTHORIZATION BY THE BOARD OF DIRECTORS TO REMOVE BENEFIT PLANS FROM THE CONSORTIUM'S MENU OF BENEFIT PLAN OFFERINGS" BY RESTRICTING PLAN ENROLLMENT

MOVED by Ms. Drake, seconded by Ms. McCarthy. The resolution was unanimously adopted by voice vote of members present, and visibly seen members via remote locations to approve the following resolution.

WHEREAS, to achieve administrative efficiencies the Consortium removed from the Consortium's Menu of Benefit Plan Offerings effective January 1, 2021 the following benefit plans:

Indemnity Plan MM3
Plan Description:
MM3 – Basic Benefits with "Major Medical" $100/$200 Deductible & $750/$2,250 Out-of-Pocket Maximum

Medicare Supplement Plans MS1. MS2. MS5, and MS6
Plan Descriptions:
MS1 - Medicare Supplement Plans with No Prescription Drug Coverage
MS2 - Medicare Supplement Plans with $5/$15/$30 Rx Copay Plan
MS5 - Medicare Supplement Plans with 20%/20%/40% Rx Copay Plan
MS6 - Medicare Supplement Plans with 20%/30%/50% Rx Copay Plan

, and

WHEREAS, to maintain continued administrative efficiencies the Consortium removed from the Consortium's Menu of Benefit Plan Offerings effective January 1, 2023 the follow benefit plans:

Indemnity Plan MM3- Classic Blue MM RX (No ProAct Prescription Coverage)
Plan Description:

MM3- Classic Blue MM RX $50/150 Deductible & $400/ $1,200 Out-of-Pocket Maximum

PPO3- PPO $20/35
Plan Description:
PPO $20/35 with $2,000/$6,000 Out-of-Pocket Maximum and $750/ $2,250 Out of Network Deductible

, and

WHEREAS, per Resolution No. 032-2022, the Consortium voted to remove from the Consortium's Menu of Benefit Plan Offerings effective January 1, 2024, the following benefit plan:

Comprehensive MM6 Plan
Plan Description:
$500/$1500 Deductible & $2,500 $7,500 Out-of-Pocket Maximum
Due to End December 31,2023

WHEREAS, to achieve further administrative efficiencies the Consortium wishes to continue consolidation and streamlining its menu of benefit plan offerings, and

WHEREAS, although included in the menu of benefit plan offerings, there are medical and prescription drug plans that are not being utilized by Consortium Participants and have no one enrolled or less than five Participants, now therefore let it be

RESOLVED, on recommendation of the Operations Committee and the Joint Committee on Plan Structure and Design, That the Executive Committee, on behalf of the Board of Directors, hereby Amends Resolution No. 032-2022 and Resolution No. 011-2020 "Authorization by the Board of Directors to Remove Benefit Plans from the Consortium's Menu of Benefit Plan Offerings" to include the following benefit plans be removed from the Consortium's Menu of Benefit Plan Offerings, and any new Participants will be restricted from enrolling in the following plans due to low enrollment, to be effective January 1, 2024.

3T11- 3 Tier Prescription Drug Plan
Plan Description:
3T11- 3 Tier 20%/20%/40% Prescription Coverage

3T13- 3 Tier Prescription Drug Plan
Plan Description:
3T13- 3 Tier 20%/30%/50% Prescription Coverage

PPO1 $10/35 OV Kids $0
Plan Description:
PPO1 $10/35 OV Kids $0 Copay Under 19 for select services with $1,000/ $3,000 Out-of-Pocket Maximum & $250/$750 Out of Network Deductible.

Indemnity Plan MM1 Classic Blue $100/300 Medical Plan
Plan Description:
Classic Blue $100/$300 Deductible & $400/$1,200 Out-of-Pocket Maximum

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Resolution: Complete and Close 2022 Dependent Audit: Ms. Dowd explained that the Consortium started a dependent audit in 2022, where some extensions were given. She said these audits support the Consortium to pay claims effectively by removing dependents who are no longer qualified dependents. These records will be audited on a more regular basis every three years to confirm that municipalities are keeping updated records, due to divorced individuals, new retirees, as well as stepchildren, or aged children turning 26 that should be terminated coming off coverage that should not be covered. Currently, all audits have been completed. Ms. Rodrigues added that during the audit, the Consortium did not find many who carried unqualified dependents. She said Excellus has taken on notifying people when dependents age out, which has helped dramatically. She said this wasn't happening previously, which was portion of why some adult dependents were still on the plan when they shouldn't have been.

Resolution No. XXX- 2023: Complete and Close 2022 Dependent Audit

MOVED by Ms. Pulliam, seconded by Mr. Emerson. The resolution was unanimously adopted by voice vote of members present, and visibly seen members via remote locations to approve the following resolution.

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

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

WHEREAS, the GTCMHIC has a responsibility to all employees and employers to ensure that the Plan covers only eligible spouses and/or dependents, and

WHEREAS, the latest deadline for completion, May 15, 2022, for the Dependent Certification Audit, as outlined in Resolution No. 01-2015, by all municipal members has expired, and

WHEREAS, the Consortium member municipalities have completed the dependent verification process and have documented that 40 enrollees needed to be moved from active class to retiree class but there were no errors of the certified contracts with dependents found, and

WHEREAS, Resolution No. 013-2023, Directing Executive Director and Staff to Complete the City of Ithaca's Dependent Certification Audit, has been completed as of September 15, 2023, with the exception of the union groups IPFFA and COU, per the City of Ithaca's request and per the Memorandum Of Understanding, MOU, recently established with the IPFFA and COU unions, and

WHEREAS, The City of Ithaca will complete the audit for these groups as of November 30, 2023, now therefore be it

RESOLVED, on the recommendation of the Operations Committee and the Executive Committee that the Dependent Audit has been completed and all municipal members have sent in reports to the Consortium, and be it

FURTHER RESOLVED, pending the completion by the City of Ithaca dependent audit on November 30, 2023, the 2022 Dependent Audit can be closed.

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Resolution: Amendment of Outdated Resolution No. 001 of 2017 "Adoption of GTCMHIC Records Retention Policy" and Adopt the UPDATED LGS-1: Ms. Dowd explained that the Department of Financial Services (DFS) recommended during their audit of the Consortium that the Consortium must adopt a 2017 "Records Retention Policy" that New York State Archives updated in 2021. The LGS-1 features records for the general administration of all local government NY State archives.

RESOLUTION NO. XXX - 2023 – AMENDMENT OF OUTDATED RESOLUTION NO. 001 OF 2017 "ADOPTION OF GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM (GTCMHIC) "RECORDS RETENTION POLICY" and ADOPT THE UPDATED LGS-1 FEATURING RECORDS FOR THE GENERAL ADMINISTRATION OF ALL LOCAL GOVERNMENT NY STATE ARCHIVES

MOVED by Ms. Drake, seconded by Mr. Emerson. The resolution was unanimously adopted by voice vote of members present, and visibly seen members via remote locations to approve the following resolution.

WHEREAS, Per Resolution No. 001-2017, The GTCMHIC adopted the New York State Archives CO-2 as its records retention schedule for the Consortium's administrative records, and

WHEREAS, The record retention report the GTCMHIC adopted via resolution, is now deemed outdated by the NYS Department of Financial Services (DFS), and

WHEREAS, Per New York State Archives, 2021 LGS-1 consolidates, supersedes, and replaces Schedule CO-2, MU-1, MI-1 and ED-1, therefore now be it,

RESOLVED, By the GTCMHIC that *Retention and Disposition Schedule for New York Local Government Records (LGS-1)*, issued pursuant to Article 57-A of the Arts and Cultural Affairs Law, and containing legal minimum retention periods for local government records, is hereby adopted for use by all officers in legally disposing of valueless records listed therein.

FURTHER RESOLVED, that in accordance with Article 57-A:

(a)only those records will be disposed of that are described in *Retention and Disposition Schedule for New York Local Government Records (LGS-1),* after they have met the minimum retention periods described therein;

(b)only those records will be disposed of that do not have sufficient administrative, fiscal, legal, or historical value to merit retention beyond established legal minimum periods.

FURTHER RESOLVED, On recommendation of the Operations Committee, That the Executive Committee on behalf of the Board of Directors, hereby adopts the amended 2021 Records Retention Policy – LGS-1 as the record retentions policy for the Greater Tompkins County Municipal Health Insurance Consortium effective immediately.

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Future Discussion Topics:

Update Appeal Procedure with new Excellus PBM in place
Summary Plan Language

Adjournment

The meeting was adjourned at 1:32 p.m.

The next meeting will be held February 1, 2024 (1st Thursday) @ 1:30PM

Respectfully submitted by Lynne Sheldon, Clerk of the Board

Executive Director Report
December 2023

In December the Consortium is focused on finishing the open enrollment process, setting up new members, year-end reporting, and the transition to our new pharmacy benefit manager, Excellus, effective January 1, 2024. In addition, we have just completed our move to new offices located in the Village of Cayuga Heights. We are still in the process of getting settled and look forward to welcoming you to our new location soon.

New ID cards will be issued to all members due to the pharmacy benefit manager change. All subscribers must present their new ID card to their retail pharmacy to make sure prescriptions are filled with the new administrator. Excellus is sending letters directly to each subscriber and Benefit Clerks have been asked to communicate this to all employees.

We are still looking for a few municipalities to send in the 2023 signed MCA with supporting municipal resolution so we can close our files on that update. Once all signed MCAs are received, we will start the process to secure approval on the 2024 MCA update.

The staff and our consultants are working on updating all our Certificates of Coverage for approval with the Department of Financial Services. In addition, new plan summaries will be posted on the website to reflect Excellus as the pharmacy manager and to also include any other benefit changes that have happened or will happen in 2024.

We have seen our claims rising in 2023. As of the end of October medical claims are 3.6% over plan and prescription drugs are 12.47 % over plan. We are keeping our eyes on several large losses representing 23.64% of our total claims. As a result, we are now planning to fall short of our annual budget thus relying more on our unencumbered fund balance than we had planned. Nationally medical claims are trending higher as new expensive drugs are being introduced and inflation contributes to the overall increase in general costs.

We are seeing more participants in our Wellness program. Monthly challenges focus on helping your employees understand the value of managing their overall health in fun creative ways to help improve long term health results. There was major concern in the Blue4U results with 2023 participants. Due to municipal wellness incentive programs involvement with subscribers utilizing this program to get their biometric measurements has grown significantly. Thus, the Consortium can look at overall comorbidity statistics for our subscribers. The level of subscribers failing on several of the comorbidity metrics could be the reason for our increased claims cost.

The Department of Financial Services (DFS) audit for the years 2018 – 2021 is coming to conclusion. Teri Apalovich and I attended our first exit meeting with DFS sharing the auditors' findings and recommendations. Overall, it was a good audit and Teri received compliments on the way she effectively managed the audit and the ability of all our partners to share data efficiently with the examiners. We will have several recommendations on how to improve our cyber security and at least eleven general recommendations including some changes we have already incorporated into the organization. Closing out the audit will happen sometime early next year when we will be able to provide you with a full report.

<u>Executive Committee</u>

The Executive Committee continues to review data related to premium equivalent rates and offering a four-tier premium model. New data will be reviewed at the December meeting that compares what a Consortium four tier model would look like compared to similar Excellus plan tiers. Once this data has

been reviewed and discussed in detail, a decision will be made if we would like to change our model and what an implementation plan would look like.

Aetna has decided to withdraw their group pricing to the Consortium for Medicare Advantage 2024 plans. Therefore, we will not be offering any Medicare Advantage plans in 2024. We will regroup early in 2024 to see what options we will want to offer retirees going forward.

Operations

We have approved the Consortium partnering with Lifetime Benefit Solutions to handle COBRA administration notification and enrollment. All small groups will now have this service commencing in 2024.

Clean up work has started to eliminate some medical and prescription drug plans from the Consortium offerings. The plans being eliminated either had less than 10 enrollees or no subscribers in them. Those with current enrollees were asked to voluntarily move to comparable plans. Once confirmation was made that municipalities would move to the alternative plans, approval was secured to eliminate these plans. Eliminating plans that are no longer in use help streamline administrative work.

The dependent audit of 2022 is now closed. I am pleased to report that minimal changes needed to be made and the Consortium experienced no additional costs for claims processed for ineligible dependents.

Audit and Finance

The Audit and Finance Committee was instrumental in suggesting that the Consortium utilize the rate stabilization reserve to keep premium increases at the 8% level for 2024. All member municipalities have now received their first 2024 invoice at the new premium equivalent rate level.

The committee is also advancing recommendations to add new resources to our mix. Due to the DFS examination we will increase our consultant portfolio to include a cybersecurity expert and expand our actuarial resources.

The Finance team will continue to keep Locey and Cahill informed of any changes to revenue and expense changes. In turn, Locey and Cahill will continue to manage our large losses to ensure we are managing cash flow effectively and utilizing our reserves appropriately.

Joint Committee on Plan Structure and Design

The Committee reviewed a proposal for municipal members to voluntarily select an Employee Assistance Program for their employees. The ESI EAP was selected as the vendor of choice with 694 new subscribers covered under the plan.

Nominations and Engagement

Due to local election results and retirement, there are new vacancies in some of our committees. After the new year we will review the changes and meet to fill any vacancies.

Executive Director Report
December 2023

Claims and Appeals

BMI continues to audit both our Excellus medical claims and ProAct prescription drug claims. We hope to close the medical audit early in 2024 but don't expect the prescription drug audit to close until the end of the second quarter.

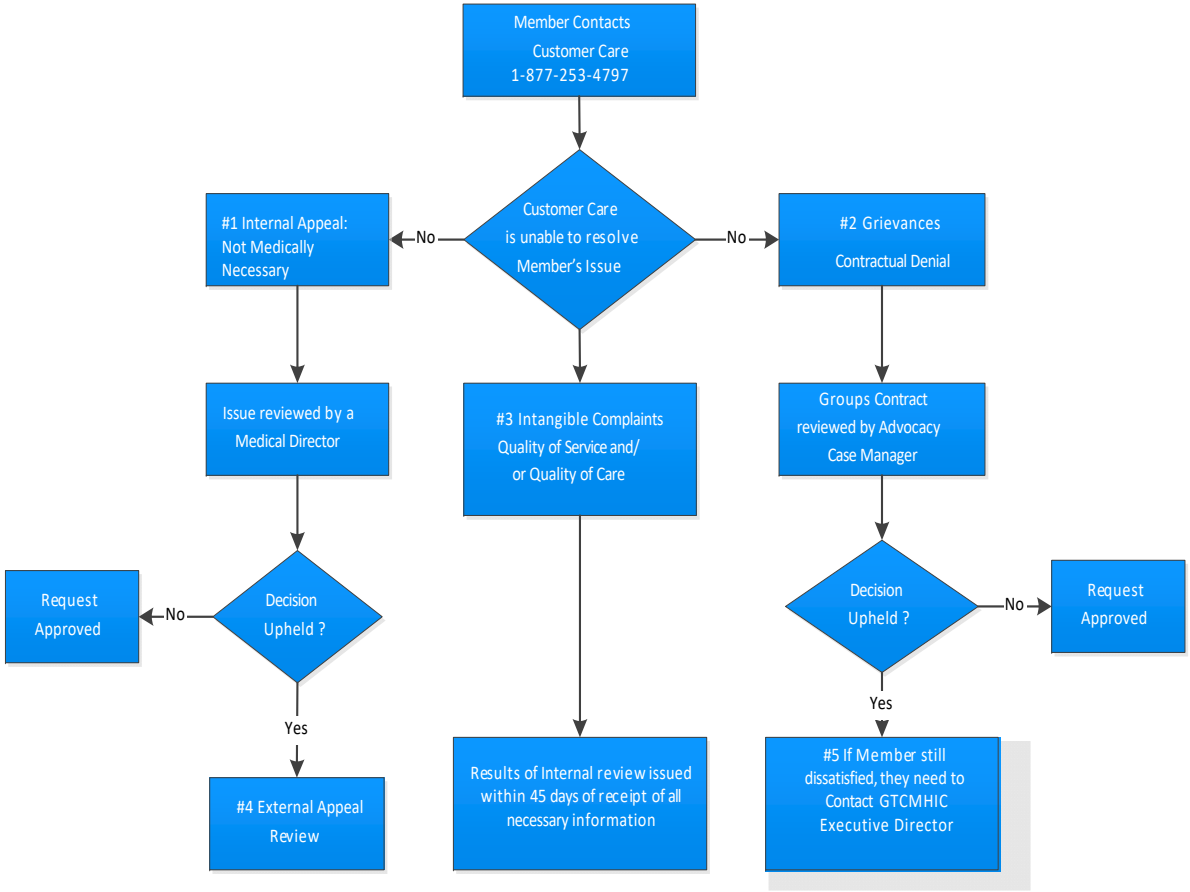
After reviewing an appeal, the committee is recommending a plan change to increase physical therapy allowable days from 45 per year to 60 per year.

Please sign up on our website to receive the Consortium Connection electronically or follow this link to read December's newsletter
https://healthconsortium.net/Newsletter/2023/Newsletter/December

Our presence on Facebook is growing, to see what is happening in wellness each month, please visit our Facebook site. Link to FB page

Respectfully submitted by Elin R. Dowd, Executive Director, December 5, 2023.

Greater Tompkins County Municipal Health Insurance Consortium
Internal Appeals / Grievance Process



Excellus Contact Information:
Dedicated Customer Service Line: 1-877-253-4797

Appeal Mailing Address:
Excellus BCBS
Customer Advocate Unit
PO BOX 4717
Syracuse, NY 13221

Excellus

1) Internal Appeal: Not Medically Necessary

- Member, or an authorized representative, has 180 days following receipt of the notification to file an Appeal regarding the decision.
- Excellus has 15 days to acknowledge receipt of the appeal and has either a) 30 days for pre-service appeals, b) 30 days from receipt of all necessary information for post-service appeals, not to exceed 60 days or c) for urgent cases it is the lessor of 72 hours or 2 business days to respond. If upheld, Excellus will issue a Final Adverse Determination.
- Excellus BCBS, Customer Advocate Unit, PO BOX 4717, Syracuse, NY 13221

2) Grievance: Contractual Benefit Denial

- Member, or authorized representative, has 180 days following receipt of notification to file a grievance regarding the decision.
- Excellus has 15 days to acknowledge receipt of the grievance and 30 days to respond for both pre-service and post-service grievances. If upheld, Excellus will issue a notice of determination.

3) Complaint: Dissatisfaction with Services or Quality of Care Issue

- Member, or authorized representative can file a complaint.
- Excellus has 15 days to acknowledge receipt, request input and / or medical records from provider. Results of review will be issued within 45 days of receipt of all necessary information to conduct review.

4) External Appeal:

- Member, or an authorized representative, has 4 months from the Final Adverse Determination to file an External Appeal with NYS Department of Financial Service. Notice of decision will be issued directly from NYS.
- DFS- Department of Financial Service- 1-800-342-3736

5) Appeal to GTCMHIC- Greater Tompkins County Municipal Health Insurance Consortium:

- If member, or an authorized representative remains dissatisfied with the plan's decision, they can file an appeal directly with the employer group, within 120 days from receiving the Excellus Internal Adverse Benefit determination.
- GTCMHIC, Att: Executive Director, PO BOX 7, Ithaca, NY 14851, Phone: (607) 274-5590, Email: consortium@tompkins-co.org

EBSA: Employee Benefits Security Administration

- For questions about your rights, this notice for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

REVISED 02-01-2024 ~~03-24-2014~~

APPEALING A CLAIM

Claims Other Than Medical Necessity or Experimental/Investigational Services
This section describes the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC") appeal process that applies to a claim denied, in whole or in part, for a reason other than a lack of medical necessity or the experimental/investigational nature of the service. (If a claim relates to medical necessity or the experimental/investigational nature of the service, please refer to the Section titled "Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure" for the applicable claim determination and appeal procedure.)

If a claim is denied in whole or in part, the covered person will receive notification of a claim denial via an explanation of benefits (EOB) form. The EOB form will be provided by the plan administrator, ~~either~~ Excellus BlueCross BlueShield ~~or ProAct, Inc.~~ The EOB will show the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for the consideration of the claim, the plan administrator will request it.

If a covered person does not agree with the denial of a claim, the covered person may follow the review steps outlined below:

Initial Contact or Inquiry:
The covered person may contact Excellus BlueCross BlueShield ~~or ProAct, Inc~~. by phone or by written correspondence to inquire as to the related contract or coverage provisions, the quality of the care, ~~or~~ lodge a service complaint, or file a grievance/appeal. The Customer Service Representative will initiate a review based on this contact and provide a response to the covered person. The covered person may contact Excellus BlueCross BlueShield ~~or ProAct, Inc~~. by calling the following numbers:

Excellus BlueCross BlueShield	~~***ProAct, Inc.***~~
~~1-800-499-1275~~ 1-877-253-4797	~~1-877-635-9545~~

~~If the inquiry is related to a claim issue or denial and the matter is not resolved to the covered person's satisfaction, the covered person should then speak to a supervisor or manager at either Excellus BlueCross BlueShield or ProAct, Inc. At that point, a final determination will be made and the covered person will be notified in writing of the plan administrator's determination.~~

First Level of Review (Internal Appeal):
If the covered person is unable to resolve a contractual benefit or quality of care issue informally through the initial contact with a Customer Service Representative, the covered person or the covered person's advocate may request a formal review of the case. A formal request for a review may be accepted from the covered person, the covered person's designee, or the covered person's medical provider via written correspondence within 180 calendar days of the covered person receiving the initial determination on the claim(s) in question. The inquiry will be researched by the appropriate personnel and a formal response will be provided to the covered person. The covered person may submit their internal appeal request for medical and pharmaceutical claims to Excellus BlueCross BlueShield ~~or for pharmaceutical claims to ProAct, Inc.~~ at the following address~~es~~:

Excellus BlueCross BlueShield	~~***ProAct, Inc.***~~
Customer Advocate Unit	~~% Clinical Appeals Department~~
PO Box 4717	~~1230 US Highway 11~~
Syracuse, NY 13221	~~Gouverneur, NY 13642~~
	~~Fax: 315-287-7864~~

~~A review by the GTCMHIC Claims and Appeals Committee of the Plan and/or arbitration may be available; see the Sections titled "Review by the Claims and Appeals Committee" and "Arbitration" below.~~

Review by the Claims and Appeals Committee

If a covered person is not satisfied with an appeal determination regarding a claim that does not relate to a medical necessity or experimental/investigational services denial, the covered person may request a claim review by the GTCMHIC Claims and Appeals Committee by filing a written request for a review to the following address:

Greater Tompkins County Municipal Health Insurance Consortium
~~% Tompkins County~~ 408 East Upland Road
~~125 East Court Street~~ Suite 2
Ithaca, NY 14850
Attn: ~~Appeals Committee~~ Executive Director

Upon receipt of a written request, copies of all pertinent information will be gathered and presented to the GTCMHIC Claims and Appeals Committee. The covered person may also submit written opinions and/or any comments regarding the claim which will be included with the materials and information presented to the GTCMHIC Claims and Appeals Committee.

Requests for review by the GTCMHIC Appeals Committee should be filed promptly; however, requests may be filed at any time within 120 days of the final adverse determination by ~~one of~~ the plan administrator~~s~~, Excellus BlueCross BlueShield ~~or ProAct, Inc~~.

The GTCMHIC Claims and Appeals Committee will render its decision within 60 days of the receipt of the written request for review, unless specific circumstances warrant an extension. The decision of the GTCMHIC Claims and Appeals Committee pertaining to the review will be delivered in writing to the covered person, stating the specific reasons for the decision and the specific reference to the pertinent plan provisions upon which the decision is based.

Arbitration

If the covered person and/or the covered person's labor organization is not satisfied with the decision of the GTCMHIC Claims and Appeals Committee; and if the labor organization determines that the claim is meritorious and further appeal is in the best interests of the labor organization, the labor organization may submit the claim to arbitration, the outcome of which will be binding on all parties. The cost of the arbitration shall be divided equally between the GTCMHIC and the labor organization. The voluntary rules of the American Arbitration Association will apply, and a mutually acceptable arbitrator competent in the field of medical claims arbitration will be used.

If a covered person is not in a recognized bargaining unit, the written request for arbitration must be submitted directly to the plan administrator from the covered person. In such a case, the cost of the arbitration will be divided equally between the Plan and the covered person.

A request for arbitration must be submitted, in writing, to the GTCMHIC ~~Chairperson~~ Executive Director within 30 days of receipt of the written decision of the GTCMHIC Claims and Appeals Committee to the following address:

~~Ms. Elin R. Dowd, Executive Director~~
Greater Tompkins County Municipal Health Insurance Consortium
~~% Tompkins County~~ 408 East Upland Road
~~125 East Court Street~~ Suite 2
Ithaca, NY 14850
Attn: ~~Arbitration Request~~ Executive Director

Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure

This section explains the utilization review (UR) procedure applicable to the Plan's decisions that relate to the medical necessity of care, including the appropriateness of the level of care or the provider of care; or to the experimental and/or investigational nature of care.

- Services will be deemed medically necessary only when all the following criteria are met:
    - Provide for the treatment or diagnosis of an illness or injury, including premature birth, congenital and other birth defects;
    - Necessary to meet a patient's basic health needs;
    - Appropriate for the symptoms, consistent with the diagnosis, and in accordance with generally accepted medical practice and professionally accepted standards;
    - Not recommended because it is more convenient for the patient, the physician, or other provider; and
    - The most appropriate method of providing safe and adequate care.

Confinement in a hospital or other facility is considered medically necessary when the covered person needs to be confined because of the nature of the services that the covered person requires, or when treatment for the covered person's condition would be considered unsafe or inadequate if performed on an outpatient basis.

Treatment that is educational or done primarily for research will not be considered medically necessary.

A benefit payment will not be made if the plan administrator determines that the service, care, or supply was not medically necessary. However, the Plan will pay benefits if directed to do so pursuant to an external appeal.

The fact that any particular physician or health care professional may prescribe, order, recommend, or approve service, supply or technology does not, in itself, make the services medically necessary.

The definition of medical necessity relates only to coverage and may differ from the way in which a provider engaged in the practice of medicine may define medical necessity.

Utilization Review Procedure
Given the voluntary nature of the Plan's managed care program, most of the UR procedures under this section including the pre-admission review process and the concurrent review process will not be applicable unless the covered person requests such a review.

UR decisions are made when a pre-admission review is requested for care (the "prospective review process"), a request is made for review of a case during the course of care (the "concurrent review process"), and after care is rendered (the "retrospective review process").

Examples of cases that would be reviewed under the UR procedure include a refusal of prior authorization for an inpatient hospital stay because the care is available on an outpatient basis; or a determination that a covered person can be released from a hospital because the covered person's condition no longer requires 24-hour nursing service; or a determination that the treatment received by a covered person is experimental and/or investigational, in light of the covered person's condition.

1. **PRE-ADMISSION REVIEW PROCESS**

   a. All requests for pre-admission review of care are reviewed to determine medical necessity (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is experimental and/or investigational. The initial review is performed by a nurse. If the nurse determines that the proposed care is medically necessary and not experimental and/or investigational, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

   b. Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to the covered person, a designee authorized in writing by the covered person (if any), and the provider, by telephone and in writing, within three (3) business days of the request. If additional information is needed, it will be requested within 3 business days. The covered person or the covered member's provider will then have 45 calendar days to submit the information. A notice of the determination will be provided to the covered person (or the covered member's designee) and the covered member's provider, by telephone and in writing within three (3) business days of the earlier of our receipt of the information or the end of the 45-day time period.

   c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will also describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation, if any, needed to make an internal appeal determination.

d. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within three (3) business days from the date of reconsideration. All of the information described in paragraph 1.c. above will be included in this notice.

2. **CONCURRENT REVIEW PROCESS**

a. When a covered person is receiving services and requests a concurrent review, a nurse will assess the medical necessity and experimental and/or investigational nature of services received throughout the course of treatment.

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary and not experimental and/or investigational. If so, the nurse will authorize the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). If additional information is needed, it will be requested within one (1) business day. The covered member or the covered member's provider will then have 45 calendar days to submit the information. Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

c. The covered member (or the covered member's designee) and the provider will be notified of the concurrent review decision, by telephone and in writing, within 1 business day of the earlier of the plan administrator's receipt of all information or documentation needed for the review or the end of the 45 day period.

e. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

f. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within 1 business day from the date of reconsideration. All of the information described in paragraph 2.d. above will be included in this notice.

3. **RETROSPECTIVE REVIEW PROCESS**

a. At the option of the plan administrator, a nurse will review retrospectively the medical necessity and the experimental and/or investigational nature of services, which are subject to utilization review. If the nurse determines that care received was medically necessary and not experimental and/or investigational, the nurse will authorize benefits. If the nurse determines that the care was not medically necessary or was experimental and/or investigational, the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

b. The covered person, an authorized designee, and the provider will be notified of the retrospective review determination, in writing, within 30 calendar days from receipt of the claim by the plan administrator. If additional information is needed it will be requested within 30 calendar days. The covered member's or the covered member's provider will then have 45 calendar days to submit the information. A determination will be made and notice provided to the covered member and the covered member's provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to request a review of the adverse determination; give instructions for initiating standard, expedited, or external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

d. The provider who rendered care for which benefits are denied may request an internal appeal of the retrospective adverse determination on behalf of the covered person (even if not authorized in writing by the covered person to act as designee).

4. **REVIEW OF ADVERSE DETERMINATIONS**

a. ***Request for internal appeal***

i. The covered person, an authorized designee, and, in a retrospective review case, the health care provider may request an internal appeal of an adverse determination, verbally or in writing, within ~~45 days~~ 180 days from the date that notice of the adverse determination is received. (If the notice received does not specify all information required to conduct an internal appeal, the time period for appealing will be extended.) To submit an internal appeal verbally, the covered person, an authorized designee, or the provider may call 1-877-253-4797 ~~1-800-499-1275~~. To submit a written internal appeal, the covered person, an authorized designee, or the provider may write to the plan administrator.

ii. The procedure that will be followed in reviewing a case will differ, depending upon the urgency of the case. In most cases, a standard internal appeal, described in paragraph b. below, will be appropriate. In "urgent cases," an expedited internal appeal is available; expedited internal appeal is described in paragraph c. below.

b. ***Standard internal appeal***

i. The plan administrator will acknowledge an internal appeal in writing, within 15 calendar days after receiving it. The acknowledgment will identify the plan administrator (including the address and telephone number) as the person designated to respond to the appeal.

ii. When one or more internal appeals are received (for example, the covered person submits an appeal, then the health care provider submits an appeal on behalf of the covered person), a single internal appeal will be conducted by a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition) who did not make the initial adverse determination.

iii. The clinical peer reviewer will render a determination within ~~60~~ 45 calendar days after receipt of all necessary information. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Written notice of the determination will be provided to the covered person and any other qualified party submitting an internal appeal, within 2 business days after the determination is made. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

iv. The notice will include detailed reasons and the clinical rationale for the determination. If the determination is adverse, the notice will describe the process, and enclose an application, for requesting an external appeal of the adverse determination. The external appeal process is described in paragraph d. below.

c. ***Expedited/Urgent Internal Appeal***

i. For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment; or any other issue with respect to which a provider requests an immediate review), the covered person, an authorized designee, or the provider may request an expedited internal appeal of the initial adverse determination. For prospective reviews that involve urgent matters, the plan administrator will make a determination and provide notice to the covered member (or the covered member's designee) and the covered member's provider within 72 hours of the receipt of the request. For concurrent reviews that involve urgent matters, we will make a determination and provide notice to the covered member (or the covered member's designee) and the covered member's provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified for prospective; pre-service claims.

ii. When a request for expedited internal appeal is received, the appeal will be conducted by a clinical peer reviewer (defined in subparagraph (b)(ii) above) who did not render the initial adverse determination. Reasonable access to the clinical peer reviewer assigned to the appeal will be provided within 1 business day following receipt of notice of the request for appeal, to ensure that all relevant information is available to the clinical peer reviewer. Upon request, the covered person's provider and the clinical peer reviewer may exchange information by telephone or fax. If additional information is needed, it will be requested within 24 hours of the appeal request. The covered member or the covered member's provider will then have 48 hours to submit the information.

iii. In regards to concurrent reviews for urgent matters, if the plan administrator has approved a course of treatment, the plan administrator will not reduce or terminate the approved services unless the plan administrator has given the covered member enough prior notice of the reduction or termination so that the covered member can complete the appeal process before the services are reduced or terminated.

iv. Within 24 hours of receipt by the plan administrator of all information needed for the appeal, the clinical peer reviewer will render a determination on the expedited internal appeal. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

v. Notice will be provided to the covered person, an authorized designee, and the provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period. The notice will include all of the information described and enclosed in a notice of standard internal appeal determination (see subparagraph b. iv. above), and will describe the right to a standard internal appeal following an adverse determination on expedited internal appeal. The covered person, an authorized designee, and, where appropriate, the provider will be advised that, if a standard internal appeal is requested after the expedited internal appeal, the standard internal appeal may take longer than the 45-day time frame for requesting an external appeal through New York State Department of Financial Services, which begins on the date of receipt of the final adverse determination notice upon completion of expedited internal appeal.

External appeal – The covered member's right to an External Appeal
In some cases, the covered member has a right to an external appeal of a denial of coverage. Specifically, if coverage is denied on the basis that a service does not meet the requirements for Medical Necessity including appropriateness, health care setting, level of care or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases). The covered person or the covered person's representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for the covered member to be eligible for an external appeal the covered member must meet the following two requirements:

- The service, procedure or treatment must otherwise be a Covered service under the Policy: and

- In general, the covered member must have received a final adverse determination through the Internal Appeals Process. But, the covered member can file an external appeal even though the covered member has not received a final adverse determination through the Internal Appeal process if:

  - It is agreed in writing that the internal appeal is waived. The Plan is not required to agree to the covered member's request to waive the internal appeal; or

  - The covered person files an external appeal at the same time as the covered person applies for an expedited internal appeal; or

  - The Plan fails to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to the covered member, and the Plan can demonstrate that the violation was for good cause or due to matters beyond the Plan's control and the violation occurred during an ongoing, good faith exchange of information between the parties).

A Covered Person's Right to Appeal a Determination that a Service is:

1. **Not Medically Necessary**
   If, coverage is denied on the basis that the service does not meet the requirements for medical Necessity, the covered member may appeal to an External Appeal Agent if the covered member meets the requirements for an external appeal outlined above.

2. **Experimental or Investigational**
   If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, the covered person must satisfy the two requirements for an external appeal above and the covered person's attending Physician must certify that:

   a. The covered person's condition or disease is one for which standard health services are ineffective or medically inappropriate; **or**

   b. The covered person's condition or disease is one for which there does not exist a more beneficial standard service or procedure covered by us; **or**

   c. The covered person's condition or disease is one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, the covered person's attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the covered member than any standard Covered Service (only certain documents will be considered in support of this recommendation – The covered member's attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which the covered member is eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which the covered person's attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to the covered member than the requested service, the requested service is likely to benefit the covered member in the treatment of the covered member's rare disease, and such benefit out-weights the risk of the service. In addition, the covered members' attending Physician must certify that the covered member's condition is a rare disease that is currently or was previously subject to a research study by the Nation Institutes of Health Rare Disease Clinical Research network or that it affects fewer than 200,000 U.S. residents per year.

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

A Covered Person's right to Appeal a Determination that a Service is Out-of-Network
If the Plan has denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, the covered member may appeal to an External Appeal Agent if the covered member meets the two requirements for an external appeal above, and the covered member requested preauthorization for the Out-of-Network treatment.

In addition, the covered member's attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-network health service.

For purposes of this section, the covered person's attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat the covered person for the health service.

The covered person does not have the right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-network to provide the particular health service requested by the covered member.

The External Appeal Process

The covered person has four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an External Appeal. If the covered person is filing an external appeal based on the Plan's failure to adhere to claim processing requirements, the covered member has four (4) months from such failure to file a written request for an External Appeal.

The Plan Administrators will provide an external appeal application with the final adverse determination issued through the Internal Appeal process or the written waiver of an Internal Appeal. The covered person may also request an External Appeal application from the New York State Department of Financial Services at 1-800-342-3736. Submit the completed application to the Department of Financial services at the address indicated on the application. If the covered member meets the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent. ***Please note that although the Greater Tompkins County Municipal Health Insurance Consortium is a self-insured medical benefits plan it is a Certified Municipal Cooperative Health Benefit Plan pursuant to Article 47 of the New York State Insurance Law and as such follows the same external appeals process as an Article 43 not-for-profit insurance company.***

Under the No Surprises Act (NSA) a member may file an external appeal if issued a final adverse determination for any of the following reasons:

- The health plan determines that out-of-network emergency services received were non-emergent; or
- The health plan determines that the out-of-network services received do not qualify as a surprise bill; or
- Incorrect cost-sharing was applied to the member's bill for either emergency services or a surprise bill; or
- There is a question on whether the claim for out-of-network care you received was coded correctly by the provider and accurately reflects the treatment received, and the associated NSA protections related to cost sharing and surprise billing.

The covered person can submit additional documentation with the External Appeal request. If the External Appeal Agent determines that the information submitted represents a material change from the information on which the Plan based its denial, the External Appeal Agent will share this information with the Plan in order for the Plan to exercise its right to reconsider the Plan's decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm the decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the covered person's completed application. The External Appeal Agent may request additional information from the covered person, the covered person's physician or the Plan. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the covered member in writing of its decision within two (2) business days.

If the covered member's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the covered person's health; or if the covered person's attending Physician certifies that the standard external appeal time frame would seriously jeopardize life, health or ability to regain maximum function; or if the covered member received emergency services and has not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, the covered member may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of the covered member's completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the covered member and the Plan by telephone or facsimile of that decision. The External Appeal Agent must also notify the covered person in writing of its decision.

If the External Appeal Agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of the covered person's plan. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to the covered member according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the covered member's plan for non-investigational treatment provided in the clinical trial.

The External Appeal Agent's decision is binding on both the covered member and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

The plan may charge the covered member a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. The Plan will waive the fee if it is determined that paying the fee would be a hardship to the covered member. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to the covered member.

The Covered Member's Responsibilities

It is the covered member's RESPONSIBILITY to start the external appeal process. The covered member may start the external appeal process by filing a completed application with the New York State Department of Financial Services. The covered member may appoint a representative to assist them with the covered member's application; however, the Department of Financial Services may contact the covered member and request that the covered member confirm in writing that the covered member has appointed the representative.
Under New York State law, a covered member's completed request for an external appeal must be filed within four (4) months of either the date upon which the covered member receives a final adverse determination, or the date upon which the covered member receives a written waiver of any Internal Appeal, or the Plan's failure to adhere to claim processing requirement. The Plan has no authority to extend this deadline.

Greater Tompkins County Municipal Health Insurance Consortium

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"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

RESOLUTION NO. XXX-2024 - AMENDMENT TO RESOLUTION NO. 031-2023 - CREATION OF 2024 COMMITTEE STRUCTURE AND APPOINTMENTS OF COMMITTEE MEMBERS – APPOINTMENT OF VALERIE SAUL TO OPERATIONS COMMITTEE

WHEREAS, a vacancy on the Operations Committee exists because of a retirement of Ms. Schelley Michell-Nunn at the City of Ithaca, and

WHEREAS, it is deemed to be in the best interest of Committees to continue to have a member, such as Valerie Saul, Deputy Director of Human Resources at the City of Ithaca, who will represent the interests on this Committee, now therefore be it

RESOLVED, on recommendation of the Operations Committee, That the Executive Committee, on behalf of the Board of Directors, appoints the above committee member effective January 1, 2024 with the term expiring December 31, 2024.

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Greater Tompkins County Municipal Health Insurance Consortium

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RESOLUTION NO. XXX–2024 - DISSOLUTION OF THE "OWNING YOUR OWN HEALTH COMMITTEE" FOR THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

WHEREAS, by Resolution No. 001 of 2016, the Board of Directors established the "Owning Your Own Health Committee" for the purpose of identifying and recommending processes to promote a culture of preventative health care, supporting benefit clerks in that outreach to our employees and retiree members, coordinating wellness activities with our claim's administrators and community associates, and

WHEREAS, as the Consortium has grown it became necessary to re-evaluate the purpose of the Committee and to consider whether there could be efficiencies and value in addition to increased engagement of members by incorporating the Committee's work into the Joint Committee on Plan Structure and Design, and

WHEREAS, by Resolution No. 019-2020, it was Resolved that the Joint Committee on Plan Structure and Design shall assume the Consortium's wellness initiatives, and "Owning Your Own Health Committee" was temporarily suspended and the Executive Director to report back to the Board of Directors with a recommendation following an evaluation period, now therefore be it

RESOLVED, the Executive Director has reported back to the Operations Committee that the incorporation of the "Owning Your Own Health Committee" processes into the Joint Committee has been extremely successful and the Joint Committee has absorbed all aspects and processes during the evaluation period,

RESOLVED, further, on recommendation of the Operations Committee, That the Executive Committee, on behalf of the Board of Directors, approves the dissolution of "Owning Your Own Health Committee" effective immediately.

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