REPORT ON EXAMINATION

OF

ST. LAWRENCE-LEWIS COUNTIES SCHOOL DISTRICTS

EMPLOYEES MEDICAL PLAN

AS OF

JUNE 30, 2013

DATE OF REPORT **MARCH 17, 2017**

EXAMINER **EDOUARD MEDINA**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

March 17, 2017

Madam:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 31213, dated September 16, 2014, attached hereto, I have made an examination of St. Lawrence-Lewis Counties School Districts Employees Medical Plan, a municipal cooperative health benefit plan certified pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2013, and respectfully submit the following report thereon.

The examination was conducted at the Plan's main administrative office located at 40 West Main Street, Canton, New York.

Wherever the term the "Plan" appears herein, without qualification, it should be understood to refer to St. Lawrence-Lewis Counties School Districts Employees Medical Plan.

Wherever the term the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

The Plan reported its required minimum surplus as per Section 4706(a)(5) of the New York Insurance Law impaired in the amount of $583,906 as of June 30, 2013. Such impairment was removed as of September 30, 2013.

1. SCOPE OF THE EXAMINATION

The previous examination covered the period July 1, 2005 through December 31, 2008. This combined (financial and market conduct) examination covered the period from January 1, 2009 through June 30, 2013.

The financial component of the examination was conducted on a risk-focused basis in accordance with the provisions of the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2014 Edition* (the "Handbook"), which provide guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

Information concerning the Plan's organization structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually for the years 2009 through 2013, by the accounting firm of Pinto Mucenski Hooper Van House & Company ("CPA"). For the fiscal years ending June 30, 2009 through June 30, 2012, the Plan received an unmodified opinion. However, for the fiscal year ending June 30, 2013 the Plan received a modified opinion. The basis for the modified opinion, as evidenced in the CPA's June 30, 2013 financial statements, is because the Plan reported its incurred but not reported claims liability in accordance with Article 47 of the New York Insurance Law. In the CPA's opinion, this liability should have been computed on an actuarial basis, as is required under generally accepted accounting principles.

Certain audit work papers of Pinto Mucenski Van House & Company were reviewed and relied upon in conjunction with this examination.

During this examination, an information systems review was made of the Plan's computer systems and operations on a risk-focused basis, in accordance with the provisions of the Handbook.

This report on examination is confined to financial statements and comments on those matters which involve departure from laws, regulations or rules, or which require explanation or description.

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2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies during the examination period. The most significant findings of this examination include the following:

- The Plan did not establish appropriate service agreements delineating the services that the Board of Cooperative Educational Services of St. Lawrence-Lewis Counties ("BOCES") provides to the Plan and the fees to be paid for such services, in violation of Section 4705(d)(2)(A) of the New York Insurance Law.

- The Plan did not adopt written expense allocation procedures for the expenses that it shares with BOCES and the other school district participants to ensure compliance with Section 4705(d)(2)(A) of the New York Insurance Law.

- The Plan did not file its community rating methodology with the Department, in violation of Section 4705(d)(5)(B) of the New York Insurance Law.

- The Plan's stop-loss coverage limitations were not based on expected claims certified by a qualified actuary, in violation of Sections 4707(a)(1) & (2) of the New York Law.

- The Plan retained paid employees during the years under examination, in violation of Section 4704(a)(5) of the New York Insurance Law. Such section requires that the Plan utilize personnel of the Plan's participants or contract with an administrator or other service provider to provide services to the Plan.

- The Plan did not have a Chief Fiscal Officer, in violation of Section 4705(a)(6) and Section 4705(b)(1) of the New York Insurance Law which require that the Plan designate the fiscal officer of a participating municipal corporation to be the chief fiscal officer of the Plan and to have custody of all monies received or expended by the Plan.

- The Plan was late in filing certain quarterly and annual statements to the Department, in violation of Section 4710(a)(2) & (3) of the New York Insurance Law.

- The Plan charged its participating school districts a second premium to cover administrative expenses, in violation of Section 4705(d)(6) of the New York Insurance Law. Assessing the participating municipal cooperation for additional contributions should occur only if actual losses due to the benefits paid out, administrative expenses and reserve and surplus requirements exceed amounts held in the Plan's joint funds.

- The Plan did not have a Chief Fiscal Officer furnish, within ninety days of the end of each fiscal year, a detailed report of the operations and condition of the Plan's reserve funds to the governing board, in violation of Section 4706(d) of the New York Insurance Law.

- The Plan did not file its policy form No. 5 and No. 9 with the Department prior to issuance, in violation of Section 3201(b)(1) of New York Insurance Law.

- As in the previous examination, the Plan did not include in its explanation of benefits form a clear identification of the service(s) for which the claim was made, in violation of Section 3234(b)(3) of the New York Insurance Law.

3. DESCRIPTION OF THE PLAN

The Plan was formed on July 1, 1978 by the participating school districts and the Board of Cooperative Educational Services ("BOCES") of St. Lawrence-Lewis Counties. The Plan's objectives are to provide, develop and administer a program of health care benefits for its employees, retirees and their dependents. Each participating school district and BOCES member pays to the Plan a monthly health insurance premium based upon a schedule of rates determined by the Plan's actuary and approved by its board of governors.

The Plan, which is regulated by the Department pursuant to Article 47 of the New York Insurance Law, obtained a Certificate of Authority from the Superintendent of Insurance, effective October 6, 2009. The Plan maintains its main administrative office at 40 West Main Street Canton, New York. During the examination period, the Plan consisted of eighteen (18) participating school districts and BOCES.

As of June 30, 2013, the (18) participating school districts and BOCES was as follows:

Brasher Falls Central School District
Canton Central School District
Clifton-Fine Central School District
Colton-Pierrepont Central School District
Edwards-Knox Central School District
Gouverneur Central School District
Hammond Central School District
Harrisville Central School District
Hermon-Dekalb Central School District
Heuvelton Central School District
Lisbon Central School District
Madrid-Waddington Central School District
Massena Central School District
Morristown Central School District
Norwood-Norfolk Central School District
Ogdensburg City School District
Parishville-Hopkinton Central School District
Potsdam Central School District
St. Lawrence-Lewis BOCES

A. Corporate Governance

Pursuant to the Plan's Municipal Cooperation Agreement, management of the Plan is to be vested in a governing board comprised of one representative from each municipality. The governing board of the Plan as of June 30, 2013 was as follows:

Name	Affiliation
Nicole Ashley	Financial Director, St. Lawrence-Lewis BOCES
Fred Bean	School Board Member, Ogdensburg City School
Janet Boyd	Business Office Manager, Hermon-Dekalb Central School
Dennis Durant	School Board Manager, Heuvelton Central School
David Glover	School Board Member, Morristown Central School
Laura Hart	School Business Manager, Potsdam Central School

Name	Affiliation
Joseph Kardash	District Superintendent, Colton-Pierrepont Central School
Suzanne Kelly	District Superintendent, Edwards-Knox Central School
Carol LaSala	Business Office Manager, Gouverneur Central School
Douglas McQueer	District Superintendent, Hammond Central School
Lisa Mitras	Business Administrator, Norwood-Norfolk Central School
Stephen Putman	District Superintendent, Brasher Falls Central School
Judy Reinbeck	Business Office Manager, Canton Central School
Lynn Roy	District Superintendent, Madrid-Waddington Central School
Darin Saiff	District Superintendent, Parishville-Hopkinton Central School
Susan Shene	District Superintendent, Clifton-Fine Central School
Rolf Waters	District Superintendent, Harrisville Central School
Wendy White	Business Office Manager, Lisbon Central School
Angela Wood	Business Office Manager, Massena Central School

The board met four times during each calendar year within the examination period. The minutes of the board meetings indicate that the meetings were well attended

The Plan's officers and administrator as of June 30, 2013, were as follows:

Name	Title
Darin Saiff	President
Sue Collins-Rickett	Secretary
Patricia Rowan-Lalonde	Chief Financial Officer
Jayne Carbone	Plan Administrator

The Plan's governing board did not sign off on the previous report on examination as required by Section 312(b) of the New York Insurance Law.

Section 312(b) of the New York Insurance Law states:

> "(b) A copy of the report shall be furnished by such insurer or other person to each member of its board of directors and each such member shall sign a statement which shall be retained in the insurer's files confirming that such member has received and read such report. The superintendent may require that a copy of the report shall also be furnished by such insurer to the supervising insurance official of each state in the United States in which such insurer is authorized to do an insurance business."

It is recommended that the Plan's board members sign off on the Department's reports on examination as required by Section 312(b) of the New York Insurance Law. This will allow the board to be cognizant of the findings and therefore, help the board in managing, controlling and administering the Plan.

The Plan does not have a written conflict of interest policy. Nor does it require its board members, officers and responsible employees to sign a conflict of interest statement on an annual basis to ensure compliance with Section 4705(d)(2)(C) of the New York Insurance Law.

Section 4705(d)(2)(C) of the New York Insurance Law states in part:

> "(d) The municipal cooperation agreement shall provide that the governing board…
> (2) may enter into an agreement with a contract administrator or other service provider, determined by the governing board to be qualified, to receive, investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that:..
> (C) no member of the plan's governing board or any member of such member's immediate family shall be an owner, officer, director, partner, or employee of any contract administrator retained by the plan;…"

It is recommended that the Plan implement a conflict of interest policy/statement to ensure compliance with Section 4705(d)(2)(C) of the New York Insurance Law.

Pinto Mucenski Hooper Van House & Company, the Plan's CPA firm for the fiscal years July 1, 2009 through June 30, 2013 also provided accounting services to the Plan. Those accounting services included receiving financial information from the Plan, maintaining the general ledger, establishing the trial balance and assisting in putting together annual and quarterly statements reported to the Department.

Insurance Regulation No. 118 (11 NYCRR 89.5(e)(1)(i)) states in part:

> "(e)(1) A company may not utilize for any purpose of this Part any work performed or prepared by a CPA if that CPA also contemporaneously provides any of the following non-audit services to that company:..
> (i) bookkeeping or other services related to the accounting records or financial statements of the company;…"

Insurance Regulation No. 118 (11 NYCRR 89.5(g)) states:

> "(g) A company having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from subdivision (e)(1) of this section. The company shall file with the superintendent a written statement discussing the reasons why the company should be exempt from these provisions. The superintendent may grant the exemption upon a finding that compliance would constitute a financial or organizational hardship upon the company."

It is recommended that the Plan comply with Insurance Regulation (11 NYCRR 89.5(e)(1)(i)) and refrain from utilizing any CPA firm that contemporaneously audits its statements of financial position and renders non-audit services to the Plan. The Plan may

file for an exemption from the requirements of Part 89.5(e)(1)(i) as prescribed by Part 89.5(g) of such regulation.

B. Territory and Plan of Operation

The Plan provides hospital, medical and pharmacy benefits to eligible members of the participating schools in St. Lawrence-Lewis Counties within New York State. The Plan reported annual written premiums of $62,950,377 for the fiscal year ending June 30, 2013. The Plan's enrollment as of June 30, 2013 was 5,092.

C. Affiliated Transactions

1. The Plan provided health care for 18 school districts and the BOCES. Pursuant to a service agreements dated June 1978 between the BOCES and the school districts, except for Clifton Fine Central School District and Massena Central School District, which were not yet participants at that time, the BOCES agreed to manage or contract with an outside party for the administration of the Plan. The agreements did not detail the services to be rendered by the BOCES, nor did such agreement mention the remuneration the BOCES is to be receive for these services. The BOCES collected premiums on behalf of the Plan, provided Information Technology services, and was responsible for Plan's funds. It was noted during the examination, the BOCES received premium credits from the Plan.

Section 4705(d)(2)(A) of the New York Insurance Law states:

> "(d) The municipal cooperation agreement shall provide that the governing board:..
> (2) may enter into an agreement with a contract administrator or other service provider, determined by the governing board to be qualified, to receive,

> investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that:
> (A) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts as required in subdivision six of section ninety-two-a of the general municipal law;"

It is recommended that the Plan comply with Section 4705(d)(2)(A) of the New York Insurance Law by establishing appropriate service agreements delineating the services the BOCES will provide to the Plan and the fees to be paid for the services.

2. The examination of the Plan's administrative expenses indicated that the Plan paid the full salary for fifteen employees, shared 50% of the salary of the Plan Administrator with the Workers Compensation Plan, paid a salary portion of four of the BOCES' employees, shared the fringe benefits and consultant services of such employees with BOCES and other Plan participants. It was noted that the Plan did not have a written expense allocation procedure in place relative to the above shared expenses.

It is recommended that the Plan adopt a written expense allocation procedure retrospective to the beginning of the examination period and going forward relative to the expenses that it shares with the BOCES and the other Plan participants to ensure compliance with Section 4705(d)(2)(A) of the New York Insurance Law.

D. Service Agreements

The Plan entered into contractual agreements with the following vendors that provided various administrative services to the Plan:

- Board of Cooperative Educational Services ("BOCES") provides or contracts for the administration of the Plan.

- Locey & Cahill, LLP, an independent consultant, performs consulting services for the Plan related to rates, benefits and enrollment. The firm assists in the review and revision of the plan benefit structure and design.

- Claimright, LLC, an independent consultant, performs consulting services for the Plan related to the review of and negotiations pertaining to medical claims that are provided by the Plan Administrator.

- Nancy A. Girard, D.O., P.C., an independent consultant, performs consulting services for the Plan related to hospital pre-certification, inpatient concurrent review, outpatient claims management, interpretation of Plan benefits provisions (including determinations of experimental and investigational claims, and reviews of medical necessity), provider utilization review, medical case management, and workers compensation case management.

- Bonnie Marra, RN, an independent consultant, performs consulting services for the Plan related to hospital pre-certifications, in-patient concurrent reviews, DRG validations (pending implementation of a managed care system), provider UCR fee negotiations, out-patient claims management, assistance with provider and hospital payment discount negotiations, and workers compensation case management and review.

It was noted that there was no evidence of a formal bidding process by the Plan's board relative to the selection of the above consultants and providers of services.

It is recommended that the Plan's board establish a formal bidding process relative to the selection of the Plan's consultants and providers of services.

E. Stop-loss Coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintained both aggregate excess of loss coverage and specific excess of loss coverage with an insurer authorized in New York. The following is a summary of the Plan's stop-loss program as of June 30, 2013:

Type	Limits
Excess-of-loss (one layer)	100% of $750,000 excess of $250,000 per member, per contract year

Aggregate excess-of-loss: $1,000,000 excess of annual aggregate attachment point ($88,000,147), for the current contract year.

The Plan's excess of loss agreements for years ended June 30, 2013 and June 30, 2014 did not include the insolvency clause prescribed by Section 1308(a)(2)(A)(i) of the New York Insurance Law.

Section 1308(a)(2)(A)(i) of the New York Insurance Law states:

> "(i) the reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer."

It is recommended that the Plan comply with Section 1308(a)(2)(A)(i) of the New York Insurance Law by including in its excess of loss agreements a clause requiring that the assuming entity pay the stop-loss liability on the basis of the Plan's liability under the contracts reinsured without diminution because of the insolvency of the Plan.

The Plan relied on an estimate of claim costs set by the underwriters of the excess of loss insurance carrier, Standard Security Life Insurance Company of New York to determine the aggregate excess of loss and the specific excess of loss coverages. Therefore, during the Plan years ended June 30, 2013 and June 30, 2014, the Plan's aggregate excess of loss and specific excess of loss coverages were not maintained within the guidelines prescribed by Section 4707(a) of the New York Insurance Law.

Section 4707(a) of the New York Insurance Law states:

> "(a) The governing board of a municipal cooperative health benefit plan shall obtain and maintain on behalf of the plan a stop-loss insurance policy or policies delivered in this state and issued by a licensed insurer, providing:
> (1) aggregate stop-loss coverage with an annual aggregate retention amount or attachment point not greater than one hundred twenty five percent of the amount certified by a qualified actuary to represent the expected claims of the plan for the current fiscal year; and
> (2) specific stop-loss coverage with a specific retention amount or attachment point not greater than four percent of the amount certified by a qualified actuary to represent the plan's expected claims for the current fiscal year."

It is recommended that the Plan comply with Section 4707(a) of the New York Insurance Law by obtaining stop-loss coverage with limitations based on expected claims certified by a qualified actuary.

F. Municipal Cooperation Agreement ("MCA")

1. Section G.2 of the of the Plan's MCA (February 11, 2015 version) states:

> "Officers of the Fund 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 Fund, shall not be deemed employees of the Fund. The Board of Directors shall not have any authority to engage the services of any person as an employee of the Fund. Each third party vendor shall provide for all necessary services and materials pursuant to annual contracts with the Fund. The officers of the Fund shall serve without compensation from the Fund."

As of June 30, 2013, the Plan maintained fifteen full-time employees and four part-time employees who were also employees of BOCES. The Plan was not able to justify having employees to service the Plan.

It is recommended that the Plan comply with Section G.2 of the MCA by not treating officers and employees of participants as employees of the Plan.

Section 4704(a)(5) of the New York Insurance Law states in part:

> "(a) The superintendent shall issue a certificate of authority to a municipal cooperative health benefit plan if all of the following conditions, after examination and investigation, have been met to the superintendent's satisfaction: …
> (5) the municipal cooperative health benefit plan has within its own organization adequate facilities and competent personnel to service the plan or, in order to provide such services, in whole or part, has contracted with a contract administrator or other service provider, determined by the governing board to be qualified based upon written documentation furnished to the governing board, provided that such documentation shall be made available to the superintendent upon request;"

It is recommended that the Plan comply with Section 4704(a)(5) of the New York Insurance Law by utilizing personnel within the Plan's participants or contracting with an administrator or other service providers to service the Plan.

2. Section N of the Plan's MCA states:

> "The following reports shall be prepared and furnished to the Board of Directors, to the participants, and to the Superintendent:
> 1. Annually, not later than one hundred and twenty days after the close of the Plan's fiscal year:
> a) a report showing the financial condition and affairs of the Plan, in such a form and providing such other information as the Superintendent may prescribe, together with an audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the Plan. Such a report, audit, and opinion thereon must be in compliance with Section 307 of the Insurance Law and Insurance Department Regulation No. 118.
> (b) an 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 year and projected for the next fiscal year.
> 2. Quarterly, within forty-five days of the end of each quarter, a report that is in such a form and providing such other information as the Superintendent may prescribe, showing the financial condition of the Plan as of the end of such Quarter."

The above section of the MCA is in violation of Section 4705(e) of the New York Insurance Law which requires that the above reports be furnished also to the unions which are the exclusive bargaining representatives of the employees covered by the Plan.

Section 4705(e) of the New York Insurance Law states:

> "(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of employees covered by the plan and to the superintendent:
> (1) 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;
> (2) an annual report and quarterly reports describing the plan's current financial status; and
> (3) an annual independent actuarial opinion on the financial soundness of the plan, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current year and projected for the next fiscal year."

It is recommended that the Plan comply with Section 4705(e) of the New York Insurance Law by revising its MCA to require that the Plan provide the CPA annual audit reports, annual independent actuarial opinions, and other annual and quarterly reports describing the Plan's current financial status to those unions which are the exclusive bargaining representatives of employees covered by the Plan.

3. Section F.3 of the MCA requires that the board designate one board member to have custody of all reports, statements and other documents of the Plan. During the examination period, the board did not designate such board member, which is a violation of Section 4705(c)(2) of the New York Insurance Law and the MCA.

Section 4705(c)(2) of the New York Insurance Law states:

> "(c) A municipal cooperation agreement shall include a provision:
> (2) designating one governing board member to have custody of all reports, statements and other documents of the plan;"

It is recommended that the Plan comply with its MCA and Section 4705(c)(2) of the New York Insurance Law by designating one board member to have custody of all reports, statements and other documents of the Plan.

4. Section F.12 of the Plan's MCA requires that the board select the Chief Fiscal Officer (Treasurer) of the Plan who should be the Treasurer of the St. Lawrence-Lewis Counties BOCES. Furthermore, Section J.1, of the Plan's MCA states that the Chief Fiscal Officer shall have custody of all monies received or expended by the Plan. During the examination period it was noted that there were several individuals who interacted with the banks on behalf of the Plan to sign checks, make deposits and/or authorize transfers. The Plan's board did not select a specific individual to be the Chief Fiscal Officer of the Plan, which is a violation of the above Sections.

Section 4705(a)(6) of the New York Insurance Law states:

> "(a) The municipal cooperation agreement, under which the municipal cooperative health benefit plan is established and maintained, and any amendment thereto, shall be approved by each participating municipal corporation by majority vote of each such corporation's governing body, and shall:
> (6) designate the fiscal officer of a participating municipal corporation to be the chief fiscal officer of the municipal cooperative health benefit plan"

Section 4705(b)(1) of the New York Insurance Law states:

> "(b) The municipal cooperation agreement shall provide that the plan's chief fiscal officer:
> (1) shall have custody of all moneys received by the municipal cooperative health benefit plan or made available for expenditure under the plan."

It is recommended that the Plan comply with its MCA and Sections 4705(a)(6) and Section 4705(b)(1) of the New York Insurance Law by designating the fiscal officer of a participating municipal corporation to be the Chief Fiscal Officer of the Plan and ensure

that the Plan's Chief Fiscal Officer have custody of all monies received or expended by the Plan.

It is also recommended that all individuals who interact with the Plan's banks on behalf of the Plan such as signing checks, make deposits and/or authorize transfers be approved by a majority of the Plan's entire board of directors.

Section J.3 of the municipal cooperation agreement states that the Chief Fiscal Officer of the Plan is to be bonded for all monies received from the participants. However, the Plan was unable to verify that it was in compliance with Section 4703(b)(2) relative to the bonding of its Chief Fiscal Officer. The Jurat page of the June 30, 2013 annual statement indicated that Patricia Rowan-Lalonde was the Chief Financial Officer of the Plan as of such date. She was also the Treasurer of the BOCES.

Section 4703(b)(2) of the New York Insurance Law states:

> "(b) The governing board shall file an application for a certificate of authority on such form as the superintendent may prescribe, and shall provide to the satisfaction of the superintendent the following:
> (2) evidence that the plan's chief fiscal officer is adequately bonded in a manner acceptable to the superintendent, who may accept or consider for this purpose any bond required under the applicable provisions of the education law, general municipal law or public officers law;"

It is recommended that the Plan comply with its MCA and Section 4703(b)(2) of the New York Insurance Law by ensuring that the Plan's Chief Fiscal Officer is bonded in a manner that is acceptable to the Superintendent of Financial Services.

6. Section H of the MCA requires that the board designate the Plan Administrator and other service providers of the Plan, provided that the charges, fees and other

compensation for any contacted services shall be clearly stated in written administrative services contracts. This section of the municipal cooperation agreement is in compliance with Section 4705(d)(2)(A) of the New York Insurance Law.

The Plan maintains a Plan Administrator position. The Plan pays approximately fifty percent of the Plan Administrator's salary. That individual is also the Plan Administrator for St. Lawrence-Lewis Counties School District Employees – Workers Compensation Plan, ("SLLCSDEWCP") also located at 40 Main Street, Canton, NY. SLLCSDEWCP, during the examination period paid the remaining portion of the Plan Administrator's salary. The Plan, at the time of examination, did not maintain a contract with the Plan Administrator which is a violation of Section 4705(d)(2)(A) of the New York Insurance Law.

Section 4705(d)(2)(A) of the New York Insurance Law states in part:

> "(d) The municipal cooperation agreement shall provide that the governing board:…
> (2) may enter into an agreement with a contract administrator or other service provider, determined by the governing board to be qualified, to receive, investigate, recommend, audit, approve or make payment of claims under the municipal cooperative health benefit plan, provided that:
> (A) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts as required in subdivision six of section ninety-two-a of the general municipal law"

It is recommended that the Plan comply with its MCA and Section 4705(d)(2)(A) of the New York Insurance Law by entering into an agreement with the Plan Administrator which will clearly state the services to be provided to the Plan and the fees to be paid for such services.

G. Accounts and Records

1. Cash and invested assets - The Plan has three different accounts: An investment account with New York Cooperative Liquid Assets Security System (NYCLASS) which is located at 999 18th Street, Suite 1230 Denver, Colorado; A money market account with Community Bank, N.A (CBNA) which is located at 80 Main Street, Canton, NY; And a Public Funds Commercial Money Market Deposit account with J. P. Morgan Chase Bank, N.A. (Chase) which is located at P.O. Box 659754, San Antonio, TX.

The Plan's accounts, except for the Chase account No. 3033358697 in the amount of $9,619,234, are insured with the FDIC Insurance and protected by an M&T Investment Group pledged collateral, account number 140166208, owned by the BOCES.

The Plan, as of June 30, 2013, maintained custodial agreements for the CBNA and the Chase accounts, but not with NYCLASS.

It is recommended that, as a good business practice, the Plan establish a formal custodial agreement with NYCLASS.

Furthermore, a review of the Plan's checks issuance process shows St. Lawrence-Lewis BOCES as the issuer of checks and only one signature is required in order to withdraw money from the above accounts.

It is recommended that, as a good business practice, the Plan implement controls that will require more than one signature for check issuance.

It is further recommended that, as a good business practice, the Plan include the name St. Lawrence Lewis Counties School District Employees Medical Plan on the

checks that are issued on behalf of the Plan. This procedure will prevent errors related to the co-mingling of funds belonging to the Plan and the BOCES.

2. Premium revenue - The Plan splits its premium revenue in two parts: the basic premium ($60,835,711) that covers the hospital/medical benefits and the administrative premium ($2,114,666) that covers the administrative expenses. The administrative premium is a second premium billed and collected from the participants by the BOCES to cover all the administrative expenses. The Plan should charge one premium which will support the benefits and the administrative expenses. Additional premium collected from the participants should only be authorized as assessments and should only occur when actual losses due to benefits paid out, administrative expenses and reserves and surplus requirements exceed amounts held in the Plan's fund, as mandated by Section 4705(d)(6) of the New York Insurance Law.

Section 4705(d)(6) of the New York Insurance Law states in part:

> "(d) The municipal cooperation agreement shall provide that the governing board:…
> (6) shall be authorized to assess participating municipal corporations for additional contributions, if actual losses due to benefits paid out, administrative expenses and reserve and surplus requirements exceed amounts held in the plan's joint funds…"

It is recommended that the Plan comply with Section 4705(d)(6) of the New York Insurance Law by assessing the participating school districts and BOCES for additional contributions only if actual losses due to the benefits paid out, administrative expenses and reserve and surplus requirements exceed amounts held in the Plan's joint funds.

Furthermore, when the Plan split the premium as shown above, it understated the surplus that it needed to establish and maintain pursuant to Section 4706(a)(5)(A) of the New York Insurance Law.

Section 4705(a)(5)(A) of the New York Insurance states:

> "(a) Notwithstanding any provision of law, the governing board of a municipal cooperative health benefit plan shall establish a reserve fund, and the plan's chief fiscal officer shall cause to be paid into the reserve fund the amounts necessary to satisfy all contractual obligations and liabilities of the plan, including:
> (5) a surplus account, established and maintained for the sole purpose of satisfying unexpected obligations of the municipal cooperative health benefit plan in the event of termination or abandonment of the plan, which shall not be less than:
> (A) five percent of the annualized earned premium equivalents during the current fiscal year of a municipal cooperative health benefit plan which consists of five or more participating municipal corporations and covers two thousand or more employees and retirees;"

It is recommended that the Plan report accurate premium information. The premium revenue directly impacts the required Section 4706(a)(5) surplus that is based on five percent of the premium revenue.

3. Record retention - The Plan was unable to provide support for a transfer charge made during the fiscal year ended June 30, 2013, relative to its administrative expenses. Also, the Plan was unable to provide the examiner with its chart of accounts, general ledger, and statements of reconciliation between its books of accounts and the amounts reported on its June 30, 2013 annual statement. Therefore, the Plan was in violation of Part 243.2(b)(7) of Insurance Regulation No. 152 (11 NYCRR 243.2).

Part 243.2(b)(7) states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
> (7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement work papers, evidence of asset ownership, and source documents, for six calendar

> years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer."

It is recommended that the Plan comply with Part 243.2(b)(7) of Insurance Regulation No. 152 by keeping on site, for six years, the financial records necessary to verify the financial condition of the Plan.

4. The Plan was late in filing all its annual statements subsequent to and during the examination period, in violation of Sections 4710(a)(2) & (3) of the New York Insurance Law.

Sections 4710(a)(2) & (3) of New York Insurance Law state:

> "(a) The governing board of the municipal cooperative health benefit plan shall:
>
> (2) annually, not later than one hundred twenty days after the close of the plan year, file a report with the superintendent showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) as of the end of the preceding plan year, in such form and providing such other information as the superintendent may prescribe
> (3) file a report each quarter with the superintendent describing the plan's current financial status and providing such information as the superintendent may prescribe."

It is recommended that the Plan comply with Sections 4710(a)(2) & (3) of the New York Insurance Law by filing its annual statements with the Department no later than one hundred twenty days after the close of the plan year.

H. Reserve Fund

The Plan does not designate a Chief Fiscal Officer to, among other duties, report on the operations and condition of the Plan's reserve funds to the governing board, as required by Section 4706(d) of the New York Insurance Law.

Section 4706(d) of the New York Insurance Law states:

> "(d) The plan's chief fiscal officer, within ninety days of the end of each fiscal year, shall furnish a detailed report of the operations and condition of the plan's reserve funds to the governing board."

It is recommended that the Plan comply with Section 4706(d) of the New York Insurance Law by designating a Chief Fiscal Officer who will furnish, within ninety days of the end of each fiscal year, a detailed report of the operations and condition of the Plan's reserve funds to the governing board.

4. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities and surplus as of June 30, 2013 as contained in the Plan's June 30, 2013 filed annual statement, a condensed summary of operations and a reconciliation of the net worth account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Plan's financial condition as presented in its financial statements contained in the June 30, 2013 filed annual statement.

Independent Accountants

The firm of Pinto Mucenski Hooper Van House & Company ("CPA") was retained by the Plan to audit the Plan's combined statutory basis statements of financial position as of June 30 of each year in the examination period, and the related statutory-basis statements of operations and surplus, for the year then ended.

Pinto Mucenski Hooper Van House & Company concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Plan at the fiscal year end June 30, 2009 through June 30, 2012 audit dates. However, for the fiscal year ending June 30, 2013, the Plan received a modified opinion. The basis for the modified opinion, as evidenced in the CPA's June 30, 2013 financial statements, is because the Plan reported its incurred but not reported claims liability in accordance with Article 47 of the New York State Insurance Law. In the CPA's opinion, this liability

should have been computed on an actuarial basis, as is required under accounting principles generally accepted in the United States of America.

Assets	
Cash and cash equivalents	$ 12,929,822
Aggregate write-ins for invested assets	463,571
Aggregate write-ins for other assets	1,039,825
Total assets	$ 14,433,218
Liabilities	
Claims payable reserve	$ 10,797,813
Aggregate write-ins for other liabilities	1,177,526
Total liabilities	$ 11,975,339
Net worth	
Unassigned funds	$ (583,906)
Surplus per Section 4706(a)(5)	3,041,786
Total surplus	$ 2,457,880
Total liabilities and surplus	$ 14,433,219

Note: The Plan reported its required minimum surplus as per Section 4706(a)(5) of the New York Insurance Law impaired in the amount of $583,906 as of June 30, 2013. Such impairment was removed as of September 30, 2013.

B. Statement of Revenue, Expenses and Surplus

Surplus decreased by $14,772,951 during the examination period from January 1, 2009 through June 30, 2013, detailed as follows:

Revenue		
Premium	$ 247,080,951	
Net investment income	412,872	
Aggregate write-ins for other revenue	9,637,048	
Total revenue		$ 257,130,871
Expenses		
Claims	$ 270,054,682	
Claim adjustment expenses	(3,335,339)	
General administrative expenses	6,422,347	
Total expenses		$ 273,141,690
Net income		$ (16,010,819)

Change in capital and surplus

Surplus, per filed annual statement, as of December 31, 2008			$ 17,230,831
	Gains in Surplus	Losses in Surplus	
Net income		$ 16,010,819	
Change in contingency reserves		471,360	
Change in retained earnings	$ 242,125		
Aggregate write-ins for change in other surplus items	1,467,103		
Net decrease in surplus			(14,772,951)
Surplus, per report on examination, as of June 30, 2013			$2,457,880

5. CLAIMS STABILIZATION RESERVE

The Plan did not maintain a claims stabilization reserve as of June 30, 2013.

Pursuant to the provisions of Sections 4706(a)(1) and 4706(a)(5) of the New York Insurance Law, the Plan must maintain total reserves at least equal to 150% of the sum of the claims unpaid and surplus required by Section 4706(a)(5) of the Insurance Law.

Inasmuch as the Plan has only maintained approximately 104%, a claim stabilization reserve should be gradually accumulated until the Plan is in compliance with the previously mentioned sections of the law**.**

6. CONCLUSION

The Plan reported its required minimum surplus as per Section 4706(a)(5) of the New York Insurance Law impaired in the amount of $583,906 as of June 30, 2013. Such impairment was removed as of September 30, 2013.

7. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The review was directed at the practices of the Plan in the following major areas:

A. Claims prompt payment review
B. Grievances
C. Utilization review
D. Policy forms
E. Explanation of benefits statements
F. Community rating methodology

A. Claims Prompt Payment Review

A review to test for compliance with the Prompt Pay Law, Section 3224-a of the New York Insurance Law, was performed by using a statistical sampling methodology covering claims submitted to the Plan during the period July 1, 2012 through June 30, 2013.

The review of the Plan's submitted medical and hospital claims data for the period July 1, 2012 through June 30, 2013, relative to compliance with Section 3224-a of the New York Insurance Law did not reveal any problem areas.

B. Grievances

The Plan submitted eight (8) grievance cases closed during the Plan year 2012/2013. The examination reviewed all eight (8) cases to ensure compliance with Section 4802 of the New York Insurance Law. The following violations were noted:

1. The Plan failed to issue an acknowledgement letter for five of the eight grievance cases reviewed. This is a violation of Section 4802(d) of the New York Insurance Law.

Section 4802(d) of the New York Insurance Law states, in part:

> "(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance"

It is recommended that the Plan comply with Section 4802(d) of the New York Insurance Law by providing written acknowledgement within fifteen business days of the receipt of the grievance.

2. The Plan failed to issue appeal rights for three of the eight grievance cases reviewed. This is a violation of Section 4802(g)(3) of the New York Insurance Law.

Section 4802(g)(3) of the New York Insurance Law states, inpart

> "(g)The notice of a determination shall include:…
> (3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal. …"

It is recommended that the Plan comply with Section 4802(g)(3) of the New York Insurance Law by providing to the member the procedures for the filing of an appeal of the determination.

3 The Plan failed to issue a determination notice for two of the eight grievance cases reviewed. This is a violation of Section 4802(f) of the New York Insurance Law.

Section 4802(f) of the New York Insurance Law states:

> "(f) The notice of a determination of the grievance shall be made in writing to the insured or to the insured's designee. In the case of a determination made in conformance with subparagraph (1) of subsection (d) of this section, notice shall be made by telephone directly to the insured with written notice to follow within three business days"

It is recommended that the Plan comply with Section 4802(f) of the New York Insurance Law by notifying the insured in writing of the grievance determination.

4 The Plan failed to reach a timely resolution in two of the eight grievance cases reviewed. This is a violation of Section 4802(d)(2) of the New York Insurance Law.

Section 4802(d)(2) of the New York Insurance Law states:

> "(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:
> (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract;

It is recommended that the Plan comply with Section 4802(d)(2) of the New York Insurance Law by reaching a resolution within thirty days after the receipt of all necessary information in the case of requests for referrals or determination concerning whether a requested service is covered.

C. Utilization Review

The Plan submitted 889 utilization review cases and 26 utilization review appeal cases closed during the fiscal year 2012 – 2013 for review. The examination reviewed 167 utilization review cases and all the 26 utilization review appeal cases to ensure compliance with Article 49 of the New York Insurance Law. The following violations were noted:

1. The Plan failed to file biennial reports of its utilization program to the Superintendent of Financial Services. This is a violation of Section 4901(a) of the New York Insurance Law.

Section 4901(a) of the New York Insurance Law states:

> "(a) Every utilization review agent shall biennially report to the superintendent of financial services, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section."

It is recommended that the Plan comply with Section 4901(a) of the New York Insurance Law by biennially reporting its utilization program to the Superintendent of Financial Services.

2. The Plan failed to reach a timely initial adverse determination in 45 of the 167 utilization review cases selected for review. This is a violation of Section 4903(d) of the New York Insurance Law.

Section 4903(d) of the New York Insurance Law states:

> "(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.:"

It is recommended that the Plan comply with Section 4903(d) of the New York Insurance Law by making a utilization review determination involving delivered health care services within thirty days of receipt of the necessary information.

3. The Plan failed to issue a determination letter for 15 of the 26 utilization review appeal cases. This is a violation of Section 4904(c) of the New York Insurance Law.

Section 4904(c) of the New York Insurance Law states:

> "(c) A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination."

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law by notifying the insured in writing of the appeal determination.

4. The Plan failed to issue an acknowledgement letter for 21 of the 26 utilization review appeal cases reviewed. This is a violation of Section 4904(c) of the New York Insurance Law, as quoted above.

It is recommended that the Plan comply with Section 4904(c) of the New York Insurance Law by providing written acknowledgement of the filing of the appeal within fifteen days of the filing of such filing.

5. In 3 of the 26 utilization appeal cases reviewed, the Plan failed to have the appeals reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination. This is a violation of Section 4904(d) of the New York Insurance Law.

Section 4904(d) of the New York Insurance Law states:

> "(d) Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination."

It is recommended that the Plan comply with Section 4904(d) of the New York Insurance Law by providing that appeals be reviewed by a clinical peer reviewer other that the clinical peer reviewer who rendered the first adverse determination.

Also, a review of the Plan's grievance and utilization review policy was conducted. It was noted that relative to items 2 through 5 above, the Plan's grievance and utilization review policy does not have the appropriate guidelines to ensure compliance with Section 4802 and Article 49 (Sections 4901, 4902, 4903 and 4904) of the New York Insurance Law.

It is recommended that the Plan revise its grievance/utilization procedures and include the appropriate procedural guidelines to ensure compliance with Section 4802 and Article 49 of the New York Insurance Law.

D. Plan Document

The Plan provides coverage by means of a traditional plan (Plan A); a Plan B that comprises 4 riders (Riders 5, 6, 7 and 9); and a Plan C, which is a high deductible plan. The Plan did not file Riders 5 and 9 with the Department for approval prior to implementation Therefore, the Plan is in violation of Section 3201(b)(1) of the New York Insurance Law.

Section 3201(b)(1) of the New York Insurance Law states:

> "(b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law."

It is recommended that the Plan comply with Section 3201(b)(1) of the New York Insurance Law by filing its Plan Document policy forms with the Department for approval prior to implementation.

E. Explanation of benefits Statements

A review of the Plan's explanation of benefits forms ("EOB") which were issued to the Plan's insureds relative to paid and denied claims, was conducted by the examiner. The review noted that, as in the prior report on examination, the Plan issued EOBs that do not contain an identification of the service for which the claim is made. Therefore, the Plan is still in violation of Section 3234(b)(3) of the New York Insurance Law.

Section 3234(b)(3) of the New York Insurance Law states:

"(b) the explanation of benefits form must include at least the following:
(3) an identification of the service for which the claim is made;"

It is, again recommended that the Plan comply with the requirements of Section 3234(b)(3) of the New York Insurance Law, by amending its EOB forms to include clear identification of the services for which the claim was made.

F. Community Rating Methodology

As of June 30, 2013 the Plan did not have a formal community rating methodology filed with the Department, nor approved by the Department, as required by Section 4705(d)(5)(B) of the New York Insurance Law.

Section 4705(d)(5)(B) of the New York Insurance Law states:

> "(d) The municipal cooperation agreement shall provide that the governing board:
> (5) shall prepare an annual budget for the municipal cooperative health benefit plan to determine the premium equivalent rates for participating municipal corporations to be deposited in the plan's joint fund or funds during the fiscal year, provided that:
> (B) the governing board shall establish premium equivalent rates for participating municipal corporations on the bases of a community rating methodology filed with and approved by the superintendent and,"

It is recommended that the Plan comply with Section 4705(d)(5)(B) of the New York Insurance Law by filing its community rating methodology with the Department for the Department's approval.

8. SUBSEQUENT EVENTS

Effective January 1, 2015 Madrid-Waddington Central School District withdrew from the Plan.

9. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained the following comments and recommendations (page number refers to the prior report on examination):

ITEM		PAGE NO.
	Municipal Cooperation Agreement	
1.	It is recommended that the Plan include a provision in its Municipal Cooperation Agreement that authorizes the governing board to establish a joint fund or funds to finance all of the Plan's expenditures, including claims, reserves, surplus, administration, stop-loss insurance and other expenses, in accordance with Section 4705(d)(4) of the New York Insurance Law. *The Plan has complied with this recommendation.*	6
	Stop-Loss Coverage	
2.	It is recommended that the Plan comply with the requirements of Section 4707(a)(1) of the New York Insurance Law by reducing the initial aggregate attachment point and the minimum aggregate attachment point of its stop-loss coverage to an amount not in excess of one hundred twenty-five percent of the amount of expected claims of the Plan for the current fiscal year, as certified by its qualified actuary. *The Plan has not complied with this recommendation. A similar recommendation will be contained in the report.*	7
	Claims Procedures	
3.	It is recommended that the Plan comply with the requirements of Section 4704(a)(8) of the New York Insurance Law by establishing procedures in its Plan Document for handling claims for benefits in the event of the Plan's dissolution. *The Plan has complied with this recommendation.*	11

ITEM **PAGE NO.**

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Surplus	
	The Plan reported its required minimum surplus as per Section 4706(a)(5) of the New York Insurance Law impaired in the amount of $583,906 as of June 30, 2013. Such impairment was removed as of September 30, 2013.	1, 27, 29
B.	Corporate Governance	
i.	It is recommended that the Plan's board members sign off on the Department's reports on examination as required by Section 312(b) of the New York Insurance Law. This will allow the board to be cognizant of the findings and therefore, help the board in managing, controlling and administering the Plan.	9
ii.	It is recommended that the Plan implement a conflict of interest policy/statement to ensure compliance with Section 4705(d)(2)(C) of the New York Insurance Law.	10
iii.	It is recommended that the Plan comply with Insurance Regulation No. 118 (11 NYCRR 89.5(e)(1)(i)) and refrain from utilizing any CPA that contemporaneously audits its statements of financial position and renders non-audit services to the Plan. The Plan may file for an exemption from the requirements of Part 89.5(e)(1)(i) as prescribed by Part 89.5(g) of such regulation.	10
C.	Affiliated Transactions	
i.	It is recommended that the Plan comply with Section 4705(d)(2)(A) of the New York Insurance Law by establishing appropriate service agreements delineating the services BOCES will provide to the Plan and the fees to be paid for the services.	12
ii.	It is recommended that the Plan adopt a written expense allocation procedure retrospective to the beginning of the examination period and going forward relative to the expenses that it shares with the BOCES and the other Plan participants to ensure compliance with Section 4705(d)(2)(A) of the New York Insurance Law.	12

ITEM **PAGE NO.**

Respectfully submitted,

_____
Edouard Medina
Associate Insurance Examiner

STATE OF NEW YORK)
) SS
)
COUNTY OF NEW YORK)

Edouard Medina, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____
Edouard Medina

Subscribed and sworn to before me
this _____ day of_____

APPOINTMENT NO. 31213

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Edouard Medina

as a proper person to examine the affairs of

St. Lawrence-Lewis Counties School Districts Employees Medical Plan

and to make a report to me in writing of the condition of said

Plan

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed my name and affixed the official Seal of the Department at the City of New York

this 16th day of September, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau