REPORT ON EXAMINATION

OF THE

STEUBEN AREA

SCHOOL EMPLOYEES' BENEFIT PLAN

AS OF

JUNE 30, 2010

DATE OF REPORT	**MAY 23, 2012**
EXAMINER	**GAIL A. ROSS**

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May 23, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30712, dated April 20, 2011, attached hereto, I have made an examination into the condition and affairs of Steuben Area Schools Employees' Benefit Plan, a municipal cooperative health benefit plan licensed pursuant to the provisions of Article 47 of the New York Insurance Law, as of June 30, 2010, and respectfully submit the following report thereon.

The examination was conducted at the home office of Steuben Area Schools Employees' Benefit Plan located at 8455 County Route 125, Campbell, New York.

Wherever the designations the "Plan" or "SASEBP" appear herein, without qualification, they should be understood to indicate the Steuben Area Schools Employees' Benefit Plan.

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

It should be noted that the New York State Insurance Department merged with the New York State Banking Department on October 3, 2011 to become the New York State Department of Financial Services.

1. SCOPE OF EXAMINATION

The previous examination of the Plan was conducted as of June 30, 2005. This examination of the Plan was a combined financial and market conduct examination and covered the five-year period from July 1, 2005 through June 30, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook. Where deemed appropriate by the examiner, transactions occurring subsequent to fiscal year June 30, 2010 were also reviewed.

The financial portion of the examination was conducted on a risk-focused basis in accordance with the provisions of the Handbook, which provides 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 identify prospective risks that may threaten the future solvency of SASEBP. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Plan.

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 NAIC Annual Statement instructions.

Information concerning the Plan's organizational 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 2005 through 2010, by the accounting firm Ciaschi, Dietershagen, Little, Mickelson & Company, LLP. The Plan received an unqualified opinion in each of those years. Certain audit work papers of Ciaschi, Dietershagen, Little, Mickelson & Company, LLP were reviewed and relied upon in conjunction with this examination.

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

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations contained in the prior report on examination.

2. DESCRIPTION OF THE PLAN

Steuben-Allegany Board of Cooperative Educational Services ("BOCES") and its eight (8) original member school districts ("Participants") formed a Consortium, effective July 1, 1981. The purpose of the Consortium was to provide for the efficient and economic evaluation, processing, administration and payment of health benefits through self-insurance. The Plan provides benefits to covered employees and their eligible dependents as defined in the plan booklet.

On June 1, 2001, the Plan was issued a certificate of authority by the Superintendent of Insurance under Article 47 of the New York Insurance Law. Pursuant to such certificate of authority, the Participants have agreed to share the costs and assume the liabilities for medical, surgical, prescription drugs, and hospital benefits provided to covered employees (including retirees) and their dependents.

On February 10, 2005, the Commissioner of Education ordered the merger of Steuben-Allegany BOCES and Schuyler-Chemung Tioga BOCES. Effective July 1, 2006 the common name of the merged BOCES became the Greater Southern Tier BOCES. Steuben-Allegany BOCES withdrew from the Plan and as a result of such withdrawal, all of Steuben-Allegany BOCES employees covered under the Plan were terminated from the Plan effective July 1, 2006.

The Hornell City School District ("Hornell") joined the Plan on February 1, 2006 under a contractual agreement, which required Hornell to make a $1,517,822 reserve contribution buy-in, paid in five installments. An initial payment of $126,486 was received in the 2006 plan year and $347,384 was received in 2007. The Plan deferred the remaining three payments of $347,384, due July 2007 through July 2009, for one additional year with the final payment due in 2010 with no interest consideration. On September 15, 2008, the agreement between the Plan and Hornell for $1,517,822 reserve contribution buy-in was revised to reduce the total buy-in amount to $1,308,700. Hornell paid their contributions in full as of June 30, 2010.

There are currently eight school districts participating in the Plan. The Plan Participants are as follows:

Arkport Central School
Avoca Central School
Campbell-Savona Central School
Canaseraga Central School
Canisteo-Greenwood Central School
Hammondsport Central School
Hornell City School District
Jasper-Troupsburg Central School

Steuben Area School Employees' Benefit Plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). To be a grandfathered plan, the policy or group health plan must have had at least one individual enrolled in coverage on March 23, 2010, and the policy or plan must have continuously covered someone since March 23, 2010. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverages that were already in effect when that law was enacted. A grandfathered health plan means the plan has the discretion not to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits. See Item 5B of this report on examination for additional details regarding this issue.

A. Management and Controls

Pursuant to the Municipal Cooperative Agreement, management of the Plan is to be vested in a governing board, comprised of one representative from each participating school district.

The governing board of the Plan as of June 30, 2010 was as follows:

Name and Residence	Affiliation
Timothy Allard Campbell, New York	Business Manager, Campbell-Savona Central School
Jeff Ahearn Hornell, New York	Business Manager, Hornell City School District
Marie Blum Canaseraga, New York	Superintendent, Canaseraga Central School
Kyle Bower Hammondsport, New York	Superintendent, Hammondsport Central School
Gay Fairbrother Avoca, New York	Business Manager, Avoca Central School
Chad Groff Jasper, New York	Superintendent, Jasper-Troupsburg Central School
Theresa McKenna Canisteo, New York	Business Manager, Canisteo-Greenwood Central School
William Locke* Arkport, New York	Superintendent, Arkport Central School

*Effective August 2010 Wendell Binley, Interim Superintendent, replaced William Locke as representative of Arkport Central School on the governing board.

*Effective December 2010 Glen Niles, Superintendent, replaced Wendell Binley as representative of Arkport Central School on the governing board.

Section 4705(a)(1) of the New York Insurance Law states in part:

> "(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:
>
> (1) specify all municipal corporations participating in the municipal cooperative health benefit plan and describe the form or type of municipal corporations eligible for participation;"

The municipal cooperation agreement did not list the Hornell City School District as a participant of the Plan.

It is recommended that the Plan comply with Section 4705(a)(1) of the New York Insurance Law and amend its Municipal Cooperation Agreement and its by-laws to reflect the current composition of the Plan.

According to the Municipal Cooperation Agreement, the governing board shall meet quarterly in the months of October, January, April, and July. The board may call special meetings at any time. The governing board scheduled regular quarterly meetings during the period under examination. The minutes of all meetings of the governing board were reviewed. All such meetings were well attended.

Section 624(a) of the Business Corporation Law states:

> "(a) Each corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders, board and executive committee…"

It was noted that the Plan's Governing Board has established specific committees as follows: Executive Committee, Medicare Supplement Committee, and Investment Policy Subcommittee. However, no minutes of meetings were taken during the examination period relative to such committees meetings.

It is recommended that the Plan comply with the requirements of Section 624(a) of the New York State Business Corporation Law by maintaining minutes of all board committee meetings held.

The officers of the Plan as of June 30, 2010 are as follows:

Officers	Title
Chad Groff	Chair & President
Timothy Allard	Chief Financial Officer
Rebecca Towner	Treasurer & Secretary

Section 4705(a)(7) of the New York Insurance Law states in part:

> "(a) The municipal cooperation agreement under which the municipal cooperative health plan is established and maintained, … shall be approved by each participating municipal corporation by majority vote of each such corporation's governing body, and shall:
>
> (7) designate the plan's attorney-in-fact to receive service of summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving such municipal cooperative health benefit plan;…"

A review of the governing board's minutes held during the examination period revealed that the Plan had not appointed an attorney-in-fact.

It is recommended that the Plan comply with Section 4705(a)(7) of the New York Insurance Law and designate an attorney-in-fact to receive service of summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan.

The Plan's governing board, subsequently acted, on February 6, 2012, to appoint Timothy Allard as the Plan's attorney-in-fact.

B. Territory and Plan of Operation

The Plan provides hospital, medical and pharmacy benefits to eligible members of the participating school districts in Steuben and Allegany counties within New York State. The Plan reported annual written premiums of $11,671,397 for the fiscal year ending June 30, 2010. The Plan's enrollment as of June 30, 2010 was 1,368. There was no significant change in membership throughout the examination period.

C. Corporate Governance

A review of the Plan's service contract with Ciaschi, Dietershagen, Little, Mickelson & Company, LLP, the Plan's Certified Public Accounting ("CPA") firm, indicates that such audits were not designed to provide assurance relative to the Plan's internal controls or identify deficiencies in such internal controls.

Section 4705(e)(1) of the New York Insurance Law states in part:

> "(e) The municipal cooperation agreement shall provide for the following to be prepared and furnished to the governing board… 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;"

It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis, in order to comply with the requirements of Section 4705(e)(1) of the New York Insurance Law.

Subsequent to the examination date, the Plan's CPA firm provided an opinion relative to the Plan's internal controls within its 2011 audit report.

A review of the Plan's corporate governance structure revealed that the Governing Board did not adopt written procedures that would allow the board to obtain certification, annually, from either an internal auditor or independent CPA that the responsible officers have implemented the procedures adopted by the board, and from the Plan's general counsel, a statement that the Plan's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations.

It is recommended that, as a prudent business practice, the board adopt written procedures that would require the board to obtain annual certification, either from an internal auditor, or the Plan's independent CPA firm and the Plan's general counsel, that the Plan's responsible officers have implemented procedures adopted by the board and that the Plan's current claims adjudication procedures, including those set forth in current claims manuals, are in accordance with applicable Department statutes, rules and regulations.

Also, as part of the corporate governance structure, the Plan's responsibilities include the overseeing of management's handling of the claims adjudication process which extends to outside parties who, pursuant to an agreement with the Plan, perform claims adjudication procedures on behalf of the Plan.

It is recommended that, as prudent business practice, the Plan's board of governors obtain annual certifications from its third party claims administrators that claims are being processed in accordance with the Plan Document and applicable Department statutes, rules and regulations.

D. Stop-Loss Coverage

As required by Section 4707 of the New York Insurance Law, the Plan maintains both aggregate stop-loss coverage and specific stop-loss coverage. The provider of the stop-loss coverage is authorized in New York. The following is a summary of the Plan's stop-loss program as of June 30, 2010:

Type	Limits
Excess of loss (one layer)	100% of $800,000, excess of $200,000 per member, per contract year.
Aggregate excess of loss	$1,000,000 excess of annual aggregate attachment point ($18,230,977), for the current contract period.

E. Administrative Services Agreements

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

- Excellus Health Plan, Inc. ("Excellus") provides processing of the medical and hospital claims, administrative services, preparation and delivery of reports required under the administrative service agreement, medical review and managed care services, and maintenance of an adequate provider network.

Section 2101(g)(1) of the New York Insurance Law states in part:

> "(g) In this article "adjuster" means any "independent adjuster" or "public adjuster" as defined below:
>
> (1) the term "independent adjuster" means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer… as are incidental to such claims and also includes any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster…"

Section 2102(a)(1) of the New York Insurance Law states:

> "(a)(1) No person, firm, association or corporation shall act as an… insurance adjuster… in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

Section 2108(a)(3) of the New York Insurance Law states in part:

> "(a)(3) No adjusters shall act on behalf of an insurer unless licensed as an independent adjuster…"

A review of the claims adjudication process by the examiner revealed that, while acting in its capacity for the Plan, neither Excellus nor any of its employees assigned to process the Plan's claims possessed a New York claims adjuster license. This is a violation of Sections 2102(a)(1) and 2108(a)(3) of the New York Insurance Law.

It is recommended that Excellus and each of its employees who perform claim adjusting services on behalf of the Plan be licensed as independent claims adjusters, in accordance with Sections 2101(g)(1) and 2108(a)(3) of the New York Insurance Law.

- InformedRX maintains an electronic system for processing and paying prescription drug claims and furnishing related services through a network of pharmacies and other professional facilities, for the purpose of administering the Plan's prescription drug benefit.

- Orville A. Boden, Jr., an independent consultant, performs consulting services for the Plan related to rates, benefits and enrollment. He assists in the review and revision of the plan benefit structure and design. He is compensated monthly by means of a fee that was approved by the Board of Trustees.

- The Segal Company performs actuarial services for the Plan. The firm certifies the reserves.

- Ciaschi, Dietershagen, Little, Mickelson & Company, LLP provided accounting support and auditing services to the Plan during the examination period.

F. Conflict of Interest Policy

The Plan does not have a code of conduct policy and does not require its officers to annually complete conflict of interest statements. It is good business practice to have board members and senior officers complete and sign conflict of interest disclosure forms annually.

It is recommended that the Plan establish a formal code of conduct policy and require that its board members, officers and key employees sign a conflict of interest disclosure form on an annual basis.

G. Accounts and Records

Contingent Reserve

Section 4706(a)(5)(B) of the New York Insurance Law states:

> "(a)(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:"
>
> "(5)(B) seven percent of the annualized earned premium equivalents during the current fiscal year of the municipal cooperative health benefit plan which consists of four or fewer participating municipal corporations or covers fewer than two thousand employees and retirees."

Although an examination change was not made relative to this report on examination, a review of the Plan's contingency reserve as of June 30, 2010 indicated that the Plan did not calculate its contingent reserve in accordance with Section 4706(a)(5)(B) of the New York Insurance Law. The Plan calculated its contingency reserve at five percent of annualized earned premium instead of the required seven percent.

It is recommended that the Plan comply with Section 4706(a)(5)(B) of the New York Insurance Law when reporting its contingent reserve in future statements to this Department.

Annual and Quarterly Statement preparation

A review of the annual statements filed during the period under examination revealed the Plan incorrectly completed NY Schedule F – Claims Payable Analysis for all

years under examination. Specifically, the Plan reported the same amount in Column F-Claims Paid during the year and Claims Unpaid at End of Current Year on Claims Incurred During Prior Years and the Column G-Estimated Liability of Unpaid Claims at End of Prior Year. The reporting of the same amount in the aforementioned sections of Schedule F indicates that an actual run-off of claims and claims unpaid was not reported.

It is recommended that the Plan report its actual one-year claims run-off within its NY Schedule F – Claims Payable Analysis in its filed annual statements.

In addition, the Plan reported its unpaid claim adjustment expense reserves as a component of its unpaid claims reserves in its filed annual statements during the examination period.

It is recommended that the Plan report its liability for its claims adjustment expenses as a separate line item within its filed annual statements.

3. FINANCIAL STATEMENTS

A. Balance sheet

The following shows the assets, liabilities and surplus as determined by this examination as of June 30, 2010. This statement is the same as the balance sheet reported by the Plan in its filed annual statement.

	Examination	Plan
Assets		
Cash and cash equivalents	$8,389,332	$8,389,332
Claim deposit	59,700	59,700
Total Assets	$8,449,032	$8,449,032
Liabilities		
Accounts payable	$8,714	$8,714
Claims payable	$2,208,245	$2,208,245
Total Liabilities	$2,216,959	$2,216,959
Net Worth		
Contingency reserves	$595,482	$595,482
Retained earnings/fund balance	5,636,591	5,636,591
Total Net Worth	$6,232,073	$6,232,073
Total Liabilities and Net Worth	$8,449,032	$8,449,032

B. Statement of Revenues and Expenses and Change in Net Worth

Net worth increased $4,500,212 during the five-year examination period, July 1, 2005 through June 30, 2010, detailed as follows:

Revenues:		
Premiums	$59,924,317	
Investment income	953,476	
Aggregate write-ins for other revenue	2,811,052	
Total revenues		$63,688,845
Expenses:		
Hospital and medical claims	$32,993,010	
Drug claims	22,966,609	
Claims Subtotal	$55,959,619	
Reinsurance expenses net of recoveries	506,994	
Net Claims Incurred	$56,466,613	
Administrative Expenses	$ 3,327,655	
Total Expenses		$59,794,268
Net Income		$ 3,894,577

	Increases In Net worth	Decreases In Net worth	
Net worth, per report on examination, as of June 30, 2005			$ 1,731,861
Net income	$3,894,577		
Decrease in contingency reserve		$185,910	
Aggregate write-ins for changes in retained earnings	791,545		
Net increase in net worth			$4,500,212
Net worth, per report on examination, as of June 30, 2010			$6,232,073

4. CLAIMS PAYABLE

The examination liability of $2,208,245 is the same as the amount reported by the Plan as of June 30, 2010.

The Plan's liability for unpaid claims was established in compliance with the requirement of Section 4706(a)(1) of the New York Insurance Law. The Plan received permission from the Department on September 30, 2005 to reduce the required minimum amount of its unpaid claims reserve from 25% of total expected incurred claims and expenses to 17% of total incurred claims and expenses, starting with its September 30, 2005 quarterly statement.

The examination analysis of the claims unpaid reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination analysis was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date.

5. 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 subscribers 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 general review was directed at practices of the Plan in the following areas:

(A) Claims review
(B) Policy forms/benefits
(C) Complaints
(D) Underwriting and rating

A. Claims Review

Claims attribute review

A claims attribute review was performed for claims submitted to the Plan during the period, July 1, 2009 through June 30, 2010. A statistical random sampling process

was performed which tested several attributes deemed to be necessary for the appropriate processing of claims. The objective of the sampling process was to test and reach conclusions concerning the predetermined attributes, individually or in combination.

The claims attribute review did not reveal any problem areas.

Claims prompt payment review

A review to test for compliance with Section 3224-a of the New York Insurance Law (Prompt Payment Law) was performed by using a statistical sampling methodology covering claims submitted to the Plan during the period July 1, 2009 though June 30, 2010.

The review of the Plan's submitted medical and hospital claims data for the period, July 1, 2009 through June 30, 2010 relative to compliance with Section 3224-a of the New York Insurance Law did not reveal any problem areas.

B. Policy Forms/Benefits

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, requires that, in order to maintain status as a grandfathered health plan, SASEBP must include a statement, in all plan materials which are distributed to participants and beneficiaries and which describe the benefits provided under the Plan, that the Plan believes it is a grandfathered health plan within the meaning

of Section 1251 of the Affordable Care Act. Additionally, contact information for questions and complaints must be provided.

Section 1251 of the Patient Protection and Affordable Care act states in part:

> "The following language can be used to comply with disclosure requirement:
>
> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits..."

The Plan did not provide notification to its members, in any plan materials, beginning with the first year to which such provisions would otherwise apply, that described the benefits provided under the plan or health insurance coverage and that indicated the Plan is a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act.

It is recommended that the Plan comply with the requirements of Section 1251 of the Patient Protection and Affordable Care Act and include the required disclosure statement to its policyholders.

On February 14, 2012, the Plan filed Amendment No. 8 to its Plan Document, which included the aforementioned disclosure statement with the Department.

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C. Complaints

New York Insurance Department Circular Letter No. 11 (1978) states the following:

> "As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity."

It was determined that the Plan did not maintain an ongoing central log as part of its complaint handling function.

It is recommended that the Plan, as a good business practice, maintain a complaint log in a manner consistent with New York Insurance Department Circular Letter No. 11 (1978).

D. Rating

The Plan's premium rates are developed by the Plan based on a review of its past claims experience and projections of the Plan's future financial performance. Such premium rates are established and are approved by the Plan's governing board prior to each plan year, which must be community rated.

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

> "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…"

It was noted that the Plan did not file its community rating methodology formula with this Department.

It is recommended that the Plan comply with the requirements of Section 4705(d)(5)(B) of the New York Insurance Law by submitting its community rating methodology formula to the Superintendent for approval.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included eleven (11) recommendations detailed as follows (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Administrative Agreements	
1.	It is recommended the Plan submit its administrative agreements to the New York State Insurance Department for approval pursuant to the provisions of Section 4710(a)(1) of the New York Insurance Law.	7
	The Plan has complied with this recommendation.	
	Internal controls	
2.	It is recommended that checks received by the Plan that have not been deposited be kept in a locked drawer and deposited in the Plan's depository the next business day.	8
	The Plan has complied with this recommendation.	
3.	It is recommended that checks exceeding a certain amount as established by the Plan's board of trustees be required to have two signatures.	8
	The Plan has complied with this recommendation.	
	Annual Statement Preparation	
4.	It is recommended that the Plan exercise an increased level of care in the preparation of its annual statements to avoid filing amended statements.	8
	The Plan has complied with this recommendation.	
5.	It is recommended that the Plan accurately report its administrative expenses in Report #2 – Statement of Revenue, Expenses and Net Worth of the annual statement.	9
	The Plan has complied with this recommendation.	

ITEM NO. PAGE NO.

Mandated Benefits

6. It is recommended that the Plan comply with the provisions of Section 4303(s) of the New York Insurance Law and provide coverage for medical conditions leading to infertility. 14

The Plan has complied with this recommendation.

7. It is recommended that the Plan comply with the provisions of Section 4303(x) of the New York Insurance Law and provide coverage for post-mastectomy reconstruction. 15

The Plan has complied with this recommendation.

8. It is recommended that the Plan comply with the provisions of Section 4303(q) of the New York Insurance Law and provide coverage for cancer drugs. 16

The Plan has complied with this recommendation.

9. It is recommended that the Plan comply with the provisions of Section 4303(b)(b) of the New York Insurance Law and provide coverage for bone density measurements, testing, drugs, and devices. 17

The Plan has complied with this recommendation.

10. It is recommended that the Plan comply with the provisions of Section 4303(c) of the New York Insurance Law and provide coverage for contraceptive drugs or devices. 17

The Plan has complied with this recommendation.

11. It is recommended that the Plan include all mandated benefits within its Plan Document (group contract), and file the amended Plan Document for approval with the Superintendent of Insurance pursuant to Section 4308(a) of the New York Insurance Law. 18

The Plan has complied with this recommendation.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM NO.		PAGE NO.
A.	Management and Controls	
i.	It is recommended that the Plan comply with Section 4705(a)(1) of the New York Insurance Law and amend its Municipal Cooperation Agreement and its by-laws to reflect the current composition of the Plan.	9
ii.	It is recommended that the Plan comply with the requirements of Section 624(a) of the New York State Business Corporation Law by maintaining minutes of all board committee meetings held.	9
iii.	It is recommended that the Plan comply with Section 4705(a)(7) of the New York Insurance Law and designate an attorney-in-fact to receive service of summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Plan. The Plan's governing board, subsequently acted, on February 6, 2012, to appoint Timothy Allard as the Plan's attorney-in-fact.	10
B.	Corporate Governance	
i.	It is recommended that the Plan amend its contract with its CPA firm to include a review and rendering of an opinion of the Plan's internal control systems on an annual basis, in order to comply with the requirement of Section 4705(e)(1) of the New York Insurance Law. Subsequent to the examination date, the Plan's CPA firm provided an opinion relative to the Plan's internal controls within its 2011 audit report.	11

Appointment No. 30712

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Gail Ross

as a proper person to examine into the affairs of the

Steuben Area School Employees' Benefit Plan

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

Municipal Cooperative Health Benefit Plan

with such other information as he shall deem requisite.

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

This 21st day of April, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR