
**AGENDA & REPORTS**
**MARCH 22, 2021**
**CONFERENCE CALL**
**1:15 PM**

Join Zoom Meeting
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Meeting ID: 545 508 0980

**STATEMENT OF COMPLIANCE WITH OPEN PUBLIC MEETINGS ACT**

Pursuant to Executive Order Number 103 dated March 9, 2020, Governor Murphy declared a Public Health Emergency and a State of Emergency in New Jersey. On March 20, 2020 P.L. 2020 Chapter 11 amended the Open Public Meetings Act to allow local public bodies to conduct Remote Public Meetings by use of electronic communications technology during a period declared as a Public Health Emergency or a State of Emergency.

Adequate Notice and Electronic Notice of this meeting was given by:

1. Sending advance written notice to The Atlantic City Press

2. Filing advance written notice of this meeting with the Clerk/Administrator of each member.

3. Sending advance electronic mail notice of this meeting to the Clerk/Administrator of each member.

4. Posting electronic notice of this meeting on the Fund's website which notice provided the time, date and instructions for: (i) access to the Remote Public Meeting, (ii) how to provide public comment and (iii) how to access the agenda.

5. Posting a copy of the meeting notice on the public bulletin board of all members.

6. During the business session portion of this Remote Public Meeting the audio of all members of the public attending the meeting will be muted. At the end of the business session of the meeting, a time for public comment will be available. Members of the public who desire to provide comment shall raise their virtual hand in the Zoom application and/or submit a written comment via the text message section of the application. The meeting moderator will queue the members of the public that wish to provide comment and the Chairperson will recognize them in order. Public comment shall be concise and to the point and shall not contain abusive, defamatory, or obscene language.

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND AGENDA**
**MEETING: MARCH 22, 2021**
**CONFERENCE CALL**
**1:15 PM**

**MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ**

**FLAG SALUTE**

**ROLL CALL OF THE 2021 EXECUTIVE COMMITTEE**

Pasquale Yacovelli, Chair
Nicole Albanese, Secretary
Bruce Harbinson, Executive Committee
Jerry Velazquez, Executive Committee
Stephanie Kuntz, Executive Committee
Richard Davidson, Executive Committee
Paige Sharpe-Rumaker, Executive Committee
Megan Duffield, Executive Committee Alternate
Cherie Bratty, Executive Committee Alternate

**APPROVAL OF MINUTES:** January 25, 2021..... Appendix I

**CORRESPONDENCE**

**PUBLIC COMMENT**

**REPORTS:**

**EXECUTIVE DIRECTOR (PERMA)**
Monthly Report.....**Page 1**

**PROGRAM MANAGER– (Shared Health Alliance)**
Monthly Report.....**Page 9**

**GUARDIAN NURSES**
Monthly Report.....**Page** 17

**TREASURER – (Michael Zambito/Verrill & Verrill)**
February 2021 Bills List.....**Page 18**
March 2021 Bills Lists (Resolution 15-21) .....**Page 20**
January 2021 Treasurers Report.....**Page 22**
Confirmation of Claims Paid/Certification of Transfers
Ratification of Treasurers Report

**ATTORNEY – (Marmero Law, LLC)**
Monthly Report

**NETWORK & THIRD PARTY ADMINISTRATOR – (Aetna)**
Monthly Report.....**Page 25**

**NETWORK & THIRD PARTY ADMINISTRATOR – (Amerihealth)**
Monthly Report.....**Page 31**

**PRESCRIPTION ADMINISTRATOR – (Express Scripts)**
Monthly Report .....**Page 41**

**CONSENT AGENDA .....Page 43**
Resolution 14-21: Wellness Grant Approval .....**Page 44**
Resolution 15-21 February and March 2021 Bills Lists.....**Page 45**

**OLD BUSINESS**

**NEW BUSINESS**

**PUBLIC COMMENT**

**RESOLUTION - EXECUTIVE SESSION FOR CERTAIN SPECIFIED PURPOSES**
**PERSONNEL - CLAIMS – LITIGATION**

**MEETING ADJOURNED**

# Southern Coastal Regional Employee Benefits Fund
# Executive Director's Report
# March 22, 2021

## FINANCES & CONTRACTS

### PRO FORMA REPORTS

- **Fast Track Financial Reports –** as of January 31, 2021 (page 3)
  - **Historical Income Statement**
  - **Consolidated Balance Sheet**
  - **Indices and Ratios Report**
  - **Budget Status Report**

### AMERIHEALTH (AHA) CONTRACT

The AHA contract with the Coastal Fund has been updated with the most current public sector language requirements and to reflect more terms that are standard for AHA. The compensation amounts are unchanged. This new contract will cover the period from 1/1/2019 to 12/31/2021. The contract is included in Appendix IV.

*Motion: Authorize Fund Chairman and Secretary to sign new AHA contract.*

## OPERATIONS & NOMINATIONS

### MUNICIPAL REINSURANCE HEALTH INSURANCE FUND

The MRHIF met on February 10 to reorganize. In addition, the Fund took action on the following items:

1. Awarded a contract to ELMC to facilitate the PBM RFP process, perform 18 month market checks and the annual audits of the PBM contract.

2. Approved a release of an RFP for the PBM contract.

3. Approved a release of an RFP for the Medicare Advantage/EGWP policies. Further discussion will be brought to the local Funds in the next few months.

4. The State Wide contracts committee will be engaged in the above mentioned RFPs. Current committee is below. More Commissioners are welcome to join (no more than 3 per Fund):

**MRHIF RFP/ Contracts Committee**

| | |
|---|---|
| Lorene Wright | NJHIF |
| Brian Brach | CJHIF |
| Donato Nieman | CJHIF |
| Lisa Giovanelli | SHIF |
| Tammy Smith | NJHIF |

5. The Aetna Audit has been completed and we will provide the report to each of the Funds in the next month.

**MEL/MR-HIF/ CEL EDUCATIONAL SEMINAR**

The 2021 seminar will be held virtually on the mornings of Friday, May 14th and Friday, May 21st. The information on how to register is included in Appendix V. The agenda includes two ethics courses, and presentations on implicit bias, insurance market conditions, proposals to change the Workers' Compensation law and a discussion of proposed changes to the Affordable Care Act.

**FINANCIAL DISCLOSURE FILINGS**

Commissioners should anticipate the online filing of the Financial Disclosure forms as both a Southern Coastal Regional Employee Benefits Fund Commissioner, as well as any municipal related position that requires filing and Joint Insurance Fund. It is expected the Division of Local Government Services will distribute a notice in April and forms will need to be filed by April 30th.

## WELLNESS & CLAIMS

**GRANT APPROVAL**

The Fund has received a wellness grant request from Buena Board of Education for $10,000. The Wellness Committee has reviewed the grant request and are recommending for approval. The grant application is included in appendix III and a resolution approving the grant is included in the consent agenda.

The Wellness Committee met earlier this month to discuss grant policies. Minutes are included in Appendix II. The Program Manager will provide an update.

# SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

## FINANCIAL FAST TRACK REPORT

**AS OF January 31, 2021**

| | | | THIS MONTH | YTD CHANGE | PRIOR YEAR END | FUND BALANCE |
|---|---|---|---|---|---|---|
| 1. | **UNDERWRITING INCOME** | | **8,598,159** | **8,598,159** | **397,943,517** | **406,541,676** |
| 2. | **CLAIM EXPENSES** | | | | | |
| | Paid Claims | | 6,844,247 | 6,844,247 | 315,000,408 | **321,844,655** |
| | IBNR | | 271,125 | 271,125 | 8,409,061 | **8,680,186** |
| | Less Specific Excess | | - | - | (7,172,954) | **(7,172,954)** |
| | Less Aggregate Excess | | - | - | - | - |
| | **TOTAL CLAIMS** | | **7,115,373** | **7,115,373** | **316,236,515** | **323,351,888** |
| 3. | **EXPENSES** | | | | | |
| | MA & HMO Premiums | | 0 | 0 | 1,379,784 | **1,379,784** |
| | Excess Premiums | | 218,627 | 218,627 | 13,066,151 | **13,284,778** |
| | Administrative | | 834,480 | 834,480 | 37,242,568 | **38,077,049** |
| | **TOTAL EXPENSES** | | **1,053,107** | **1,053,107** | **51,688,504** | **52,741,611** |
| 4. | **UNDERWRITING PROFIT (1-2-3)** | | 429,679 | 429,679 | 30,018,498 | **30,448,177** |
| 5. | **INVESTMENT INCOME** | | 20,490 | 20,490 | 1,691,068 | **1,711,558** |
| 6. | **DIVIDEND INCOME** | | 0 | 0 | 1,601,102 | **1,601,102** |
| 7. | **STATUTORY PROFIT (4+5+6)** | | **450,169** | **450,169** | **33,310,668** | **33,760,837** |
| 8. | **DIVIDEND** | | 0 | 0 | 19,979,182 | **19,979,182** |
| 9. | **Transferred Surplus** | | 0 | 0 | 9,855,397 | **9,855,397** |
| | **STATUTORY SURPLUS (7-8+9)** | | **450,169** | **450,169** | **23,186,883** | **23,637,052** |
| | | | ***SURPLUS (DEFICITS) BY FUND YEAR*** | | | |
| | **Closed** | **Surplus** | 6,060 | 6,060 | 9,930,324 | **9,936,384** |
| | | **Cash** | (188,397) | (188,397) | 19,386,417 | **19,198,020** |
| | **2019** | **Surplus** | (28,982) | (28,982) | 4,757,678 | **4,728,697** |
| | | **Cash** | (28,982) | (28,982) | 10,413,577 | **10,384,596** |
| | **2020** | **Surplus** | (968,277) | (968,277) | 8,498,881 | **7,530,604** |
| | | **Cash** | (4,942,828) | (4,942,828) | 15,621,513 | **10,678,685** |
| | **2021** | **Surplus** | 1,441,367 | 1,441,367 | | **1,441,367** |
| | | **Cash** | 4,187,049 | 4,187,049 | | **4,187,049** |
| | **TOTAL SURPLUS (DEFICITS)** | | **450,169** | **450,169** | **23,186,883** | **23,637,052** |
| | **TOTAL CASH** | | **(973,158)** | **(973,158)** | **45,421,508** | **44,448,349** |
| | | | ***CLAIM ANALYSIS BY FUND YEAR*** | | | |
| | **TOTAL CLOSED YEAR CLAIMS** | | **556** | **556** | **156,856,086** | **156,856,642** |
| | **FUND YEAR 2019** | | | | | |
| | Paid Claims | | 34,736 | 34,736 | 80,320,077 | **80,354,813** |
| | IBNR | | - | 0 | 0 | **0** |
| | Less Specific Excess | | - | 0 | (830,796) | **(830,796)** |
| | Less Aggregate Excess | | - | 0 | 0 | **0** |
| | **TOTAL FY 2019 CLAIMS** | | **34,736** | **34,736** | **79,489,280** | **79,524,016** |
| | **FUND YEAR 2020** | | | | | |
| | Paid Claims | | 5,077,178 | 5,077,178 | 73,012,645 | **78,089,823** |
| | IBNR | | (4,100,782) | (4,100,782) | 8,409,061 | **4,308,279** |
| | Less Specific Excess | | 0 | 0 | (1,530,558) | **(1,530,558)** |
| | Less Aggregate Excess | | 0 | 0 | 0 | **0** |
| | **TOTAL FY 2020 CLAIMS** | | **976,396** | **976,396** | **79,891,149** | **80,867,545** |
| | **FUND YEAR 2021** | | | | | |
| | Paid Claims | | 1,731,777 | 1,731,777 | | **1,731,777** |
| | IBNR | | 4,371,907 | 4,371,907 | | **4,371,907** |
| | Less Specific Excess | | 0 | 0 | | **0** |
| | Less Aggregate Excess | | 0 | 0 | | **0** |
| | **TOTAL FY 2021 CLAIMS** | | **6,103,684** | **6,103,684** | | **6,103,684** |
| | **COMBINED TOTAL CLAIMS** | | **7,115,373** | **7,115,373** | **316,236,515** | **323,351,888** |

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

# Southern Coastal Regional Employee Benefits Fund

## CONSOLIDATED BALANCE SHEET

### AS OF JANUARY 31, 2021

### BY FUND YEAR

| | COASTAL 2021 | COASTAL 2020 | COASTAL 2019 | CLOSED YEAR | FUND BALANCE |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| Cash & Cash Equivalents | 4,187,049 | 10,678,685 | 10,384,596 | 19,198,020 | 44,448,349 |
| Assesstments Receivable (Prepaid) | 1,755,041 | 68,667 | - | - | 1,823,708 |
| Interest Receivable | - | 61 | (23) | (38) | 0 |
| Specific Excess Receivable | - | 1,530,558 | 1,637 | - | 1,532,194 |
| Aggregate Excess Receivable | - | - | - | - | - |
| Dividend Receivable | - | - | - | 558,434 | 558,434 |
| Prepaid Admin Fees | 6,098 | - | - | - | 6,098 |
| Other Assets | - | 340,000 | - | - | 340,000 |
| **Total Assets** | 5,948,188 | 12,617,970 | 10,386,210 | 19,756,416 | 48,708,783 |
| **LIABILITIES** | | | | | |
| Accounts Payable | - | - | - | - | - |
| IBNR Reserve | 4,371,907 | 4,308,279 | - | - | 8,680,186 |
| A4 Retiree Surcharge | 116,829 | 582,239 | - | - | 699,069 |
| Dividends Payable | - | - | 5,607,513 | 9,820,032 | 15,427,545 |
| Accrued/Other Liabilities | 18,084 | 196,847 | 50,000 | - | 264,931 |
| **Total Liabilities** | 4,506,820 | 5,087,366 | 5,657,513 | 9,820,032 | 25,071,731 |
| **EQUITY** | | | | | |
| Surplus / (Deficit) | 1,441,367 | 7,530,604 | 4,728,697 | 9,936,384 | 23,637,052 |
| **Total Equity** | 1,441,367 | 7,530,604 | 4,728,697 | 9,936,384 | 23,637,052 |
| **Total Liabilities & Equity** | 5,948,188 | 12,617,970 | 10,386,210 | 19,756,416 | 48,708,783 |
| **BALANCE** | - | - | - | - | - |

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

Fund Year allocation of claims have been estimated.

## SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

## RATIOS

| INDICES | 2020 | JAN | |
|---|---|---|---|
| | | | |
| Cash Position | 45,421,508 | $ 44,448,349 | |
| IBNR | 8,409,061 | $ 8,680,186 | |
| Assets | 48,047,179 | $ 48,708,783 | |
| Liabilities | 24,860,296 | $ 25,071,731 | |
| Surplus | 23,186,883 | $ 23,637,052 | |
| | | | |
| Claims Paid -- Month | 7,565,964 | $ 6,844,247 | |
| | | | |
| Claims Budget -- Month | 7,373,031 | $ 7,695,332 | |
| | | | |
| Claims Paid -- YTD | 79,877,564 | $ 6,844,247 | |
| | | | |
| Claims Budget -- YTD | 88,476,372 | $ 7,695,332 | |
| | | | |
| | | | |
| **RATIOS** | | | |
| Cash Position to Claims Paid | 6.00 | 6.49 | |
| | | | |
| Claims Paid to Claims Budget -- Month | 1.03 | 0.89 | |
| | | | |
| Claims Paid to Claims Budget -- YTD | 0.90 | 0.89 | |
| | | | |
| Cash Position to IBNR | 5.40 | 5.12 | |
| | | | |
| Assets to Liabilities | 1.93 | 1.94 | |
| | | | |
| Surplus as Months of Claims | 3.14 | 3.07 | |
| | | | |
| IBNR to Claims Budget -- Month | 1.14 | 1.13 | |

# Southern Coastal Regional Employee Benefits Fund

## 2021 Budget Report

as of January 31st, 2021

| Expected Losses | Cumulative | Annual | Latest Filed | Cumulative Expensed | $ Variance | % Varaiance |
|---|---|---|---|---|---|---|
| Medical Aetna 1/1 Renewal | 2,757,831 | 33,022,237 | 33,519,698 | | | |
| Medical Aetna 7/1 Renewals | 2,892,239 | 35,248,497 | 35,151,743 | | | |
| Medical AmeriHealth 1/1 Renewal | 1,395,869 | 16,763,260 | 16,676,756 | | | |
| Medical AmeriHealth 7/1 Renewal | 439,418 | 5,300,141 | 1,107,606 | | | |
| Subtotal Medical | 7,485,357 | 90,334,135 | 86,455,803 | 5,843,273 | 1,646,836 | 22% |
| Prescription Claims 1/1 Renewals | 98,412 | 1,167,613 | 1,023,665 | | | |
| Prescription Claims 7/1 Renewals | 153,944 | 1,870,955 | 2,056,776 | | | |
| Less Formulary Rebates | (50,471) | (607,710) | (616,088) | | | |
| Subtotal Prescription | 201,885 | 2,430,858 | 2,464,353 | 254,218 | (52,333) | -26% |
| Dental Claims 1/1 Renewals | 0 | 0 | 0 | | | |
| Dental Claims 7/1 Renewals | 3,338 | 40,782 | 77,014 | | | |
| Subtotal Dental | 3,338 | 40,782 | 77,014 | 6,193 | (2,855) | -86% |
| Vision Claims 1/1 Renewals | 0 | 0 | 0 | | | |
| Vision Claims 7/1 Renewals | 4,752 | 56,662 | 66,016 | | | |
| Subtotal Vision | 4,752 | 56,662 | 66,016 | Included in Medical | | |
| Subtotal Claims | 7,695,332 | 92,862,437 | 89,063,186 | 6,103,684 | 1,591,648 | 21% |
| | | | | | | |
| Loss Fund Contingency | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| Medicare Advantage | 30,023 | 361,677 | 360,277 | 0 | 30,023 | 100% |
| | | | | | | |
| Reinsurance | | | | | | |
| Specific | 218,356 | 2,619,608 | 2,545,531 | | | |
| | | | | | | |
| Subtotal Reinsurance | 218,356 | 2,619,608 | 2,545,531 | 218,627 | (271) | 0% |
| | | | | | | |
| Total Loss Fund | 7,943,712 | 95,843,722 | 91,968,994 | 6,322,312 | 1,621,400 | 20% |
| | | | | | | |
| Expenses | | | | | | |
| Legal | 2,125 | 25,500 | 25,500 | 2,125 | - | 0% |
| Treasurer | 1,670 | 20,036 | 20,036 | 1,670 | - | 0% |
| Executive Director | 101,721 | 1,220,536 | 1,160,989 | 101,799 | (78) | 0% |
| Program Manager | 188,018 | 2,256,194 | 2,144,407 | 188,140 | (122) | 0% |
| Brokerage | 156,683 | 1,881,517 | 1,774,016 | 156,726 | (43) | 0% |
| TPA - Med Aetna | 152,543 | 1,830,270 | 1,832,035 | Included below in Med AmerihealthAdmin | | |
| TPA - Med AmeriHealth Admin | 56,251 | 674,618 | 555,857 | 210,372 | (1,245) | -1% |
| Guardian Nurses | 35,000 | 420,000 | 420,000 | 35,000 | - | 0% |
| TPA - Dental | 477 | 5,722 | 5,279 | 477 | - | 0% |
| TPA - Vision | 333 | 3,988 | 4,586 | Included below in Med AmerihealthAdmin | | |
| Actuary | 3,049 | 36,587 | 36,587 | 3,049 | - | 0% |
| Auditor | 1,649 | 19,788 | 19,788 | 1,649 | 0 | 0% |
| Subtotal Expenses | 699,519 | 8,394,755 | 7,999,080 | 701,006 | (1,487) | 0% |
| | | | | | | |
| Contingency | 1,250 | 15,000 | 15,000 | 209 | 1,041 | 83% |
| Wellness Program | 12,706 | 152,471 | 152,471 | 12,706 | (0) | 0% |
| Plan Documents | 1,250 | 15,000 | 15,000 | 1,250 | 0 | 0% |
| Affordable Care Act Taxes | 2,479 | 29,747 | 28,257 | 2,479 | 0 | 0% |
| Retiree Surcharage | 114,509 | 1,371,902 | 1,314,355 | 116,829 | (2,320) | -2% |
| | | | | | | |
| Total Expenses | 831,713 | 9,978,875 | 9,524,163 | 834,480 | (2,767) | 0% |
| | | | | | | |
| Total Budget | 8,775,425 | 105,822,596 | 101,493,157 | 7,156,792 | 1,618,633 | 18% |

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**
**Year: 2021, As of March 15, 2021**

| Yearly Items | Filing Status |
|---|---|
| **Budget** | **Filed** |
| **Assessments** | **Filed** |
| **Actuarial Certification** | **Filed** |
| **Reinsurance Policies** | **Filed** |
| **Fund Commissioners** | **Filed** |
| **Fund Officers** | **Filed** |
| **Renewal Resolutions** | **Filed** |
| **Indemnity and Trust** | **Compliance Listing included on page 8** |
| **New Members** | **N/A** |
| **Withdrawals** | **N/A** |
| **Risk Management Plan and By Laws** | **Filed** |
| **Cash Management Plan** | **Filed** |
| **Unaudited Financials** | **Year End unsigned filed** |
| **Annual Audit** | **12/31/19 Filed** |
| **Budget Changes** | **N/A** |
| **Transfers** | **N/A** |
| **Additional Assessments** | **N/A** |
| **Professional Changes** | **N/A** |
| **Officer Changes** | **N/A** |
| **RMP Changes** | **N/A** |
| **Bylaw Amendments** | **N/A** |
| **Contracts** | **Filed** |
| **Benefit Changes** | **N/A** |

| Fund Professional | Contract Received | Contract Term |
|---|---|---|
| Executive Director - PERMA | Yes | 1/1/2019 - 12/31/2021 |
| Program Manager - Shared Health Alliance | Yes | 1/1/2019 - 12/31/2021 |
| Attorney - Grace Marmero | Yes | 1/1/2021-12/31/2021 |
| Auditor - Bowman & Company | Yes | 1/1/2021-12/31/2021 |
| Actuary - John Vataha | Yes | 1/1/2021-12/31/2021 |
| Treasurer - Mike Zambito | Yes | 1/1/2021-12/31/2021 |
| Deputy Treasurer - Verrill & Verrill | Yes | 1/1/2021-12/31/2021 |
| Aetna | Yes | *ONE YEAR RENEWALS NEGOTIATED |
| AmeriHealth | Yes | *ONE YEAR RENEWALS NEGOTIATED |
| Delta | Yes | *ONE YEAR RENEWALS NEGOTIATED |
| Guardian Nurses | Yes | 4/1/2020 - *ONE YEAR AUTO RENEWS |

## INDEMNITY & TRUST AGREEMENT COMPLIANCE

| MEMBER | I & T end date |
|---|---|
| Pittsgrove | in progress |
| WOODSTOWN BOROUGH | 12/31/2023 |
| CITY OF BRIGANTINE | 6/30/2021 |
| DENNIS TOWNSHIP BOE | 6/30/2021 |
| Penns Grove | 6/30/2021 |
| Vineland Board of Education | 6/30/2021 |
| West Cape May | 6/30/2021 |
| Woodbine BOE | 7/31/2021 |
| Cumberland County Charter School Network | 6/30/2022 |
| Downe Township BOE | 6/30/2022 |
| HOPEWELL BOE | 6/30/2022 |
| Lower Township | 6/30/2022 |
| Ocean City BOE | 6/30/2022 |
| Waterford BOE | 6/30/2022 |
| Cumberland County Improvement Authority | 12/31/2022 |
| UPPER DEERFIELD BOE | 6/30/2023 |
| Alloway Township BOE | 12/31/2023 |
| Bridgeton BOE | 12/31/2023 |
| BUENA REGIONAL BOE | 12/31/2023 |
| CUMBERLAND COUNTY TECHNICAL EDUCATION CENTER | 12/31/2023 |
| CUMBERLAND REGIONAL BOE | 12/31/2023 |
| LOWER CAPE MAY REGIONAL BOE | 12/31/2023 |
| MILLVILLE BOE | 12/31/2023 |
| Salem County | 12/31/2023 |
| Lawrence Township BOE | 12/31/2023 |

**Shared Health Alliance**
**Program Manager Report**
**March 22, 2021**

## PROSPECTS

Wildwood Crest, Boro of
- In preliminary discussions

Vineland, City of
- Will begin 2 year review of claims in July

Egg Harbor Township
- In review for July 1, 2021

## COASTAL FUND MEETING DATES *(ZOOM MTG TILL FURTHER NOTICE)*

- March 22, 2021
- May 24, 2021
- July 26, 2021
- September 20, 2021
- October 25, 2021
- November 22, 2021

## COASTAL FUND BROKERS

- Allen Associates
- AR Fanucci
- Assured Partners
- Brown & Brown Benefit Advisors
- J Byrne Agency
- Conner Strong & Buckelew
- Cornerstone Insurance Group
- Hardenbergh Insurance Group
- Innovative Risk Solutions
- Integrity Consulting Group

## EXECUTIVE COMMITTEE

- Pasquale Yacovelli, Chair
- Nicole Albanese, Secretary
- Bruce Harbinson, Executive Committee
- Jerry Velazquez, Executive Committee
- Paige Sharpe-Rumaker, Executive Committee
- Stephanie Kuntz, Executive Committee
- Richard Davidson, Executive Committee
- Cherie Bratty, Executive Committee Alternate
- Megan Duffield, Executive Committee Alternate

## 2021 COMMITTEES

**Finance & Contracts**
Pat Yacovelli, Chair
Jerry Velazquez
Richard Davidson

**Operations & Nominations**
Nicole Albanese, Chair
Jerry Velazquez
Stephanie Kuntz

**Wellness & Claims**
Paige Sharpe Rumaker, Chair
Bruce Harbinson
Megan Duffield

## WELLNESS COMMITTEE UPDATE

Please be advised that you still have time to submit an application for a wellness grant. Please go online to www.coastalhif.com and review the wellness grant guidelines and information in order to submit a new application. Applications received now would be granted for the 2021 year. Please note the new website information from Health Fairs Direct for Biometric Screening information and other new resources. Please contact us for any additional information or assistance. **www.coastalhif.com/wellness**

- In light of the Social Distancing guidelines, many of our groups have not been able to use all of their 2020 Wellness Grant money. As a result, the Wellness Committee agreed to allow any remaining funds to be rolled over into 2021. Please reach out to corey@allenassoc.com if you would like to know your remaining balance.

- In addition, the Wellness Committee has agreed to extend the November submission deadline for 2021 Wellness Grants. Submission of 2021 Wellness Grant Applications will be accepted on a rolling basis throughout the year. Upon receipt and approval by the Wellness Committee, grant applications will be submitted to the Coastal Fund for approval via Resolution.

**WELLNESS COMMITTEE**

- There is a Wellness section on the Coastal HIF Website. Please note, applications can be submitted online.
- 2021 Grant Applications status (see below)
- 2021 Budget for Wellness Grants is $152,471
- Attached you will find the most recent Wellness Guidelines Chart.
- Attached please find the minutes from the most recent Wellness Committee Meeting (2/16/21). Due to lack of quorum, an additional meeting is being planned.

SouthernCoastal FUND

**COASTAL WELLNESS GRANTS - 2021**
**Budget Amount: $152,471**

| Group Name | Date Submitted to Committee | Date Submitted to Emily | Amount Requested | Amount Approved | Date Committee Approved | Date Resolution Passed | Amount Paid | Date Paid |
|---|---|---|---|---|---|---|---|---|
| Cumberland Co Tech | 2/1/2021 Pending Committee Review | | $7,000 | | | | | |
| Buena BOE | 2/11/2021 | 2/11/2021 | $10,000 | $10,000 | 2/11/2021 | | | |

**Reminder:** Please visit the Coastal HIF website for more details on how to apply, what is eligible, ideas for an application and additional resource information. You can always contact us for any assistance that you might need. Here's the link: https://coastalhif.com/wellness/application

## SOUTHERN COASTAL REGIONAL HEALTH INSURANCE FUND

### Wellness Grant Guidelines Chart

| Group | Number of Insured Employees | Max Grant of 1000 Insured Employees | Max Grant of 500 Insured Employees | Max Grant of 200 Insured Employees | Max Grant of 100 Insured Employees | Max Grant Under 100 Insured Employees* |
|---|---|---|---|---|---|---|
| Alloway Township BOE | 36 | | | | | $2,700.00 |
| Bridgeton BOE | 774 | | $20,000 | | | |
| Buena BOE | 210 | | | $10,000 | | |
| City of Brigantine | 103 | | | | $7,500 | |
| Cumberland County Charter School Network | 48 | | | | | $3,600.00 |
| Cumberland County Improvement Authority | 63 | | | | | $4,725.00 |
| Cumberland County Technical Education Center | 85 | | | | | $6,375.00 |
| Cumberland Regional BOE | 103 | | | | $7,500.00 | |
| Dennis Twp BOE | 81 | | | | | $6,075.00 |
| Downe Township BOE | 23 | | | | | $1,725.00 |
| Hopewell Twp BOE | 34 | | | | | $2,550.00 |
| Lawrence Twp BOE | 50 | | | | | $3,750.00 |
| Lower Cape May Regional School District | 165 | | | | $7,500.00 | |
| Lower Township Elementary School | 207 | | | $10,000.00 | | |
| Millville BOE | 665 | | $20,000.00 | | | |
| Ocean City BOE | 241 | | | $10,000.00 | | |
| Penns Grove, Boro of | 36 | | | | | $2,700.00 |
| Pittsgrove Twp | 10 | | | | | $750.00 |
| Salem County | 470 | | | $10,000.00 | | |
| Upper Deerfield BOE | 109 | | | | $7,500.00 | |
| Vineland BOE | 1324 | $30,000.00 | | | | |
| Waterford Twp BOE | 105 | | | | $7,500.00 | |
| West Cape May BOE | 8 | | | | | $600.00 |
| Woodbine BOE | 27 | | | | | $2,025.00 |
| Woodstown, Boro of | 18 | | | | | $1,350.00 |
| **Totals** | **4995** | **$30,000.00** | **$40,000.00** | **$40,000.00** | **$37,500.00** | **$38,925.00** |
| | | | | Total | | $186,425.00 |

| Key: Per Wellness Committee Meeting on 7/15/2019 | Maximum grant 2000+ insured $40,000 | Maximum grant 1000-1099 insured $30,000 | Maximum grant 500-999 insured $20,000 | Maximum grant 200-499 insured $10,000 | Maximum grant 100-199 insured $7,500 | Maximum grant 2-100 insured* $75 per employee |
|---|---|---|---|---|---|---|

For illustrative purposes only Census based on September 2020 HIF Invoices.
Census will be updated every September annually.
Retirees do not qualify.

updated: 1/18/2021

## ADVANTA HEALTH SOLUTIONS ADDED AS NEW WELLNESS PROGRAM VENDOR TO COASTAL HIF

Many employers and health plan executives identify physical inactivity as a key modifiable health risk and are looking to the fitness and wellness industry to assist them in improving the health of their employees, increasing worker productivity, reducing healthcare costs, and providing competitive benefits to attract and retain employees. Advanta Health Solutions designs physical activity programs to engage and motivate people, and to foster personal accountability for healthy behaviors. Advanta Health Solutions has been a successful vendor for wellness programs in the Schools Health Insurance Fund (SHIF). [see attached flier]

## GUARDIAN NURSES

It is important to note that the Nurses are a key piece of your health care benefits and have been authorized to work with medical providers, labs and other facilities, hospitals and also the health care carriers Aetna and AmeriHealth Administrators.

Some of the services provided are:

- **VISIT YOU AT HOME** or in the hospital to assess your care needs.
- **BE YOUR GUIDE**, coach and advocate for any healthcare issue.
- **MAKE APPOINTMENTS** for you so you can be seen as quickly as possible.
- **GO WITH YOU** to see doctors, to ask questions and to get answers.
- **IDENTIFY PROVIDERS** for all care needs and second opinions.
- **GET THINGS YOU NEED** such as healthcare equipment.
- **PROVIDE DECISION SUPPORT** when you are thinking about treatments or surgery.
- **EXPLAIN A NEW DIAGNOSIS** to help you make informed decisions.

**We have shared several informational email messages and several flyers since April for distribution to your employees. If your employees don't know who the Guardian Nurses are, they will not be inclined to request their services. So, we are asking for your help in getting the word out that the Guardian Nurses are available.** If you would like them to attend a staff meeting, a faculty meeting, an in-service event, a professional development day, a wellness event or any type of opportunity to be introduced and be of service, they are available. Please consider having your school nurses develop a relationship with the Nurses so that they become part of your wellness endeavors. They are also available to address COVID-19 issues and have already successfully conducted virtual "town hall meetings" which can help deal with stress and anxiety…for adults, as employees, and also for dealing with children.

Please let us know if you have any questions about the Guardian Nurses and how to introduce them to your staff. We look forward to them becoming a more familiar face for our healthcare benefits. Our two Nurses assigned to the Coastal HIF are Lauren Gant/609-276-4990 and Charlie Reiter/609-276/5001.

**Attached is the flyer again for distribution.**

**Also attached is the most recent Guardian Nurses newsletter "*The Flame*"**

## ADMINISTRATIVE UPDATES:

- **Online Enrollment System Training -** If you need training or would like a refresher course on the online enrollment system, please reach out to Karen Kidd at kkidd@permainc.com of PERMA.

- **Monthly Billing** -As a reminder, please be sure to check your monthly invoice for accuracy. If you find a discrepancy, please report it to the Coastal Fund enrollment team. The Fund's policy is to limit retro corrections, *including terminations,* to 60 days. We have noticed an increase in requests for enrollment changes, billing changes, terminations and additions well past the 60-day time frame. Moving forward, it is of the utmost importance to review bills for rate and enrollment accuracy on a monthly basis. If there is an error, please bring it to our attention.

- **Broker Contact Information** - Please direct any escalated claims, benefit coverages, prescription coverage, Medicare advantage or appeal related questions to our dedicated Benefit Specialists as follows: Rose Meimbresse rose@allenassoc.com , or Annie Jimenez annie@allenassoc.com .

### ONLINE ENROLLMENT SYSTEM TRAINING SCHEDULE – 2021

PERMA offers a virtual training and a refresher class on the online enrollment system the third Wednesday of each month. The sessions provide an overview of the Fund's enrollment system and shows users how to perform tasks in the system. To use the enrollment system, each HR user must complete a *system access form*. Please email Austin Flinn at **aflinn@permainc.com** and indicate which of the sessions below you would like to attend. Please include this information in the subject line:

***Training - Fund Name and Client Name.***

- Wednesday, March 17th 10:00 am - 11:00 am
- Wednesday, April 21st 10:00 am - 11:00 am
- Wednesday, May 19th 10:00 am - 11:00 am
- Wednesday, June 16th 10:00 am - 11:00 am
- Wednesday, July 14th 10:00 am - 11:00 am
- Wednesday, August 18th 10:00 am - 11:00 am
- Wednesday, September 15th 10:00 am - 11:00 am
- Wednesday, October 20th 10:00 am - 11:00 am
- Wednesday, November 17th 10:00 am - 11:00 am

## EXPRESS SCRIPTS UPDATE

### Express Scripts (ESI) National Preferred Formulary (NPF) Update

As you know, ESI periodically evaluates the formulary guide in response to marketplace changes. We were recently advised that they have successfully negotiated additional discounts with drug companies, resulting in an update to the NPF. Effective 4/1/2021 an additional 32 drugs will be excluded from the formulary list. As always, physicians may request a clinical formulary exception directly through Express Scripts for patients who are medically unable to tolerate/use clinical alternatives.

| Drug Class | Excluded Medications | Preferred Alternatives |
|---|---|---|
| Agents for Hyperhidrosis | DRYSOL | Over-the-Counter aluminum chloride containing products |
| Angiotensin Receptor Blockers (ARBs) and Combinations | EDARBYCLOR | candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide, chlorthalidone plus valsartan |
| | EDARBI | candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan |
| Beta Blockers & Combinations | BYSTOLIC | atenolol, carvedilol, metoprolol succinate |
| Bowel Evacuants | CLENPIQ, GOLYTELY PACKETS, OSMOPREP^, PLENVU, SUPREP | peg-electrolyte solution |
| Contraceptives | ANNOVERA, BALCOLTRA, LO LOESTRIN FE, NATAZIA, TAYTULLA^, TWIRLA* | generic oral and ring contraceptives, xulane patches |
| | SLYND | generic progestin-only oral contraceptives |
| Estrogens (Oral) | PREMARIN TABLETS | estradiol tablets |
| Estrogen/Progestin Combinations (Oral) | PREMPHASE, PREMPRO | amabelz, estradiol/norethindrone acetate, fyavolv, jinteli, mimvey, norethindrone/ethinyl estradiol |
| Estrogen & Estrogen Modifiers for Vaginal Symptoms | FEMRING^ | estradiol cream, estradiol patches, estradiol tablets, yuvafem, ESTRING, PREMARIN CREAM |
| | INTRAROSA^, OSPHENA | estradiol cream, yuvafem, ESTRING, PREMARIN CREAM |
| Insulins | ADMELOG^, AFREZZA, APIDRA^, FIASP^, INSULIN ASPART^, INSULIN ASPART PROTAMINE^, INSULIN LISPRO^, NOVOLOG^ | HUMALOG, LYUMJEV |
| Selective Serotonin Reuptake Inhibitors (SSRIs) Antidepressants | PEXEVA, VIIBRYD | citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline |

## AETNA UPDATE

### TELEDOC MAILING

Aetna announced they sent 2021 Teladoc Welcome Letters in Late January to members via mail. Teladoc is Aetna's telemedicine program available to COASTAL membership at no cost for most services. Member who use telemedicine services provided by their providers will continue incur applicable cost share.

## NEGOTIATIONS WITH SALEM MEDICAL CENTER – CONTRACT EXTENSION

- Aetna is currently in negotiations with Salem Medical Center located in Salem, NJ.
- Salem Medical Center granted an extension from March 29, 2021 to June 1, 2021. Due to extension, the contract is now set to terminate on June 1, 2021. Negotiations are ongoing and both parties are continuing discussions in hopes of reaching an acceptable agreement.
- Letters **are not** being released at this time, but we will advise if that changes.

**Impacted Hospital Location:**
**Salem Medical Center**
310 Salem Woodstown Road
Salem, NJ 08079

**ALTERNATE HOSPITALS**

| Salem County |
|---|
| **Inspira Medical Center- Elmer** |
| 501 Front Street |
| Elmer, NJ 08318 |
| **Cumberland County** |
| **Inspira Medical Center- Vineland** |
| 1505 W Sherman Avenue |
| Vineland, NJ 08360 |
| **Gloucester County** |
| **Inspira Medical Center- Mullica Hill** |
| 700 Mullica Hill Road |
| Mullica Hill, NJ 08062 |
| **Jefferson Washington Township Turnersville** |
| 435 Hurffville-Cross Keys Road |
| Turnersville, NJ |

| Camden County |
|---|
| **Cooper University Hospital** |
| 1 Cooper Plaza |
| Camden, NJ 08103 |
| **Jefferson Chery Hill Hospital** |
| 201 Chapel Ave W |
| Cherry Hill, NJ 08002 |
| |
| **Jefferson Strafford Hospital** |
| 18 E Laurel Road |
| Stratford, NJ 08084 |
| |
| **Virtua Our Lady of Lourdes Hospital** |
| 1600 Haddon Avenue |
| Camden, NJ 08103 |
| |
| **Virtua Voorhees Hospital** |
| 100 Bowman Drive |
| Voorhees Township, NJ 08043 |

## LEGISLATIVE UPDATES

### COVID-19 VACCINE UPDATES

#### VACCINE COVERAGE

In December 2020 the U.S. Food and Drug Administration (FDA) issued Emergency Use Authorizations (EUAs) for the use of the Pfizer-BioNTech and Moderna COVID-19 Vaccines for the prevention of coronavirus disease. Vaccines recommended by the CDC Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) will be covered under the plan. The federal government will pay the cost of the vaccine itself. The plan will fully cover the cost of administering the vaccine at participating and non-participating providers/facilities.

#### HOW TO REGISTER FOR THE VACCINE

The NJ Vaccination Scheduling System (NJVSS) provides individuals with the opportunity to preregister for the vaccine, to be notified when they are eligible, and receive information that an appointment is available to them. Eligible individuals may also visit https://covid19.nj.gov/pages/vaccine to identify a vaccination location if appointments are not immediately available on NJVSS.

**UPDATED INDEXED DOLLAR LIMITS** The Internal Revenue Service (IRS) recently announced the below 2021 limits regarding High Deductible Health Plans (HDHP) and Health Savings Accounts (HSA).

| | 2020 | 2021 |
|---|---|---|
| HDHP Minimum Required Deductible- Self Only | $1,400 | $1,400 |
| HDHP Minimum Required Deductible- Family | $2,800 | $2,800 |
| HSA Contribution Limit- Self only HDHP | $3,550 | $3,600 |
| HSA Contribution Limit- Family HDHP | $7,100 | $7,200 |
| HSA/HDHP OOP Maximum- Self Only | $6,900 | $7,000 |
| HSA/HDHP OOP Maximum- Family | $13,800 | $14,000 |

**COVID-19 FSA Relief**

The recently passed COVID-19 relief bill permits employers to allow members with Flexible Spending Accounts (FSAs) to roll over unused funds.
Key provisions of the new ruling include:

- option to amend cafeteria plans and FSAs to allow employees to:
  - carryover unused amounts from plan year ending in 2020 to the 2021 plan year
  - carryover unused amounts from plan year ending in 2021 to the 2022 plan year
  - provide a 12-month grace period at the end of the 2020 and/or 2021 plan years
- option to amend FSAs allowing employees to make prospective election changes for plan years ending in 2021 (with no change in status)
- allowing employees who cease participation in an FSA during calendar years 2020 or 2021 to receive post-termination reimbursements from unused benefits through the end of the plan year when participation ceases (including grace period if applicable)

**APPEALS** (as of 3/16/2021) –

| Type | Determination |
|---|---|
| Medical | (1) not approved |
| RX | none |

**SPECIAL NOTICE: As Program Managers for the Coastal HIF, Shared Health Alliance prioritizes the health and safety of the communities we serve. The worldwide COVID-19 outbreak has us all concerned and taking extra precautions. As a result, we wanted to assure members that we have activated our business continuity plan to ensure appropriate support to all members.**

Coastal Health Insurance Fund
Board Meeting Summary
March 22, 2021

| Referrals | 1/1/21 thru 3/2/21 | Program Start 4/1/2020 thru 3/2/2021 |
|---|---|---|
| Total Members Referred | 137 | 1,407 |
| Total Members Referred (ACUTE) | 124 | 1,281 |
| Total Members Referred (COMPLEX) | 13 | 126 |
| **Hospitalizations** | | |
| Total Members Hospitalized | 52 members/ 54 hospitalizations | 268 members/ 358 hospitalizations |
| Members Requiring ICU | 2 | 21 |
| **Mobilizations---Acute Program** | **18** | **123** |
| Inpatient Visits | 6 | 62 |
| Accompaniments – 8 in person, 2 telephonic | 10 | 43 |
| Home Visits | 2 | 18 |
| **Mobilizations---Complex Program** | **9** | **25** |
| Inpatient Visits | 1 | 4 |
| Accompaniments - 2 telephonic, 4 in person | 6 | 14 |
| Home Visits | 1 | 7 |
| **COVID-19 Diagnosis** | 10 inpatients | 25 Total (16 were inpatient) |
| **Top Inpatient Hospitals** | | |
| Inspira | 41% | 40% |
| Cooper | 11% | 9% |
| **School Districts with Most Referrals** | **Cases** | **Cases** |
| Vineland BOE | 49 | 456 |
| Millville BOE | 21 | 249 |
| Bridgeton BOE | 18 | 219 |
| **(Paid) High Claims 1/1/20---12/31/20** | **Status** | **Insurer** |
| **High Claimant** **Amount** | | |
| High Claimant #1 $ 815,098.08 should drop off | Engaged | AHA |
| High Claimant # 2 $ 693,060.73 on treatment | Engaged | Aetna |
| High Claimant # 3 $ 643,456.87 recent admission | Engaged | Aetna |
| High Claimant #4 $ 600,544.68 | Disengaged | AHA |
| High Claimant # 5 $ 535,697.50 factor deficiency | Engaged | Aetna |
| High Claimant # 6 $ 489,997.11 | Deceased | AHA |
| High Claimant # 7 $ 474,113.92 | Declined Assistance | Aetna |
| High Claimant # 8 $ 451,583.57 retired | Retired | Aetna |
| High Claimant # 9 $ 417,891.00 on treatment | Engaged | Aetna |
| High Claimant # 10 $ 409,104.08 on treatment | Engaged | Aetna |
| **Potential High Claimants** | | |
| (2) ICU admissions this quarter | Engaged with both patients | |

# SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
# BILLS LIST

**Confirmation of Payment** **FEBRUARY 2021**

**WHEREAS,** the Treasurer has certified that funding is available to pay the following bills:

**BE IT RESOLVED** that the Southern Coastal Regional Employee Benefits Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

**FURTHER**, that this authorization shall be made a permanent part of the records of the Fund.

**FUND YEAR 2020**

| CheckNumber | VendorName | Comment | InvoiceAmount |
|---|---|---|---|
| 001768 | | | |
| 001768 | PERMA | 2020 1099 AATRIX FILING | 14.95 |
| | | | **14.95** |
| 001769 | | | |
| 001769 | CUMBERLAND COUNTY IMPROVEMENT AUTHORITY | WELLNESS PURCHASES 9/20 | 4,725.00 |
| | | | **4,725.00** |
| | | **Total Payments FY 2020** | **4,739.95** |

**FUND YEAR 2021**

| CheckNumber | VendorName | Comment | InvoiceAmount |
|---|---|---|---|
| 001770 | | | |
| 001770 | AETNA HEALTH MANAGEMENT LLC | MEDICARE ADVTG 2/21 | 29,867.52 |
| | | | **29,867.52** |
| 001771 | | | |
| 001771 | DELTA DENTAL OF NEW JERSEY INC | DENTAL TPA 2/21 | 486.72 |
| | | | **486.72** |
| 001772 | | | |
| 001772 | AETNA LIFE INSURANCE COMPANY | VISION TPA 2/21 | 332.15 |
| 001772 | AETNA LIFE INSURANCE COMPANY | MEDICAL TPA 2/21 | 153,208.14 |
| | | | **153,540.29** |
| 001773 | | | |
| 001773 | PERMA | POSTAGE 1/21 | 9.00 |
| 001773 | PERMA | ADMIN FEES - MEDICAL 2/21 | 101,545.56 |
| | | | **101,554.56** |
| 001774 | | | |
| 001774 | ALLEN ASSOCIATES | BROKER FEE 2/21 | 156,582.09 |
| | | | **156,582.09** |
| 001775 | | | |
| 001775 | VERRILL & VERRILL, LLC | TREASURER FEE 2/21 | 1,001.81 |
| 001775 | VERRILL & VERRILL, LLC | POSTAGE 1/21 | 131.75 |
| | | | **1,133.56** |
| 001776 | | | |
| 001776 | MICHAEL S. ZAMBITO | TREASURER FEE 2/21 | 667.85 |
| | | | **667.85** |

| | | | |
|---|---|---|---|
| 001777 | | | |
| 001777 | SHARED HEALTH ALLIANCE | GUARDIAN NURSE SERVICE FEE 2/21 | 35,000.00 |
| | | | **35,000.00** |
| 001778 | | | |
| 001778 | SHARED HEALTH ALLIANCE | PROGRAM MANAGER FEE 2/21 | 187,665.46 |
| | | | **187,665.46** |
| 001779 | | | |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 855.00 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 67.50 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 202.50 |
| 001779 | MARMERO LAW, LLC | PROFESSIONAL FEES 1/21 | 2,346.00 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 517.50 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 67.50 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 202.50 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 67.50 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 225.00 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 135.00 |
| 001779 | MARMERO LAW, LLC | LEGAL SERVICES 1/21 | 67.50 |
| | | | **4,753.50** |
| 001780 | | | |
| 001780 | CONNER STRONG | POLICY# B6024450 - 2021 | 2,496.00 |
| | | | **2,496.00** |
| 001781 | | | |
| 001781 | MUNICIPAL REINSURANCE HIF | REINSURANCE 2/21 | 218,003.01 |
| | | | **218,003.01** |
| | | **Total Payments FY 2021** | **891,750.56** |
| | | **TOTAL PAYMENTS ALL FUND YEARS** | **896,490.51** |

_____
Chairperson

Attest:
_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____
Treasurer

# SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
# BILLS LIST

**Resolution No. 15-21** **MARCH 2021**

**WHEREAS,** the Treasurer has certified that funding is available to pay the following bills:

**BE IT RESOLVED** that the Southern Coastal Regional Employee Benefits Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

**FURTHER**, that this authorization shall be made a permanent part of the records of the Fund.

**FUND YEAR 2021**

| CheckNumber | VendorName | Comment | InvoiceAmount |
|---|---|---|---|
| 001782 | | | |
| 001782 | AETNA HEALTH MANAGEMENT LLC | MEDICARE ADVTG 3/21 | 30,178.64 |
| 001782 | AETNA HEALTH MANAGEMENT LLC | MEDICARE ADVTG 1/21 | 30,023.08 |
| | | | **60,201.72** |
| 001783 | | | |
| 001783 | DELTA DENTAL OF NEW JERSEY INC | DENTAL TPA 3/21 | 461.76 |
| | | | **461.76** |
| 001784 | | | |
| 001784 | AETNA LIFE INSURANCE COMPANY | VISION TPA 3/21 | 333.06 |
| 001784 | AETNA LIFE INSURANCE COMPANY | MEDICAL TPA 3/21 | 153,498.15 |
| | | | **153,831.21** |
| 001785 | | | |
| 001785 | AMERIHEALTH ADMINISTRATORS | WELLNESS/MARKETING 3/21 | -1,628.75 |
| 001785 | AMERIHEALTH ADMINISTRATORS | MEDICAL TPA 3/21 | 57,879.26 |
| | | | **56,250.51** |
| 001786 | | | |
| 001786 | PERMA | POSTAGE 2/21 | 8.16 |
| 001786 | PERMA | ADMIN FEES - MEDICAL 3/21 | 101,701.61 |
| | | | **101,709.77** |
| 001787 | | | |
| 001787 | ALLEN ASSOCIATES | BROKER FEE 3/21 | 156,816.96 |
| | | | **156,816.96** |
| 001788 | | | |
| 001788 | VERRILL & VERRILL, LLC | DEPUTY TREASURER FEE 3/21 | 1,001.81 |
| | | | **1,001.81** |
| 001789 | | | |
| 001789 | MICHAEL S. ZAMBITO | TREASURER FEE 3/21 | 667.85 |
| | | | **667.85** |
| 001790 | | | |
| 001790 | SHARED HEALTH ALLIANCE | PROGRAM MANAGER FEE 3/21 | 188,064.67 |
| 001790 | SHARED HEALTH ALLIANCE | GUARDIAN NURSE SERVICE FEE 3/21 | 35,000.00 |
| | | | **223,064.67** |

| | | | |
|---|---|---|---|
| 001791 | | | |
| 001791 | MARMERO LAW, LLC | PROFESSIONAL FEES 2/21 | 2,346.00 |
| | | | **2,346.00** |
| 001792 | | | |
| 001792 | ALLSTATE INFORMATION MANAGEMNT | ACCT# 963 - ARC. AND STOR. - 1.31.21 | 8.38 |
| | | | **8.38** |
| 001793 | | | |
| 001793 | MEDICAL EVALUATION SPECIALISTS | MES# 1343169 - 2/21 | 245.00 |
| | | | **245.00** |
| 001794 | | | |
| 001794 | PRESS OF ATLANTIC CITY | BALANCE DUE ON ACCT 8006196 - 1/21 | 26.04 |
| | | | **26.04** |
| 001795 | | | |
| 001795 | MUNICIPAL REINSURANCE HIF | REINSURANCE 3/21 | 218,171.37 |
| | | | **218,171.37** |
| | | **Total Payments FY 2021** | **974,803.05** |
| | | **TOTAL PAYMENTS ALL FUND YEARS** | **974,803.05** |

_____
Chairperson

Attest:
_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____
Treasurer

**CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES**

**COASTAL HEALTH BENEFITS FUND**

| | | |
|---|---|---|
| **Month** | | **January** |
| **Current Fund Year** | | **2021** |

| Policy Year | Coverage | 1. Calc. Net Paid Thru Last Month | 2. Monthly Net Paid January | 3. Monthly Recoveries January | 4. Calc. Net Paid Thru January | 5. TPA Net Paid Thru January | 6. Variance To Be Reconciled | 7. Delinquent Unreconciled Variance From | 8. Change This Month |
|---|---|---|---|---|---|---|---|---|---|
| 2021 | Medical | 0.00 | 6,522,043.81 | 0.00 | 6,522,043.81 | 0.00 | 6,522,043.81 | 0.00 | 6,522,043.81 |
| | Dental | 0.00 | 6,763.75 | 0.00 | 6,763.75 | 0.00 | 6,763.75 | 0.00 | 6,763.75 |
| | Rx | 0.00 | 322,605.65 | 0.00 | 322,605.65 | 0.00 | 322,605.65 | 0.00 | 322,605.65 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **0.00** | **6,851,413.21** | **0.00** | **6,851,413.21** | **0.00** | **6,851,413.21** | **0.00** | **6,851,413.21** |
| 2020 | Medical | 69,649,759.09 | 0.00 | 0.00 | 69,649,759.09 | 0.00 | 69,649,759.09 | 62,335,596.01 | 7,314,163.08 |
| | Dental | 66,112.79 | 0.00 | 0.00 | 66,112.79 | 0.00 | 66,112.79 | 63,025.14 | 3,087.65 |
| | Rx | 3,938,902.98 | 0.00 | 0.00 | 3,938,902.98 | 0.00 | 3,938,902.98 | 3,597,039.01 | 341,863.97 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **73,654,774.86** | **0.00** | **0.00** | **73,654,774.86** | **0.00** | **73,654,774.86** | **65,995,660.16** | **7,659,114.70** |
| 2019 | Medical | 77,582,190.16 | 0.00 | 0.00 | 77,582,190.16 | 0.00 | 77,582,190.16 | 77,446,218.87 | 135,971.29 |
| | Dental | 89,379.63 | 0.00 | 0.00 | 89,379.63 | 0.00 | 89,379.63 | 89,379.63 | 0.00 |
| | Rx | 3,260,787.38 | 0.00 | 0.00 | 3,260,787.38 | 0.00 | 3,260,787.38 | 3,261,318.63 | (531.25) |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **80,932,357.18** | **0.00** | **0.00** | **80,932,357.18** | **0.00** | **80,932,357.18** | **80,796,917.14** | **135,440.04** |
| 2018 | Medical | 167,307.38 | 0.00 | 0.00 | 167,307.38 | 0.00 | 167,307.38 | 148,278.36 | 19,029.02 |
| | Dental | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Rx | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **167,307.38** | **0.00** | **0.00** | **167,307.38** | **0.00** | **167,307.38** | **148,278.36** | **19,029.02** |
| 2017 | Medical | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Dental | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Rx | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |
| 2013 | Medical | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Dental | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Rx | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |
| 2012 | Medical | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Dental | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Rx | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Vision | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **Total** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **TOTAL** | **154,754,439.41** | **6,851,413.21** | **0.00** | **161,605,852.62** | **0.00** | **161,605,852.62** | **146,940,855.65** | **14,664,996.97** |

**COASTAL HEALTH BENEFITS FUND**

**SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED**

| **Current Fund Year: 2021**<br>**Month Ending: January** | **Medical** | **Dental** | **Rx** | **Vision** | **Med.Adv** | **Reinsurance** | **Dividend Payable** | **LFC** | **Admin** | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|
| OPEN BALANCE | 32,580,696.66 | 136,062.84 | (2,155,687.37) | 367,264.27 | 700,781.12 | 1,026,691.20 | 8,205,758.68 | 1,344,060.77 | 3,215,877.35 | 45,421,505.52 |
| RECEIPTS | | | | | | | | | | |
| Assessments | 5,782,426.04 | 2,508.23 | 152,676.51 | 3,595.51 | 22,371.04 | 169,243.74 | 0.00 | 0.00 | 614,050.36 | 6,746,871.43 |
| Refunds | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Invest Pymnts | 16,022.76 | 66.92 | 0.00 | 180.61 | 344.63 | 514.66 | 4,035.46 | 660.99 | 1,581.53 | 23,407.56 |
| Invest Adj | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Subtotal Invest | 16,022.76 | 66.92 | 0.00 | 180.61 | 344.63 | 514.66 | 4,035.46 | 660.99 | 1,581.53 | 23,407.56 |
| Other * | 25,247.28 | 0.00 | 7,166.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 32,413.28 |
| TOTAL | 5,823,696.08 | 2,575.15 | 159,842.51 | 3,776.12 | 22,715.67 | 169,758.40 | 4,035.46 | 660.99 | 615,631.89 | 6,802,692.27 |
| | | | | | | | | | | |
| EXPENSES | | | | | | | | | | |
| Claims Transfers | 6,522,043.81 | 6,763.75 | 322,605.65 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 6,851,413.21 |
| Expenses | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 218,627.19 | 0.00 | 0.00 | 705,808.91 | 924,436.10 |
| Other * | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.45 | 1.45 |
| TOTAL | 6,522,043.81 | 6,763.75 | 322,605.65 | 0.00 | 0.00 | 218,627.19 | 0.00 | 0.00 | 705,810.36 | 7,775,850.76 |
| **END BALANCE** | **31,882,348.93** | **131,874.24** | **(2,318,450.51)** | **371,040.39** | **723,496.79** | **977,822.41** | **8,209,794.14** | **1,344,721.76** | **3,125,698.88** | **44,448,347.03** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **SUMMARY OF CASH AND INVESTMENT INSTRUMENTS** | | | | | | | | | |
| **COASTAL HEALTH BENEFITS FUND** | | | | | | | | | |
| **ALL FUND YEARS COMBINED** | | | | | | | | | |
| **CURRENT MONTH** | **January** | | | | | | | | |
| **CURRENT FUND YEAR** | **2021** | | | | | | | | |
| | **Description:** | **Investors Bank** | **OceanFirst Investment Account** | **OceanFirst Operating Account** | **Republic Bank Investment Account** | **Wilmington Trust Investment Account** | **NJ Cash Management Investment Account** | **William Penn Bank Investment Account** |
| | **ID Number:** | | | | | | | |
| | **Maturity (Yrs)** | | | | | | | |
| | **Purchase Yield:** | **0.50** | **0.25** | **0.25** | **0.75** | **0.01** | **0.05** | **0.75** |
| | **TOTAL for All Accts & instruments** | | | | | | | |
| **Opening Cash & Investment Balance** | **$45,421,505.52** | **10,006,173.26** | **4,782,726.08** | **2,197,628.00** | **25,893,340.77** | **11,603.60** | **14,151.85** | **2,515,881.96** |
| **Opening Interest Accrual Balance** | **$0.11** | **-** | **-** | **-** | **-** | **0.11** | **-** | **-** |
| | | | | | | | | |
| 1 Interest Accrued and/or Interest Cost | $0.10 | $0.00 | $0.00 | $0.00 | $0.00 | $0.10 | $0.00 | $0.00 |
| 2 Interest Accrued - discounted Instr.s | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 3 (Amortization and/or Interest Cost) | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 4 Accretion | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 5 Interest Paid - Cash Instr.s | $23,407.45 | $4,250.17 | $649.29 | $342.16 | $16,493.70 | $0.00 | $0.62 | $1,671.51 |
| 6 Interest Paid - Term Instr.s | $0.11 | $0.00 | $0.00 | $0.00 | $0.00 | $0.11 | $0.00 | $0.00 |
| 7 Realized Gain (Loss) | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| 8 Net Investment Income | $23,407.55 | $4,250.17 | $649.29 | $342.16 | $16,493.70 | $0.10 | $0.62 | $1,671.51 |
| 9 Deposits - Purchases | $8,779,284.71 | $0.00 | $0.00 | $8,779,284.71 | $0.00 | $0.00 | $0.00 | $0.00 |
| 10 (Withdrawals - Sales) | -$9,775,850.76 | $0.00 | -$2,000,000.00 | -$7,775,849.31 | $0.00 | -$1.45 | $0.00 | $0.00 |
| | | OK | OK | OK | OK | OK | OK | OK |
| Ending Cash & Investment Balance | $44,448,347.03 | $10,010,423.43 | $2,783,375.37 | $3,201,405.56 | $25,909,834.47 | $11,602.26 | $14,152.47 | $2,517,553.47 |
| Ending Interest Accrual Balance | $0.10 | $0.00 | $0.00 | $0.00 | $0.00 | $0.10 | $0.00 | $0.00 |
| Plus Outstanding Checks | $543,568.71 | $0.00 | $0.00 | $543,568.71 | $0.00 | $0.00 | $0.00 | $0.00 |
| (Less Deposits in Transit) | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| Balance per Bank | $44,991,915.74 | $10,010,423.43 | $2,783,375.37 | $3,744,974.27 | $25,909,834.47 | $11,602.26 | $14,152.47 | $2,517,553.47 |

# SOUTHERN COASTAL HEALTH INSURANCE FUND

## Monthly Claim Activity Report

## March 22, 2021

# SOUTHERN COASTAL HEALTH INSURANCE FUND

| | MEDICAL CLAIMS + CAP PAID 2019 | # OF EES | PER EE | MEDICAL CLAIMS + CAP PAID 2020 | # OF EES | PER EE |
|---|---|---|---|---|---|---|
| JANUARY | $4,926,862 | 3,587 | $ 1,374 | $4,993,107 | 3,699 | $ 1,350 |
| FEBRUARY | $4,595,188 | 3,581 | $ 1,283 | $5,105,069 | 3,702 | $ 1,379 |
| MARCH | $5,596,473 | 3,577 | $ 1,565 | $6,782,942 | 3,709 | $ 1,829 |
| APRIL | $5,713,900 | 3,571 | $ 1,600 | $4,280,841 | 3,708 | $ 1,154 |
| MAY | $5,700,528 | 3,565 | $ 1,599 | $3,483,544 | 3,721 | $ 936 |
| JUNE | $5,202,054 | 3,567 | $ 1,458 | $4,251,528 | 3,706 | $ 1,147 |
| JULY | $5,767,174 | 3,776 | $ 1,527 | $5,389,393 | 3,686 | $ 1,462 |
| AUGUST | $5,867,852 | 3,749 | $ 1,565 | $5,108,502 | 3,687 | $ 1,386 |
| SEPTEMBER | $5,468,466 | 3,715 | $ 1,472 | $6,344,568 | 3,695 | $ 1,717 |
| OCTOBER | $5,519,704 | 3,698 | $ 1,493 | $6,182,409 | 3,704 | $ 1,669 |
| NOVEMBER | $5,444,012 | 3,692 | $ 1,475 | $5,855,044 | 3,698 | $ 1,583 |
| DECEMBER | $5,615,746 | 3,698 | $ 1,519 | $6,360,676 | 3,696 | $ 1,721 |
| **TOTALS** | **$65,417,959** | | | **$64,137,623** | | |
| | | | | **2020 Average** | **3,701** | **$ 1,444** |
| | | | | **2019 Average** | **3,648** | **$ 1,494** |

# SOUTHERN COASTAL HEALTH INSURANCE FUND

| | MEDICAL CLAIMS + CAP PAID 2020 | # OF EES | PER EE | MEDICAL CLAIMS + CAP PAID 2021 | # OF EES | PER EE |
|---|---|---|---|---|---|---|
| JANUARY | $4,993,107 | 3,699 | **$ 1,350** | $5,074,625 | 3,704 | **$ 1,370** |
| FEBRUARY | $5,105,069 | 3,702 | **$ 1,379** | | | |
| MARCH | $6,782,942 | 3,709 | **$ 1,829** | | | |
| APRIL | $4,280,841 | 3,708 | **$ 1,154** | | | |
| MAY | $3,483,544 | 3,721 | **$ 936** | | | |
| JUNE | $4,251,528 | 3,706 | **$ 1,147** | | | |
| JULY | $5,389,393 | 3,686 | **$ 1,462** | | | |
| AUGUST | $5,108,502 | 3,687 | **$ 1,386** | | | |
| SEPTEMBER | $6,344,568 | 3,695 | **$ 1,717** | | | |
| OCTOBER | $6,182,409 | 3,704 | **$ 1,669** | | | |
| NOVEMBER | $5,855,044 | 3,698 | **$ 1,583** | | | |
| DECEMBER | $6,360,676 | 3,696 | **$ 1,721** | | | |
| **TOTALS** | **$64,137,623** | | | **$5,074,625** | | |
| | | | | **2021 Average** | **3,704** | **$ 1,370** |
| | | | | **2020 Average** | **3,701** | **$ 1,444** |

# Large Claimant Report (Drilldown) - Claims Over $100000

| | | | |
|---|---|---|---|
| **Plan Sponsor Unique ID :** | All | **Paid Dates:** | 12/01/2020 - 12/31/2020 |
| **Customer:** | **SOUTHERN COASTAL HEALTH INSURANCE FUND** | **Service Dates:** | 01/01/2016 - 12/31/2020 |
| **Group / Control:** | 00108431,00737420,00737421 | **Line of Business:** | All |
| **Subgroup / Suffix:** | All | **Funding Category:** | All |

| | Billed Amt | Paid Amt | Diagnosis/Treatment |
|---|---|---|---|
| | $278,328.31 | $233,889.27 | ENCOUNTER FOR ANTINEOPLASTIC |
| **Total:** | **$278,328.31** | **$233,889.27** | |

# Large Claimant Report (Drilldown) - Claims Over $100000

| | | | |
|---|---|---|---|
| **Plan Sponsor Unique ID :** | All | **Paid Dates:** | 01/01/2021 - 01/31/2021 |
| **Customer:** | **SOUTHERN COASTAL HEALTH INSURANCE FUND** | **Service Dates:** | 01/01/2016 - 01/31/2021 |
| **Group / Control:** | 00108431,00169660,00737420,00737421 | **Line of Business:** | All |
| **Subgroup / Suffix:** | All | **Funding Category:** | All |

| | Billed Amt | Paid Amt | Diagnosis/Treatment |
|---|---|---|---|
| | $500,544.41 | $248,396.80 | ACUTE LYMPHOBLASTIC LEUKEMIA NOT HAVING |
| | $316,583.22 | $171,474.31 | CONGENITAL HYPERTROPHIC PYLORIC STENOSIS |
| **Total:** | **$817,127.63** | **$419,871.11** | |

aetna™

## Southern Coastal Health Insurance Fund

2/1/2020 through 1/31/21 (unless otherwise noted)

### Medical Claims Paid:
### January 2021 – January 2021

Total Medical Paid per EE: **$1,370**

### Network Discounts

| | |
|---|---|
| Inpatient: | **64.5%** |
| Ambulatory: | **64.8%** |
| Physician/Other: | **61.6%** |
| **TOTAL:** | **63.5%** |

### Provider Network

% Admissions In-Network: **99.2%**
% Physician Office in network: **97.6%**

**Aetna Book of Business:**
Admissions 98.4%; Physician 90.6%

### Top Facilities Utilized (by total Medical Spend)

- Inspira – Vineland
- Cooper Hospital
- University of Pennsylvania
- Virtua – West Jersey
- Inspira Medical Center Elmer

### Catastrophic Claim Impact
### (January 2021- January 2021)

Number of Claims Over $50,000:**4**
Claimants per 1000 members: 0.4
Avg. Paid per Claimant: $135,596
Percent of Total Paid: **12.5%**

- **Aetna BOB- HCC account for an average of 40.9% of total Medical Cost**

### Teladoc Activity:
### January 2021 – January 2021

Total Registrations: 24
Total Online Visits: **44**
Total Net Claims Savings: **$5,701**
Total Visits w/ Rx: **25**

**Utilization by Age**

**0-17: 11.4%**
**18-26: 11.4%**
**27-30: 6.8%**
**31-45: 36.4%**
**46-55: 22.7%**
**55-65: 11.4%**

New

Mental Health Visits: **6**
Dermatology Visits: **3**

New

### Allentown Service Center Performance: Metrics thru FEB 2021

#### Customer Service Performance

| | |
|---|---|
| Call Quality: **(Q4 2020)** | **95.2%** |
| 1st Call Resolution: | **95.2%** |
| Abandonment Rate: | **1.5%** |
| Avg. Speed of Answer: | **37.6 sec** |

#### Claims Performance

| | |
|---|---|
| Financial Accuracy: **(Q4 2020)** | **97.7** |
| 90% processed w/in: | **5.4 days** |
| 95% processed w/in: | **7.5 days** |

**********

#### Performance Goals

| | |
|---|---|
| Call Quality: | 95% |
| 1st Call Resolution: | 90% |
| Abandonment Rate less than: | 2.5% |
| Average Speed of Answer: | 30 sec |
| Financial Accuracy: | 99% |

**Turnaround Time**

| | |
|---|---|
| 90% processed w/in: | 14 days |
| 95% processed w/in: | 30 days |


AmeriHealth
ADMINISTRATORS

## 2020 Coastal HIF

| | MEDICAL CLAIMS PAID 2020 | TOTAL | # OF EES | PER EE |
|---|---|---|---|---|
| JANUARY | $ 1,013,249.33 | $ 1,013,249.33 | 1,091 | $ 928.72 |
| FEBRUARY | $ 1,409,771.76 | $ 1,409,771.76 | 1,085 | $ 1,299.32 |
| MARCH | $ 1,694,650.65 | $ 1,694,650.65 | 1,087 | $ 1,559.01 |
| APRIL | $ 1,976,306.64 | $ 1,976,306.64 | 1,085 | $ 1,821.48 |
| MAY | $ 821,390.32 | $ 821,390.32 | 1,091 | $ 752.87 |
| JUNE | $ 915,065.10 | $ 915,065.10 | 1,090 | $ 839.50 |
| JULY | $ 1,357,734.83 | $ 1,357,734.83 | 1,083 | $ 1,253.67 |
| AUGUST | $ 1,862,063.24 | $ 1,862,063.24 | 1,080 | $ 1,724.13 |
| SEPTEMBER | $ 1,123,308.69 | $1,123,308.69 | 1,091 | $ 1,029.61 |
| OCTOBER | $ 1,647,398.42 | $1,647,398.42 | 1,089 | $ 1,512.76 |
| NOVEMBER | $ 1,547,619.08 | $1,547,619.08 | 1,081 | $ 1,431.65 |
| DECEMBER | $ 1,547,619.08 | $1,547,619.08 | 1,085 | $ 1,426.37 |
| TOTALS | **$ 16,916,177.14** | | | |
| | | 2020 Average | | $ 1,298.26 |
| | | 2019 Average | 1336.166667 | $ 1,081.80 |

## 2021 Coastal HIF

| | MEDICAL CLAIMS PAID 2019 | # OF EES | PER EE |
|---|---|---|---|
| JANUARY | $ 807,511.05 | 1308 | $ 617.36 |
| FEBRUARY | $ 1,527,729.14 | 1,308 | $ 1,167.98 |
| MARCH | | | |
| APRIL | | | |
| MAY | | | |
| JUNE | | | |
| JULY | | | |
| AUGUST | | | |
| SEPTEMBER | | | |
| OCTOBER | | | |
| NOVEMBER | | | |
| DECEMBER | | | |
| TOTALS | $ 2,335,240.19 | 1308 | |

## PLAN SPONSOR INFORMATION SERVICES

## Large Claimant Report- Claims Over $100,000

| | | | | | |
|---|---|---|---|---|---|
| **Group:** | | **Coastal HIF** | | **Service Dates:** | - |
| **Paid Dates:** | 2/1/21-2/31/21 | | | **Line of Business:** | All |
| **Network Service** | | **ALL** | | **Product Line:** | All |

| Claimant | | Relationship | Paid Amount | Diagnosis |
|---|---|---|---|---|
| **Total** | | | | |
| 1 | | Spouse | **$ 158,486.19** | Bacterial Infection |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | **$ 158,486.19** | |

**Southern Coastal HIF**

**Paid Claims 01/01/2021-12/31/2021**

| | |
|---|---|
| Average payment per member per month 01/01-12/31/2021: | $ 350.79 |
| Number of claimants with paid claims over $100,00 YDT: | 1 |
| Total paid on those claimants: | $158,864.55 |

| Top Facilities Utilized based on paid claims: |
|---|
| COOPER UNIVERSITY HOSPITAL, NJ |
| ATLANTICARE REGIONAL MEDICAL CENTER, NJ |
| INSPIRA MEDICAL CENTER VINELAND, NJ |
| CHRISTIANA CARE HEALTH SERVICES, DE |
| INSPIRA MEDICAL CENTER MULLICA HILL, NJ |

| MD LIVE UTILIZATION |
|---|
| Total Registrations YTD: 0 |
| Total Online Visits: 0 |
| Member Satisfaction YTD: 100% |

| Provider Network |
|---|
| % Inpatient In- Network: 95.9% |
| % Professional providers In-Network: 91.6% |
| % Outpatient providers In-Network:92.4% |

| Metric | AHA January MTD | AHA February MTD |
|---|---|---|
| 1st Call Resolution | 83.70% | 85.21% |
| ASA | 124.60 | 27.06 |
| Abandonment Rate | 7.40% | 1.99% |

| Totals | 2021 YTD |
|---|---|
| Total Inpatient Admissions | 13 |
| Total Inpatient Days | 78 |

**COASTAL HIF - 0001703859**

**Claims Incurred between 3/1/2020 and 3/12/2021 and Paid between 3/1/2020 and 3/12/2021**

**COVID19 Claims currently are consider to be claims with Procedure codes 0001A, 0002A, 0011A, 0012A, 0202U, 0223U, 0224U, 0225U, 0226U, 0240U, 0241U, 86328, 86408, 86409, 86413, 86769, 87426, 87428, 87635, 87636, 87637, 87811, 91300, 91301, C9803, G2023, G2024, M0239, M0243, M0245, Q0239, Q0243, Q0245, U0001, U0002, U0003, U0004 or a Dx Code of B34.2, B97.29, U07.1, Z11.52, Z20.822**

| AGE BAND | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| <1 | 6 | 10 | $3,889.83 | $388.98 | $9.17 |
| 1-5 | 52 | 67 | $6,473.55 | $96.62 | $2.77 |
| 6-18 | 148 | 237 | $34,777.77 | $146.74 | $4.47 |
| 19-25 | 129 | 250 | $32,563.54 | $130.25 | $7.81 |
| 26-39 | 259 | 542 | $59,229.41 | $109.28 | $8.12 |
| 40-64 | 529 | 1095 | $459,547.25 | $419.68 | $31.02 |
| 65+ | 43 | 75 | $9,571.53 | $127.62 | $8.35 |
| Unknown | 0 | 0 | $0.00 | $0.00 | $0.00 |

| REL TO INS | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| Employee | 548 | 1032 | $258,784.42 | $250.76 | $17.47 |
| Spouse | 277 | 671 | $268,600.84 | $400.30 | $32.26 |
| Dependent | 330 | 573 | $78,667.62 | $137.29 | $5.30 |

| GENDER | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| Female | 640 | 1328 | $242,374.48 | $182.51 | $12.14 |
| Male | 515 | 948 | $363,678.40 | $383.63 | $20.20 |
| Undisclosed | 0 | 0 | $0.00 | $0.00 | $0.00 |

| ST CD | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| DE | 2 | 2 | $200.00 | $100.00 | $1.05 |
| NJ | 1146 | 2262 | $604,891.61 | $267.41 | $16.14 |
| PA | 4 | 9 | $766.95 | $85.22 | $7.30 |
| SC | 3 | 3 | $194.32 | $64.77 | $1.66 |

**Summary by Service Type - Outpatient and Professional Claims**

**Service Types are Limited to: Emergency Room, Pathology (Laboratory), Urgent Care, Retail Clinic, Telemedicine, Emergency Room, Pathology (Laboratory), Urgent Care, Retail Clinic, Telemedicine, Office Physician Visit, Other Physician Visit, Emergency Room With Observation Bed, and Observation Bed**

| SRVC TP DSC | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| Emergency Room | 67 | 86 | $19,089.01 | $221.97 | $0.50 |
| Emergency Room With Observation Bed | 12 | 12 | $3,563.47 | $296.96 | $0.09 |
| Observation Bed | 3 | 3 | $3,772.00 | $1,257.33 | $0.10 |
| Office Physician Visit | 29 | 33 | $2,735.27 | $82.89 | $0.07 |
| Other Physician Visit | 9 | 12 | $1,395.08 | $116.26 | $0.04 |
| Pathology (Laboratory) | 906 | 1602 | $149,008.02 | $93.01 | $3.92 |
| Telemedicine | 31 | 36 | $3,796.96 | $105.47 | $0.10 |
| Urgent Care | 206 | 253 | $44,138.92 | $174.46 | $1.16 |

**Inpatient Cost and Utlization by Age Band**

| AGE BAND | CLAIMANT COUNT | CLAIM COUNT | ADM CNT | NET PAY | ADM PER 1000 | COST PER ADM | COST PMPM | AVG LOS |
|---|---|---|---|---|---|---|---|---|
| <1 | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| 1-5 | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| 6-18 | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| 19-25 | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| 26-39 | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| 40-64 | 6 | 9 | 6 | $335,138.43 | 4.8 | $55,856.41 | $22.62 | 6.8333 |
| 65+ | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |
| Unknown | 0 | 0 | 0 | $0.00 | 0 | $0.00 | $0.00 | 0 |

**TOP PROVIDERS(TOP 25 BY NET PAYMENT)**

| PROVIDER NAME | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIM | COST PMPM |
|---|---|---|---|---|---|
| Pennsylvania Hospital of the University of Pennsylvania Health System | 5 | 10 | $153,481.74 | $15,348.17 | $4.04 |
| Atlanticare Regional Medical Center | 11 | 11 | $67,205.79 | $6,109.62 | $1.77 |
| SHORE MEDICAL CENTER | 13 | 16 | $62,015.31 | $3,875.96 | $1.63 |
| Labcorp Raritan | 432 | 571 | $48,386.49 | $84.74 | $1.27 |
| Cooper University Hospital | 23 | 28 | $34,427.23 | $1,229.54 | $0.91 |
| CAPE REGIONAL URGENT CARE LLC | 139 | 171 | $32,490.00 | $190.00 | $0.86 |
| CAPE REGIONAL MEDICAL CENTER | 66 | 80 | $30,152.24 | $376.90 | $0.79 |
| Salem Medical Center | 123 | 150 | $21,756.80 | $145.05 | $0.57 |
| Quest Diagnostics Inc | 116 | 129 | $11,550.33 | $89.54 | $0.30 |
| Alfred I Dupont Institute | 10 | 10 | $9,552.59 | $955.26 | $0.25 |
| GENESIS LABORATORY MANAGEMENT | 26 | 31 | $8,950.95 | $288.74 | $0.24 |
| Inspira Medical Center Vineland | 48 | 60 | $8,758.02 | $145.97 | $0.23 |
| PROHEALTH CARE ASSOC LLP | 32 | 39 | $7,725.00 | $198.08 | $0.20 |
| Accu Reference Medical Lab | 11 | 20 | $5,860.00 | $293.00 | $0.15 |
| GENUS3 LLC | 2 | 40 | $5,540.00 | $138.50 | $0.15 |
| MEDARBOR LLC | 22 | 31 | $4,750.00 | $153.23 | $0.13 |
| Univ of Pennsylvania Pulmonary | 1 | 2 | $4,359.22 | $2,179.61 | $0.11 |
| CAPE REGIONAL PHYSICIANS ASSOCIATES | 34 | 50 | $4,033.72 | $80.67 | $0.11 |
| Medical Diagnostic Laboratories LLC | 4 | 17 | $4,030.00 | $237.06 | $0.11 |
| SMA Medical Laboratories Inc | 44 | 50 | $3,854.55 | $77.09 | $0.10 |
| Christiana Care Health Services | 11 | 11 | $3,387.70 | $307.97 | $0.09 |
| SPARROW HEALTHCARE LLC | 1 | 24 | $3,312.50 | $138.02 | $0.09 |
| TEMPUS LABS INC. | 31 | 32 | $3,200.00 | $100.00 | $0.08 |
| CAPE EMERGENCY PHYSICIANS PA | 5 | 6 | $2,555.83 | $425.97 | $0.07 |
| Saint Barnabas Medical Center | 1 | 2 | $2,542.41 | $1,271.20 | $0.07 |

**COVID19 Vaccine Claims with Procedure codes '0001A','0002A','0011A','0012A','91300', and '91301'**

| AGE BAND | 1st Dose Vaccine CLAIMANT COUNT | 2nd Dose Vaccine CLAIMANT COUNT | NET PAY | COST PER CLAIMANT |
|---|---|---|---|---|
| <1 | 0 | 0 | $0.00 | $0.00 |
| 1-5 | 0 | 0 | $0.00 | $0.00 |
| 6-18 | 1 | 1 | $45.33 | $22.66 |
| 19-25 | 7 | 0 | $237.22 | $33.89 |
| 26-39 | 15 | 5 | $436.46 | $21.82 |
| 40-64 | 59 | 14 | $1,700.38 | $23.29 |
| 65+ | 2 | 0 | $33.88 | $16.94 |
| Unknown | 0 | 0 | $0.00 | $0.00 |

## COVID19 Claims for Urgent Care and Retail Clinics Only

### Urgent Care

| AGE BAND | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIMANT |
|---|---|---|---|---|
| <1 | 1 | 1 | $200.00 | $200,000.00 |
| 1-5 | 10 | 10 | $1,576.27 | $157,627.00 |
| 6-18 | 41 | 52 | $9,276.54 | $226,257.07 |
| 19-25 | 27 | 33 | $5,279.42 | $195,534.07 |
| 26-39 | 48 | 58 | $10,412.70 | $216,931.25 |
| 40-64 | 75 | 95 | $16,783.61 | $223,781.47 |
| 65+ | 4 | 4 | $610.38 | $152,595.00 |
| Unknown | 0 | 0 | $0.00 | $0.00 |

### Retail Clinic

| AGE BAND | CLAIMANT COUNT | CLAIM COUNT | NET PAY | COST PER CLAIMANT |
|---|---|---|---|---|
| <1 | 0 | 0 | $0.00 | $0.00 |
| 1-5 | 0 | 0 | $0.00 | $0.00 |
| 6-18 | 0 | 0 | $0.00 | $0.00 |
| 19-25 | 0 | 0 | $0.00 | $0.00 |
| 26-39 | 0 | 0 | $0.00 | $0.00 |
| 40-64 | 0 | 0 | $0.00 | $0.00 |
| 65+ | 0 | 0 | $0.00 | $0.00 |
| Unknown | 0 | 0 | $0.00 | $0.00 |

EXPRESS SCRIPTS®

## Southern Coastal Health Insurance Fund

| Total Component/Date of Service (Month) | 202001 | 202002 | 202003 | 2020Q1 | 202004 | 202005 | 202006 | 2020Q2 | 202007 | 202008 | 202009 | 2020Q3 | 202010 | 202011 | 202012 | 2020Q4 | 2020YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Average Member Age - 34.3 | | | | | | | | | | | | | | | | | |
| Membership | 2,093 | 2,079 | 2,078 | 2,083 | 2,071 | 2,082 | 2,087 | 2,080 | 2,070 | 2,065 | 2,085 | 2,073 | 2,086 | 2,087 | 2,087 | 2,087 | 2,081 |
| Total Days | 80,650 | 70,969 | 84,634 | 236,253 | 73,902 | 68,861 | 69,785 | 212,548 | 73,495 | 71,054 | 69,771 | 214,320 | 68,347 | 67,944 | 76,710 | 213,001 | 876,122 |
| Total Patients | 845 | 787 | 792 | 1,267 | 678 | 650 | 696 | 1,056 | 699 | 736 | 688 | 1,115 | 672 | 668 | 701 | 1,077 | 1,599 |
| Total Plan Cost | $314,804 | $306,798 | $347,469 | $969,070 | $348,540 | $331,295 | $327,268 | $1,007,103 | $327,539 | $348,738 | $359,753 | $1,036,029 | $356,090 | $302,447 | $315,885 | $974,422 | $3,986,624 |
| Generic Fill Rate (GFR) - Total | 84.1% | 83.6% | 81.9% | 83.2% | 82.4% | 81.6% | 82.5% | 82.2% | 83.8% | 81.6% | 81.9% | 82.4% | 81.0% | 82.5% | 83.7% | 82.4% | 82.6% |
| Plan Cost PMPM | $150.41 | $147.57 | $167.21 | $155.05 | $168.30 | $159.12 | $156.81 | $161.39 | $158.23 | $168.88 | $172.54 | $166.56 | $170.70 | $144.92 | $151.36 | $155.66 | $159.66 |
| Total Specialty Plan Cost | $151,257 | $127,773 | $127,263 | $406,293 | $172,799 | $184,866 | $158,504 | $516,169 | $171,805 | $169,710 | $175,119 | $516,634 | $197,266 | $139,082 | $113,157 | $449,505 | $1,888,601 |
| Specialty % of Total Specialty Plan Cost | 48.0% | 41.6% | 36.6% | 41.9% | 49.6% | 55.8% | 48.4% | 51.3% | 52.5% | 48.7% | 48.7% | 49.9% | 55.4% | 46.0% | 35.8% | 46.1% | 47.4% |

| Total Component/Date of Service (Month) | 202101 | 202102 | 202103 | 2021Q1 | 202104 | 202105 | 202106 | 2021Q2 | 202107 | 202108 | 202109 | 2021Q3 | 202110 | 202111 | 202112 | 2021Q4 | 2021YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Average Member Age - 34.3 | | | | | | | | | | | | | | | | | |
| Membership | 2,061 | 2,049 | | | | | | | | | | | | | | | |
| Total Days | 70,147 | 60,360 | | | | | | | | | | | | | | | |
| Total Patients | 705 | 668 | | | | | | | | | | | | | | | |
| Total Plan Cost | $273,454 | $232,693 | | | | | | | | | | | | | | | |
| Generic Fill Rate (GFR) - Total | 85.9% | 86.4% | | | | | | | | | | | | | | | |
| Plan Cost PMPM | $132.68 | $113.56 | | | | | | | | | | | | | | | |
| % Change Plan Cost PMPM | -11.8% | -21.3% | | | | | | | | | | | | | | | |
| Total Specialty Plan Cost | $125,708 | $105,067 | | | | | | | | | | | | | | | |
| Specialty % of Total Specialty Plan Cost | 46.0% | 45.2% | | | | | | | | | | | | | | | |

| | PMPM |
|---|---|
| Jan - Feb 2020 | $147.40 |
| Jan - Feb 2021 | $123.15 |
| Trend - Jan - Feb 2021 | -16.5% |

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**
**CONSENT AGENDA**
**MARCH 22, 2021**

The following Resolutions listed on the Consent Agenda will be enacted in one motion. Copies of all Resolutions are available to any person upon request. Any Commissioner wishing to remove any Resolution(s) to be voted upon, may do so at this time, and said Resolution(s) will be moved and voted separately.

**Motion**_____ **Second**_____

**RESOLUTION NO. 14-21**

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**
**ADOPTING 2021 WELLNESS GRANT PROGRAMS**

**WHEREAS**, the Southern Coastal Regional Employee Benefits Fund is duly constituted as a Health Benefits Joint Insurance Fund and is subject to certain requirements of the Local Public Contracts Law; and;

**WHEREAS,** the Executive Committee set forth a budget for the Fund year of January 1, 2021 through December 31, 2021. This budget includes $152,000 for individual member wellness grants;

**WHEREAS**, the Buena Board of Education submitted an application for a wellness grant through the Southern Coastal Regional Employee Benefits Fund which was presented and approved by the Wellness Committee

**WHEREAS**, the projected program and requested funds in the amount of $10,000 was deemed appropriate for the objectives of the Fund wellness grant program

**NOW THEREFORE BE IT RESOLVED**, on March 22, 2021 the Executive Committee of the Southern Coastal Regional Employee Benefits Fund approved Wellness Grant Programs Buena Board of Education.

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**

**ADOPTED: MARCH 22, 2021**

**BY:**_____
**CHAIRPERSON**

**ATTEST:**

_____
**SCRETARY**

**RESOLUTION NO. 15-21**

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**
**APPROVAL OF THE FEBRUARY AND MARCH 2021 BILLS LISTS**

**WHEREAS**, the Southern Coastal Regional Employee Benefits Fund held a Public Meeting on **March 22, 2021** for the purposes of conducting the official business of the Fund; and

**WHEREAS**, The Treasurer for the Fund presented bills lists to satisfy outstanding costs incurred for operating the Fund during the months of February and March 2021 for consideration and approval of the Executive Committee; and

**WHEREAS**, The Treasurer for the Fund presented a Treasurers Report which detailed the claims payments and imprest transfers for the Fund for the Month of January for all Fund Years for consideration and approval of the Executive Committee; and

**WHEREAS**, a quorum of the Executive Committee was present thereby conforming with the By-laws of the Fund to conduct official business of the Fund,

**NOW THEREFORE BE IT RESOLVED** the Commissioners of the Executive Committee of the Southern Coastal Regional Employee Benefits Fund hereby approve the Bills List for February and March 2021 prepared by the Treasurer of the Fund and duly authorize and concur said bills to be paid expeditiously, in accordance with the laws and regulations promulgated by the State of New Jersey for Municipal Health Insurance Funds.

**NOW, THEREFORE BE IT FURTHER RESOLVED,** the Commissioners of the Executive Committee of the Southern Coastal Regional Employee Benefits Fund hereby approve the Treasurers Report as furnished by the Treasurer of the Fund and concur with actions undertaken by the Treasurer, in accordance with the laws and regulations promulgated by the State of New Jersey for Municipal Health Insurance Funds.

**ADOPTED: MARCH 22, 2021**

**BY:**_____
**CHAIRPERSON**

**ATTEST:**

_____
**SECRETARY**

# APPENDIX I

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND**
**OPEN MINUTES**
**JANUARY 25, 2021**
**ZOOM MEETING**
**1:15 PM**

Meeting of Executive Committee called to order by Chair Yacovelli, Open Public Meetings notice read into record.

**PLEDGE OF ALLEGIANCE**

**ROLL CALL OF 2020 EXECUTIVE COMMITTEE:**

| | | |
|---|---|---|
| **Officers** | | |
| Pasquale Yacovelli - Chair | Buena Regional Board of Education | Present |
| Nicole Albanese - Secretary | Bridgeton Board of Education | Present |
| **Executive Committee** | | |
| Bruce Harbinson | Cumberland Regional Board of Education | Present |
| Jerry Velazquez | Cumberland County Improvement Authority | Present |
| Stephanie Kuntz | Hopewell Board of Education | Present |
| Richard Davidson | Millville Board of Education | Present |
| **Alternates** | | |
| Paige Sharpe-Rumaker | Dennis Township Board of Education | Present |
| Cherie Bratty - Secretary | Upper Deerfield Board of Education | Absent |

**PRESENT FUND PROFESSIONALS:**

| | |
|---|---|
| **FUND ADMINISTRATOR:** | **PERMA Risk Management**<br>**Emily Koval**<br>**Karen Kamprath**<br>**Paul Laracy** |
| **FUND ATTORNEY:** | **Charles Fiore** |
| **PROGRAM MANAGER:** | **Shared Health Alliance**<br>**Rich Allen** |
| **FUND TREASURER:** | **Mike Zambito**<br>**Lorraine Verrill** |
| **AETNA:** | **Jason Silverstein** |
| **AMERIHEALTH:** | **Kristina Strain** |
| **EXPRESS SCRIPTS:** | **Absent** |

**DELTA DENTAL:** **Brian Remlinger**

**ALSO PRESENT**
Christina Murphy
Lisa Gaeto
Megan Duffield
Mike Mauro
Tricia Ryan
Dina Murray
Anthony Tonzini
Billie Jo Levengood
Casey Byrne
Courtenay Higgins
Dan Fox
James Ridgway
Joe Hiles
Joe Madera
John Hansen
Jozsef Pfeiffer
Mark Mallett
Mike Mauro
Rick Alessandrini
Scott Musterel
Stacy Pennington
Timothy Kelley
Tricia Ryan
Corey Allen
Susan Dortu
Gerry Cowan
Bob Allen

**APPROVAL OF MINUTES: November 10, 2020- Open**

**MOTION TO APPROVE OPEN MINUTES OF NOVEMBER 10, 2020**

| | |
|---|---|
| Moved: | Commissioner Albanese |
| Second: | Commissioner Kuntz |
| Vote: | Unanimous |

Executive Director said an election of officers will take place.

**ROLL CALL OF 2021 FUND COMMISSIONERS**

| Commissioner | Member | Attendance |
|---|---|---|
| Shannon DuBois-Brody | Alloway Township BOE | |
| Nicole Albanese | Bridgeton BOE | Present |
| Pasquale Yacovelli | Buena Regional BOE | Present |
| Molly O'Neill | City of Brigantine | |
| Christina Murphy | Cumberland Charter School Network | Present |
| Gerard Velazquez | Cumberland County Improvement Authority | Present |
| Megan Duffield | Cumberland County Tech Ed | Present |
| Bruce Harbinson | Cumberland Regional BOE | Present |
| Paige Rumaker | Dennis Township BOE | Present |
| Lisa Dinovi | Downe Township | |
| Stephanie Kuntz | Hopewell BOE | Present |
| Lisa DiNovi | Lawrence Township BOE | |
| John Hansen | Lower Township | Present |
| Mark Mallett | Lower Cape May Regional BOE | Present |
| Richard Davidson | Millville BOE | Present |
| Timothy Kelly | Ocean City BOE | Present |
| John Washington | Penns Grove | |
| charles hughes | Pittsgrove Township | Present |
| Stacy Pennington | Salem County | Present |
| Cherie Bratty | Upper Deerfield BOE | |
| Scott Musterel (alternate) | Vineland BOE | Present |
| Dan fox | Waterford Townhship BOE | Present |
| Todd D'Anna | West Cape May BOE | |
| Darrin Harris | Woodbine BOE | |
| Joe Hiles | Woodstown Borough | Present |

Executive Director said a quorum is present and said the committee can consider nominations or the current slate of officers.

Executive Director said the nominating committee is recommending the slate as presented below:

Nominating Committee Recommendation
Pasquale Yacovelli, Chair
Nicole Albanese, Secretary
Bruce Harbinson, Executive Committee
Jerry Velazquez, Executive Committee
Stephanie Kuntz, Executive Committee
Richard Davidson, Executive Committee
Paige Sharpe-Rumaker, Executive Committee
Megan Duffield, Executive Committee Alternate
Cherie Bratty, Executive Committee Alternate

**MOTION TO APPROVE THE SLATE OF OFFICERS AS PRESENTED:**

| | |
|---|---|
| Moved: | Commissioner Albanese |
| Second: | Commissioner Harbinson |
| Vote: | 17 Ayes, 0 Nays |

Fund Attorney swore in the Executive Committee

**ROLL CALL OF 2021 EXECUTIVE COMMITTEE:**

| | | |
|---|---|---|
| Pasquale Yacovelli - Chair | Buena Regional Board of Education | Present |
| Nicole Albanese - Secretary | Bridgeton Board of Education | Present |
| Bruce Harbinson | Cumberland Regional Board of Education | Present |
| Jerry Velazquez | Cumberland County Improvement Authority | Present |
| Stephanie Kuntz | Hopewell Board of Education | Present |
| Richard Davidson | Millville Board of Education | Present |
| Paige Sharpe -Rumaker | Dennis Township Board of Education | Present |
| **ALTERNATE** | | |
| Megan Duffield | Cumberland County Tech Ed | Present |
| Cherie Bratty | Upper Deerfield Board of Education | Absent |

**MOTION TO OPEN THE MEETING TO THE PUBLIC:**

| | |
|---|---|
| Moved: | Commissioner Davidson |
| Second: | Commissioner Albanese |
| Vote: | Unanimous |

**PUBLIC COMMENT**: None

**MOTION TO CLOSE THE MEETING TO THE PUBLIC:**

| | |
|---|---|
| Moved: | Commissioner Albanese |
| Second: | Commissioner Harbinson |
| Vote: | Unanimous |

## EXECUTIVE DIRECTOR'S REPORT

**Fast Track Financial Reports –** as November 30, 2020. Executive Director said the financial fast track reflects the dividend declared in November. She said the Fund made over $10 million this year.

**2021 REORGANIZATION –** Executive Director reviewed the reorganization resolutions noting the following:

#6-21 – September meeting is the 3rd Monday to allow for enough time between budget introduction and adoption

#8-21 – Current Signatories – Pat Yacovelli, Nicole Albanese, Deputy Treasurer and Fund Treasurer. These will remain the same for 2021

#9-21 – RMP – There are a few changes from 2020 which are highlighted.

#11-21 – The MRHIF representatives were appointed as Rich Davidson and Pasquale Yacovelli as Alternate.

**MUNICIPAL REINSURANCE HEALTH INSURANCE FUND –** Executive Director said the MRHIF met on December 9 to adopt the 2021 budget.

**INDEMNITY AND TRUST AGREEMENT –** Executive Director said Indemnity and Trust Agreements and Resolutions to be adopted by the governing bodies to renew membership with the Fund for an additional 3 years were sent out to members who have renewing agreements due by December 31, 2020 and older.

**PROGRAM MANAGER REPORT**

Program Manager thanked all the Commissioners for their participation with the Fund. He also introduced Commissioner Hansen from Lower Township BOE who is a new member as of 1/1.

Lower Township BOE
- Joined Effective 1/1/21 – Implementation Complete

Ventnor BOE
- In review for 7/1/2021

Wildwood Crest, Boro of
- In preliminary discussions

Hamilton Twp BOE
- In review for 7/1/2021

Vineland, City of
- Will begin 2 year review of claims in July

Egg Harbor Twp
- In review for 7/1/2021

**Coastal Fund Meeting Dates** *(Zoom Mtg till further notice)*

- January 25, 2021
- March 22, 2021
- May 24, 2021
- July 26, 2021
- September 20, 2021
- October 25, 2021
- November 22, 2021

**Coastal Fund Brokers**

- Allen Associates
- AR Fanucci
- Assured Partners
- Brown & Brown Benefit Advisors
- J Byrne Agency
- Conner Strong & Buckelew
- Cornerstone Insurance Group
- Hardenbergh Insurance Group
- Innovative Risk Solutions
- Integrity Consulting Group

**2021 Committees**

| **Finance & Contracts** | **Operations & Nominations** | **Wellness & Claims** |
|---|---|---|
| Pat Yacovelli, Chair | Nicole Albanese, Chair | Paige Sharpe Rumaker, Chair |
| Jerry Velazquez | Jerry Velazquez | Bruce Harbinson |
| Richard Davidson* | Stephanie Kuntz | Megan Duffield* |

**WELLNESS COMMITTEE UPDATE**

Program Manager said there is still time to submit an application for a wellness grant. Please go online to www.coastalhif.com and review the wellness grant guidelines and information in order to submit a new application. Applications received now would be granted for the 2021 year. Please note the new website information from Health Fairs Direct for Biometric Screening information and other new resources. Please contact us for any additional information or assistance. **www.coastalhif.com/wellness**

- In light of the Social Distancing guidelines, many of our groups have not been able to use all of their 2020 Wellness Grant money. As a result, the Wellness Committee agreed to allow any remaining funds to be rolled over into 2021. Please reach out to corey@allenassoc.com if you would like to know your remaining balance.

  - In addition, the Wellness Committee has agreed to extend the November submission deadline for 2021 Wellness Grants. Submission of 2021 Wellness Grant Applications will be accepted on a rolling basis throughout the year.

**COASTAL WELLNESS GRANTS - 2020**
**Budget Amount: $200,000**

| Group Name | Date Submitted to Committee | Amount Requested | Amount Approved | Date Committee Approved | Date Resolution Passed |
|---|---|---|---|---|---|
| Cumberland Co Tech | 10/22/2019 | $7,000 | $7,000 | 10/22/2019 | 1/27/2020 |
| Hopewell Twp BOE | 10/31/2019 | $3,500 | $3,500 | 11/19/2019 | 1/27/2020 |
| Cumberland Regional BOE | 11/20/2019 | $7,500 | $7,500 | 11/20/2019 | 1/27/2020 |
| Millville BOE | 11/27/19 | $20,000 | $20,000 | 12/2/2019 | 1/27/2020 |
| Bridgeton BOE | 5/14/2020 | $20,000 | $20,000 | 5/14/2020 | 7/27/2020 |
| Waterford BOE | 6/3/2020 | $7,400 | $7,400 | 6/3/2020 | 7/27/2020 |
| Cumb Co Improve Auth | 6/17/2020 | $4,725 | $4,725 | 6/18/2020 | 7/27/2020 |
| Vineland BOE | 9/1/2020 | $30,000 | $30,000 | 9/10/2020 | 11/10/2020 |

**ADVANTA HEALTH SOLUTIONS ADDED AS NEW WELLNESS PROGRAM VENDOR TO COASTAL HIF**

Ms. Higgins from Advantage health was in attendance to provide an overview of the program. She said they are a health technology company. They understand the challenges of Covid and have adapted accordingly. She said their goal is to increase the physical and mental fitness of their members. She said they are holding their 2020 rates at least through the first quarter for the Fund.

**GUARDIAN NURSES**

Ms. Sambuco from Guardian Nurses was in attendance to provide and update. She reviewed the letter and report included in the Agenda.

It is important to note that the Nurses are a key piece of your health care benefits and have been authorized to work with medical providers, labs and other facilities, hospitals and also the health care carriers Aetna and AmeriHealth Administrators.

Some of the services provided are:

- **VISIT YOU AT HOME** or in the hospital to assess your care needs.
- **BE YOUR GUIDE**, coach and advocate for any healthcare issue.
- **MAKE APPOINTMENTS** for you so you can be seen as quickly as possible.
- **GO WITH YOU** to see doctors, to ask questions and to get answers.
- **IDENTIFY PROVIDERS** for all care needs and second opinions.
- **GET THINGS YOU NEED** such as healthcare equipment.
- **PROVIDE DECISION SUPPORT** when you are thinking about treatments or surgery.
- **EXPLAIN A NEW DIAGNOSIS** to help you make informed decisions.

**We have shared several informational email messages and several flyers since April for distribution to your employees. If your employees don't know who the Guardian Nurses are, they will not be inclined to request their services. So, we are asking for your help in getting the word out that the Guardian Nurses are available.** If you would like them to attend a staff meeting, a faculty meeting, an in-service event, a professional development day, a wellness event or any type of opportunity to be introduced and be of service, they are available. Please consider having your school nurses develop a relationship with the Nurses so that they become part of your wellness endeavors. They are also available to address COVID-19 issues and have already successfully conducted virtual "town hall meetings" which can help deal with stress and anxiety…for adults, as employees, and also for dealing with children.

Please let us know if you have any questions about the Guardian Nurses and how to introduce them to your staff. We look forward to them becoming a more familiar face for our healthcare benefits. Our two Nurses assigned to the Coastal HIF are Lauren Gant/609-276-4990 and Charlie Reiter/609-276/5001.

**ADMINISTRATIVE UPDATES:**

- **Online Enrollment System Training -** If you need training or would like a refresher course on the online enrollment system, please reach out to Karen Kidd at kkidd@permainc.com of PERMA.

- **Monthly Billing** -As a reminder, please be sure to check your monthly invoice for accuracy. If you find a discrepancy, please report it to the Coastal Fund enrollment team. The Fund's policy is to limit retro corrections, *including terminations,* to 60 days. We have noticed an increase in requests for enrollment changes, billing changes, terminations and additions well past the 60-day time frame. Moving forward, it is of the utmost importance to review bills for rate and enrollment accuracy on a monthly basis. If there is an error, please bring it to our attention.

- **Broker Contact Information** - Please direct any escalated claims, benefit coverages, prescription coverage, Medicare advantage or appeal related questions to our dedicated Benefit Specialists as follows: Rose Meimbresse rose@allenassoc.com , or Annie Jimenez annie@allenassoc.com .

## EXPRESS SCRIPTS UPDATE

### 2021 NATIONAL PREFERRED FORMULARY UPDATE

ESI announced their Basic Formulary updates for the 2021 plan year. ESI will work to make the transition to more affordable medications as simple and seamless as possible for any member who is impacted:

- The percentage of members required to switch to preferred medications will receive personalized notifications, reminder communications and targeted alerts about preferred options. ESI will notify physicians and pharmacists before the exclusions become effective.
- ESI's Academic Detailing pharmacists and Accredo® Physician Engagement team are actively educating prescribers on lower-cost alternatives.
- Proair, Respiclick and Ventolin HFA are leading at a combined disruption of 0.966%
- We are seeing quick movement to albuterol HFA not only from Proair HFA but also the single source brands. At the end of July, we've already seen 63% of brand claims converted to generic.
- For this reason, we anticipate the disruption % will be significantly lower by 1/1/21.

## AETNA UPDATE

### TELADOC MAILING

Aetna announced they began a member communication campaign for Teladoc. Welcome Letters containing information on Teladoc as well as member cost-share information for the 2021 plan-year, are being mailed to Aetna members.

## LEGISLATIVE UPDATES

### COVID-19 VACCINE UPDATES

- **Vaccine Coverage**
    - In December 2020 the U.S. Food and Drug Administration (FDA) issued Emergency Use

Authorizations (EUAs) for the use of the Pfizer-BioNTech and Moderna COVID-19 Vaccines for the prevention of coronavirus disease. Vaccines recommended by the CDC Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) will be covered under the plan. The cost of the vaccine itself, will be paid by the federal government for the foreseeable future. The plan will fully cover the cost of administering the vaccine at participating and non-participating providers/facilities.

- **Vaccine Eligibility**
  - The New Jersey Department of Health (DOH) released a memorandum concerning the eligibility of individuals who may currently receive the COVID-19 vaccine under Phase 1A of the State's vaccination plan of which includes (1) healthcare workers; (2) long-term care facility residents; and, (3) sworn law enforcement officers, firefighters, and other first responders.

**Updated Indexed Dollar Limits**
The Internal Revenue Service (IRS) recently announced the below 2021 limits regarding High Deductible Health Plans (HDHP) and Health Savings Accounts (HSA).

| | 2020 | 2021 |
|---|---|---|
| HDHP Minimum Required Deductible- Self Only | $1,400 | $1,400 |
| HDHP Minimum Required Deductible- Family | $2,800 | $2,800 |
| HSA Contribution Limit- Self only HDHP | $3,550 | $3,600 |
| HSA Contribution Limit- Family HDHP | $7,100 | $7,200 |
| HSA/HDHP OOP Maximum- Self Only | $6,900 | $7,000 |
| HSA/HDHP OOP Maximum- Family | $13,800 | $14,000 |

**COVID-19 FSA RELIEF**

The recently passed COVID-19 relief bill permits employers to allow members with Flexible Spending Accounts (FSAs) to roll over unused funds.
Key provisions of the new ruling include:

- option to amend cafeteria plans and FSAs to allow employees to:
  - carryover unused amounts from plan year ending in 2020 to the 2021 plan year
  - carryover unused amounts from plan year ending in 2021 to the 2022 plan year
  - provide a 12-month grace period at the end of the 2020 and/or 2021 plan years
- option to amend FSAs allowing employees to make prospective election changes for plan years ending in 2021 (with no change in status)
- allowing employees who cease participation in an FSA during calendar years 2020 or 2021 to receive post-termination reimbursements from unused benefits through the end of the plan year when participation ceases (including grace period if applicable)

**APPEALS** (as of 1/18/2021) –

| Type | Determination |
|---|---|
| Medical | n/a |
| RX | n/a |

**<u>SPECIAL NOTICE</u>: As Program Managers for the Coastal HIF, Shared Health Alliance prioritizes the health and safety of the communities we serve. The worldwide COVID-19 outbreak has us all concerned and taking extra precautions. As a result, we wanted to assure members that we have activated our business continuity plan to ensure appropriate support to all members.**

**TREASURER –** Fund Treasurer thanked the fund for their reappointment. He reviewed the bills list and treasurers report.

**Confirmation of Payment – December 2020**

| FUND YEAR | AMOUNT |
|---|---|
| 2020 | $959,312.25 |
| **TOTAL** | $959,312.25 |

**Confirmation of Payment – December 2020 Dividends**

| FUND YEAR | AMOUNT |
|---|---|
| CLOSED | $1,141,312.00 |
| **TOTAL** | **$1,141,312.00** |

**Confirmation of Payment – December Supplemental**

| FUND YEAR | AMOUNT |
|---|---|
| 2020 | $1,636.91 |
| **TOTAL** | **$1,636.91** |

**Resolution 13-21 – January 2021**

| FUND YEAR | AMOUNT |
|---|---|
| 2020 | $145.76 |
| 2021 | $924,436.10 |
| **TOTAL** | **$924,436.10** |

**FUND ATTORNEY-** Fund Attorney thanked the Fund for their reappointment.

**AETNA –** Mr. Silverstein reviewed the claims for October and November. He said there were 3 claims over $100,000 for October and 2 for November. He reviewed the dashboard and noted that they continue to perform well however they did fall before target for the average speed of answer and financial accuracy and are taking steps to correct that. He also reviewed the covid reporting included with the agenda.

**AMERIHEALTH ADMINISTRATORS –** Ms. Strain reviewed the claims for November and December. She said there was a typo on the December report. She said the total for December should be a pepm of $1,085. She said there are 2 claimants over $100,000 for this period. She also reviewed the covid reporting included in the agenda.

**EXPRESS SCRIPTS –** Executive Director said ESI was unable to attend however they provided her with an update. She said the trend for 2020 was up 3% overall. She said there will be a formulary update for 4/1 but impact to the Fund is very low.

**CONSENT AGENDA –**

**MOTION TO APPROVE THE CONSENT AGENDA WHICH INCLUDES RESOLUTIONS 1-21 THROUGH 13-21:**

| | |
|---|---|
| **MOTION:** | Commissioner Albanese |
| **SECOND:** | Commissioner Harbinson |
| **VOTE:** | **6** Ayes, 0 Nays |

**OLD BUSINESS**: None

**NEW BUSINESS**: None

**MOTION TO OPEN THE MEETING TO THE PUBLIC:**

| | |
|---|---|
| Moved: | Commissioner Harbinson |
| Second: | Commissioner Davidson |
| Vote: | Unanimous |

**PUBLIC COMMENT**: None

**MOTION TO CLOSE THE MEETING TO THE PUBLIC:**

| | |
|---|---|
| Moved: | Commissioner Albanese |
| Second: | Commissioner Harbinson |
| Vote: | Unanimous |

**MOTION TO ADJOURN:**

| | |
|---|---|
| **MOTION:** | Commissioner Harbinson |
| **SECOND:** | Commissioner Kuntz |
| **VOTE:** | Unanimous |

**MEETING ADJOURNED**: 1:30 pm

**NEXT MEETING**: March 22, 2021
1:15 PM, Zoom Meeting

# APPENDIX II

**Coastal Wellness Committee Meeting**

**10:00am, February 16, 2021**

**Meeting Minutes**

Meeting began 10:10 am.

Attendance:

Megan Duffield, Emily Koval, Susan Dortu, Corey Allen, Dina Murray. Bruce Harbinson and Paige Rumaker absent. Emily noted that we officially need two Committee members for a meeting.

Review of Agenda:

1) allowances for each entity

2) timing of submission of applications, 2 times per year vs. once per year, or intermittent throughout the year

3) affect of Covid-19 on wellness initiatives and grants, remote vs. in school activities

4) updated 2021 application, updated allowances chart, updated tracking chart, usage guide

Discussion of submission deadlines:

Current submission deadlines are May, for approval in July, and November for approval in January. Susan asked which is more convenient for the BA, July 1 or January 1 ? Megan commented that July was her preference because all her other grants worked off a fiscal date. She plans in April for submission in May for approval in July based on her schedule for other grants. Megan was not aware that there was another date. Megan suggested that a regular reminder to the BA's would be helpful in order to get the applications out timely. Megan also commented that she felt that allowing applications to be submitted anytime during the course of the year might make it more difficult to keep track of the applications. Dina mentioned that a tracking chart is included with the HIF program Manager's Report included in each agenda. Corey mentioned that an encouraging reminder with some helpful suggestions may help produce more applications. Dina mentioned that Allen Associates is always available for strategy meetings to assist with plans. Also, that a wellness ambassador is good to have to lead and/or assist the wellness program. Megan commented that it is very difficult to get someone to lead and manage the wellness initiative and maybe group entities can target certain people, i.e. admin staff. Megan said she prefers to have an admin person. Dina mentioned that the BA should always be the signatory on all plans and applications that are submitted especially since they have to approve and submit all expenses.

Affect of Covid-19 on Wellness Plans:

All agreed that Covid-19 has hampered the efforts of all entities to produce successful wellness activities. It was mentioned that Coastal now has several vendors that can offer an array of services, many of which can be done off school premises, remotely and independently. Communication to staff about these vendors is important. Coastal website does contain a section devoted to wellness and all the vendor information is included there. There was a concern that many of the commissioners may not be aware of the information available to them regarding wellness endeavors. Corey offered to prepare a list of fresh ideas to help

strategize a program, especially for groups that have never done an application. Dina mentioned that in addition to the more familiar wellness activities, there is also Covid-19 testing available within the grant allowed usages. Also, there was a discussion of unused approved monies and rollovers due to Covid-19 interference. Currently, rollovers are allowed to accommodate approved wellness plans into the following new year.

Megan asked about submitting for money over the approved allowance for an entity, as her group has submitted applications where the amount was for more than what was allowed. Emily confirmed that it was okay to submit for more than your allowed amount but that the HIF would only allow for expenses up to the allowed amount. Susan asked about the resolution to approve the grant allowance and that it should reflect only what was being approved, not what was being applied for. Emily confirmed this. It was also noted that towards the end of the year, if there are unused budgeted monies, groups may apply for additional monies and that the Wellness Committee and PERMA may approve additional monies on an individual basis. Corey asked if unused monies can be taken into a new year. Megan asked if rollovers can be used for unexecuted plans, or special events. Susan asked if rollovers would be recommended for the next year's grant and would Coastal allow rollovers into 2022? Megan was concerned about allowing rollovers for too long a time period. Emily confirmed that rollovers are ok one time for 2021 , however, due to continuing Covid-19 issues, may extend into part of 2022. This brought up another question about how Coastal grant monies are issued – calendar or fiscal year? The current Coastal process includes a timeline based on calendar year, with applications being submitted in May for approval in July, or submitted in November for approval in January of the next year. Dina mentioned that the Coastal budget is based on a calendar year and that in the past, applications were submitted for the current budget year to stay within budget guidelines. It was decided that the full committee would need to determine how the process going forward will be based – calendar or fiscal.

Megan noted that they had an early application based on the incorrect deadline time, and was denied a grant because of this. Emily asked for documentation for reconsideration. Megan will look back for the info. Megan also requested to put her recent application on hold so as to be able to use the rollover money already approved from 2020, but unused. She will resubmit her application in July 2021.

The meeting ended with the following determinations:

1) A follow up meeting with the full committee needs to be scheduled soon so that 2021 applications can be processed on a confirmed submission timeline.
2) There needs to be a confirmation about rollovers and "use it or lose it" monies and final dates. Will 2020 rollovers end on June 30, 2021.
3) Corey will prepare a wellness program reminder for release with some additional helpful information.
4) Emily will request that Karen double check and report back to us how much money was distributed to each entity in 2020.

The meeting adjourned at 11:10 am.

Respectfully submitted by:

Dina Murray

Allen Associates

# APPENDIX III

Southern Coastal FUND

REGIONAL EMPLOYEE BENEFITS FUND

Date: January 2021

To: SCREBF Member Fund Commissioners

Re: Wellness Grant Program Application 2021

The Southern Coastal Regional Employee Benefits Fund is offering an opportunity for member entities to apply for a health and wellness grant. The Fund has budgeted $152,000 in calendar year 2021 for such projects. The budgeted fund should be used only for employees enrolled under the entity's medical plan. To be eligible for the grant, an entity must select or propose the program(s) that will best meet their needs and which will also allow them to develop and sustain an employee wellness program.

All grant applications will be evaluated using criteria established by the Fund, including:
• Matching commitment of financial or management resources by the entity.
• Cost effectiveness of proposed wellness programs.
• Use of existing vendors or vendors compatible with existing vendors.
• Ability and intention of the entity to sustain the program after the grant is expended.
• Portability of the program to other Fund members.
• Compliance with all regulations and due diligence standards regarding public entity contract awards.

Examples of programs that can be applied for include but are not limited to the following:

**1. Comprehensive Biometric Screenings –** The biometric screenings would include blood pressure, body mass index; self-reported height and weight, blood glucose and cholesterol/total cholesterol which is done either a finger prick test or venipuncture. This is especially helpful to those who are borderline with any chronic conditions and to assist those who have a chronic condition in getting the care they need. The biometric screening provider should be able to provide an aggregate report. This report will allow the district to determine common health issues to develop a focus.

**2. Educational Seminars** – On-site educational seminars on varies topics including, but not limited to stress, weight loss, smoking cessation, fitness, nutrition, etc. The entity should have an available room with adequate space and technological capacities.

**3. Wellness Challenges -** Fun, engaging challenges designed to impact of health behaviors such as, but not limited to:

- fit bit challenges

- biggest loser weight loss challenges

- competitions between schools/districts

- pedometer walking challenges

**4. Wellness Committee – To develop and gain momentum, each entity should form a wellness committee** who are tasked with supporting health and wellness within the organization. They should be enthusiastic individuals who can promote the programs and resources available, motivate and encourage their coworkers and work to build a culture of health within their workplace**.**
Qualifications include:
• Desire to help colleagues improve their health.
• Ability to communicate all wellness programs and initiatives for all employees company wide.
• Assist with coordinating onsite wellness events and health screenings.
• Enjoy working with others to achieve common goals.
Any stipends for wellness champions or ambassadors would need to be paid by the submitting public entity.

**All applications are subject to review and approval by the Fund's Wellness Committee and the Fund.**

**Please send all completed applications to:**
**Shared Health Alliance | PO Box 973 | Vineland, NJ 08362, or email to: corey@allenassoc.com**


**Entity Name**

Buena Regional School District

**Detailed description of program:**

**The Buena Regional School District has planned to collaborate with local farms to distribute gift certificates to insured employees to utilize at local farm stands. These gift certificates will only be approved by the vendors for use on fresh fruits or vegetables. Each gift certificate will equate to the sum of $41.05 for 210 employees. This initiative will help support our local farms while encouraging healthy diet habits for our employees. The gift certificates provide autonomy with the selection of the fruits and vegetables to prevent waste. Employees will be given an option through a survey of which farm they would like a voucher too for their convenience. Funds for the fruits and vegetables will be distributed amongst the vendors depending on the amount of requests for each vendor. Twenty fit bits will also be purchased and will be distributed to participants at random. Fitbits will encourage employees to set healthy goals and track their heart rate, daily physical activity, as well as their quality of sleep.**

**Location(s) where program will be held:**

**Gift certificates will be distributed for use at Muzzarelli Farms, Levari Farms, or Bertuzzi Farms in Buena, NJ. Employees will choose the location and use them at their discretion.**

**Implementation timeline:**

**Gift certificates will be distributed to eligible employees on a one time basis. They will be able to use it during the duration of the grant year when they choose.**

**Other requirements:**

**Employees will be required to find their own transportation to and from the farm stand outside of school hours.**

**Participating employees will be asked to complete an initial survey to choose a farm for the voucher and a subsequent survey to review the effectiveness of the implemented program.**

**Estimated Cost :**

**$1,379 for 20 fitbit Inspire 2 devices**
**$8,621 for 210 farmstand vouchers**

# APPENDIX IV

**AMERIHEALTH ADMINISTRATORS**
**ADMINISTRATIVE AND NETWORK SERVICES CONTRACT**

This Administrative and Network Services Contract, and any exhibits, schedules and appendices hereto (together, the "Contract"), made this first (1st) day of JANUARY, 2019, by and between **AmeriHealth Administrators, Inc.**, a Pennsylvania corporation ("AmeriHealth Administrators"), and **Southern Coastal Regional Employee Benefits Fund** (the "Plan Sponsor").

**W I T N E S S E T H**

**WHEREAS**, the Plan Sponsor has established an Employee Health Benefit Plan (the "Plan"), which is attached hereto and incorporated herein as Exhibit A; and

**WHEREAS**, the Plan Sponsor desires to engage the services of AmeriHealth Administrators for purposes of performing administrative and network services for the Plan; and

**WHEREAS**, AmeriHealth Administrators wishes to provide such services in accordance with the terms and conditions set forth in this Contract;

**WHEREAS**, the benefits under the Plan are entirely funded by the Plan Sponsor and AmeriHealth Administrators provides administrative and claims payment services only;

**NOW, THEREFORE**, the Plan Sponsor and AmeriHealth Administrators agree as follows:

**Section I. Definitions.**

1.1 Definitions. Whenever used in this Contract:

"Access Fee" means Network Access Fee which can be a dollar PEPM or percentage of claim and is shown in Exhibit D

"Account" means the checking account established by AmeriHealth Administrators for purposes of transmitting benefit payments under the plan.

"Administrative Fee" means fees paid by the Plan Sponsor to AmeriHealth Administrators for the agreed upon services AmeriHealth Administrators is to provide related to the Plan pursuant to the terms of this Agreement.

"Benefit Program" means the PPO program of health care benefits administered by AmeriHealth Administrators for the Plan Sponsor.

"Claim" means any claim by a Participant for benefits under the Plan that is submitted to AmeriHealth Administrators in the time and manner and including any proof prescribed by AmeriHealth Administrators.

"Claims Funding" means claims adjudicated and finalized that the Plan Sponsor is responsible for funding.

"Covered Expense" means the dollar amount of benefits payable under the Benefit Program, as calculated in this Contract.

"Covered Service" means a service or supply provided to a Participant that is determined to be covered under the Plan and this Contract.

"Determination" means, with respect to each Claim, a decision by AmeriHealth Administrators as to whether and to what extent such Claim shall be paid, subject to review and final determination by Plan Sponsor.

"Effective Date" means January 1, 2019.

"Facility Provider" means an institution or entity licensed, where required, to provide care. Such facilities include: ambulatory surgical facility; birth center; free standing dialysis facility; free standing ambulatory care facility; home health care agency; hospice; hospital; non-hospital facility; psychiatric hospital; rehabilitation hospital; residential treatment facility; short procedure unit; and skilled nursing facility.

"Participant" means any person entitled to receive benefits under the Plan as a covered employee or dependent of a covered employee.

"PPN" means Preferred Provider Network.

"Preferred Facility Provider" means a Facility Provider that is a member of the PPN and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Participants.

"Preferred Professional Provider" means a Professional Provider that belongs to the PPN.

"Professional Provider" means a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are: Audiologist; Nurse Midwife; Certified Registered Nurse; Optometrist; Chiropractor; Physical Therapist; Dentist; Physician; Independent Clinical Laboratory; Podiatrist; Licensed Clinical Social Worker; Psychologist; Master's Prepared Therapist; Speech-language Pathologist; and Teacher of the hearing impaired.

"Run-out Claim Processing" means the process for adjudicating claims and calculating the Administrative Fees paid to Claims Administrator for post-termination claims services under this Agreement. See Exhibit D.

**Section II. Obligations, Duties and Compensation of AmeriHealth Administrators.**

2.1 Administrative Service Agent and Named Claims Fiduciary.

AmeriHealth Administrators is hereby appointed administrative service agent by the Plan Sponsor of the Plan for purposes of providing administrative and claim services in connection with the Plan as are specified in Exhibit B to this Contract, which is attached hereto and incorporated herein by reference. AmeriHealth Administrators shall not be the administrator of the Plan for purposes of ERISA.

2.2 The Account.

AmeriHealth Administrators shall provide a checking account through which benefit payments shall be made under the Plan. AmeriHealth Administrators shall have sole authority to sign checks on the Account. AmeriHealth Administrators shall notify the Plan Sponsor at reasonable intervals of the amount needed to cover Claims approved by AmeriHealth Administrators, and AmeriHealth Administrators shall pay such Claims as soon as is practical after the Plan Sponsor deposits such amount in the Account or provides the means for AmeriHealth Administrators to transfer funds electronically into the Account so that checks on the Account in such amount will be honored. Any balance in the Account shall be the property of the Plan or the Plan Sponsor if the Plan is unfunded. Any interest paid on the Account shall be retained by

AmeriHealth Administrators as additional compensation for services hereunder.

AmeriHealth Administrators shall not have the obligation of paying Claims until funds are received from the Plan Sponsor. AmeriHealth Administrators shall apply funding to administrative fees, any applicable charges other than administrative fees or Claim payments, network provider Claim payments and non-network provider Claim payments, respectively.

Claims funding requests will be available by email notification and/or based on a mutually agreed upon method and on a weekly basis.

Funding not received within forty-eight (48) hours from when the claims funding request (invoice) is made available by email and/or the mutually agreed upon method will be considered delinquent.

Furthermore, if funding is not received by the 7th$^{th}$ calendar day after the date of the initial invoice, AmeriHealth Administrators will deliver a "**Notice of Failure To Remit Payment**" to the Plan Sponsor and hold all claims payments, (with the exception of Pharmacy claims), until all past due Claims Funding is paid in full. If all past due Claims Funding is not received by the 7$^{th}$ calendar day, AmeriHealth Administrators may deny all claims and inform members that the denied claims were ineligible for coverage due to the members employer's failure to fund past due claims. If after fourteen (14) calendar days from the initial invoice date, the Plan Sponsor is delinquent in the remittance of all claims funding, AmeriHealth Administrators may immediately terminate this contract. See, Section 4.2 of this Contract.

Administrative Fee invoice (entitled: "**Administrative Fees Billing Statement**") will be provided to the Plan Sponsor by the 25$^{th}$ of each month. Funding for the Administrative Fee is due on the first business day of the following month. Payment not received within 48 hours after the due date will be considered delinquent.

**Plan Sponsor payment of monthly per employee per month fees shall be made in monthly installments, provided that AHA submits a duly authorized voucher to the FUND's Executive Director/Administrator at least 10 days prior to the next regularly scheduled meeting of the FUND's Executive Committee. Furthermore, this payment schedule is subject to any rules and regulations promulgated by the New Jersey Department of Community Affairs.**

If a Plan Sponsor self-accounts, funding for the Administrative fee is due by the first business day of each month. Plan Sponsors that self-account must ensure that Administrative Fees are accurate at the time of payment. Furthermore, AmeriHealth Administrators reserves the right to audit the Plan Sponsor's methodology for calculating its Administrative Fees to ensure that the correct amounts are being paid. Plan Sponsor shall comply with AmeriHealth Administrator's findings in such audits. Payment not received within 48 hours after the due date will be considered delinquent. .

If a Plan Sponsor self-accounts, Past Due Administrative Fees will be based on an average of the Administrative Fees collected for the prior three months.

If Plan Sponsor is delinquent in Claims Funding and Administrative Fee funding, AmeriHealth Administrators will first apply any monies received toward the Administrative Fee bill, and then apply the balance towards the Claims Funding. If after fourteen (14) calendar days from the invoice due date, the Plan Sponsor is delinquent in the remittance of all administrative funding, AmeriHealth Administrators may immediately terminate this contract. See, Section 4.2 of this Contract.

Repeated delinquencies will require advanced deposits equal to the average monthly claim amount (medical and prescription drug) and may also result in termination of the Contract.

2.3 Advance Deposit. The Plan Sponsor will furnish AmeriHealth Administrators a deposit (the "Advance") to satisfy obligations of the Plan Sponsor under this Contract that are due, including, among others, Claims Expense. The Advance is intended to secure only the Plan Sponsor's obligations to AmeriHealth Administrators.

A. The Plan Sponsor will pay to AmeriHealth Administrators, on or before the effective date of this Contract, the Advance amount as set forth in Exhibit D. Failure to provide the Advance amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to fund the Advance for each day that the Advance remains unfunded.

B. During the term of this Contract, AmeriHealth Administrators may, upon mutual consent, require a greater Advance amount from the Plan Sponsor upon renewal or upon any significant changes in membership and/or benefit design to secure the Plan Sponsor's obligations under this Contract. If AmeriHealth Administrators requires a greater amount, AmeriHealth Administrators will notify the Plan Sponsor of the required increase, which is due and payable within 20 days of the Plan Sponsor's receipt of such notice. Failure to provide the additional amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to increase the Advance for each day that the Advance is below the required amount.

C. AmeriHealth Administrators may at any time and in its discretion use amounts of the Advance to satisfy past due obligations owed by the Plan Sponsor to AmeriHealth Administrators under this Contract. Funds so used must be replenished by the Plan Sponsor within 10 days of the notification of AmeriHealth Administrators' use. Failure to provide the additional amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to replenish the Advance for each day that the Advance is below the required amount.

D. If the Plan Sponsor fails to maintain the Advance as specified in this Contract, AmeriHealth Administrators may, in its discretion terminate this Contract or suspend the performance of its obligations as set forth in this Section II.

E. AmeriHealth Administrators' right to use the Advance survives the termination of this Contract.

2.4 Administration.

AmeriHealth Administrators shall provide administration services as set forth in Part I of Exhibit B to this Contract.

2.5 Claims Services.

AmeriHealth Administrators shall process Claims as set forth in Part II of Exhibit B to this Contract.

2.6 Overpayment of Benefits. If it is determined that any benefit payment has been made to or on behalf of an ineligible individual, including payments made as a result of the fraudulent acts or omissions of a Participant

or a provider, or if it is determined that more than the correct amount has been paid by AmeriHealth Administrators, AmeriHealth Administrators will make a diligent attempt to recover the payment made to such ineligible person or overpayment, but AmeriHealth Administrators will not be required to initiate litigation for purposes of payment recovery.

2.7 Recoveries.

1. Whenever amounts recovered by AmeriHealth Administrators can be associated with a claim paid under the Benefit Program and result in a paid claim adjustment, Plan Sponsor will receive a credit against future paid claims costs in the amount of the recovery, less the Recovery Fee[1] that is retained by AmeriHealth Administrators. AmeriHealth Administrators warrants that it will exercise reasonable efforts to determine whether a recovery is associated with a claim under the Benefit Program and adjust applicable paid claims. Nevertheless, Plan Sponsor understands and agrees that not all recoveries can be reasonably tied to a particular paid claim resulting in its adjustment; for example, when a recovery arises from a settlement based upon AmeriHealth Administrators' entire book of business with insufficient information to determine individual paid claim adjustments. In such settlements, AmeriHealth Administrators will retain the Recovery Fee associated with the respective recovery. AmeriHealth Administrators will make available details of such settlements and on an annual basis upon written request.

2. Except as otherwise provided in this Agreement, AmeriHealth Administrators has no obligation to pursue a recovery from providers or manufacturers of health care products or services on behalf of the Plan Sponsor for causes of action arising out of a product/service defect (including, but not limited to, fitness for use or product recalls), violations of antitrust law, fraud, and claims relating to fraud (including claims under the Racketeering Influenced and Corrupt Organizations Act).

2.8 Preparation of Materials.

AmeriHealth Administrators shall provide the Plan Sponsor with the materials listed in Part III of Exhibit B to this Contract.

2.9 Clinical Services.

AmeriHealth Administrators will provide the Plan Sponsor with Clinical Services as described in Exhibit F to this Contract. AmeriHealth Administrators' compensation for its services under this section shall be as set forth in Exhibit D to this Contract, under the listing "Utilization Management Fee".

2.10 Advice.

AmeriHealth Administrators shall, where it deems appropriate or upon the reasonable request of the Plan Sponsor, provide the Plan Sponsor with advice and information concerning the matters listed in Part IV of Exhibit B to this Contract.

2.11 Certification of Eligibility.

AmeriHealth Administrators shall, with the assistance of the Plan Sponsor, certify as to the eligibility of a Participant in the Plan when necessary for such Participant to receive services covered under the Plan.

2.12 COBRA.

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1 No Recovery Fees will be charged to Plan Sponsor in the event of overpayments being applied in error by AmeriHealth Administrators.

AmeriHealth Administrators shall not provide administrative services for compliance with the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 except as described in Exhibit C to this Contract, which is attached hereto and incorporated herein by reference.

2.13 Miscellaneous.

In addition to the services specified in Sections 2.3 - 2.11, AmeriHealth Administrators may perform any and all optional services set forth in Exhibit C to this Contract.

2.14 Access to Files.

The Plan Sponsor shall have the right, upon reasonable request, to inspect AmeriHealth Administrators' records regarding the financial condition of the Account, payments from the Account, Claims, Determinations, Participants, and any of the optional services set forth in Exhibit C to this Contract provided with respect to the Plan under this Contract. This right to file access shall be subject to AmeriHealth Administrators' policy regarding external audits attached as Exhibit E to this Contract.

2.15 Responsibility of AmeriHealth Administrators

AmeriHealth Administrators shall make reasonable efforts to secure the reimbursement of funds disbursed from the account in error, however AmeriHealth Administrators shall itself only be liable for amounts paid or withdrawn from the Account by reason of the willful misconduct or gross negligence of any of its officers or employees. AmeriHealth Administrators shall bond each of its officers and employees who handle funds held in the Account in an amount not less than is indicated in Exhibit I.

AmeriHealth Administrators shall be entitled to rely upon representations made to it with respect to the Plan and any Participants thereunder by the President, Board of Directors, or Board of Trustees of the Plan Sponsor and any other officer or employee authorized in writing to make such representations to AmeriHealth Administrators by the President, Board of Directors, or Board of Trustees of the Plan Sponsor.

AmeriHealth Administrators shall not be responsible for investigating whether a Claim is payable, primarily or otherwise, under any plan or program other than the Plan, except for any plan or program identified as covering the Participant making such Claim in information provided to AmeriHealth Administrators by the Plan Sponsor and the Participant's own statements.

AmeriHealth Administrators shall not be responsible for pursuing the investigation of fraudulent or potentially fraudulent Claims, nor shall AmeriHealth Administrators be liable for any Claim payment which results from the fraudulent act or omission of any Participant or provider.

AmeriHealth Administrators shall not be responsible for conducting any utilization review other than that set forth in Exhibit F to this Contract or elsewhere in this Contract.

With the exception of those actions that fall within the terms of Section 8.2. (Defense of Claims Litigation), AmeriHealth Administrators shall not be required to engage in any litigation or arbitration prior to the Plan Sponsor's agreement to indemnify AmeriHealth Administrators against the costs, and expenses that it might incur relating to such litigation.

2.16 Provision of Health Care

The Plan Sponsor acknowledges that: (i) AmeriHealth Administrators does not render medical services or care to Participants; (ii) AmeriHealth Administrators is not responsible for the provision of health care by

health care providers; and (iii) network health care providers are independent contractors and are not the agents or employees of AmeriHealth Administrators.

2.17 Medicare Reporting.

AmeriHealth Administrators will comply with reporting requirements to the Centers for Medicare and Medicaid Services (CMS), as required by the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 as they apply to AHA. Plan Sponsor agrees to timely provide AmeriHealth Administrators with all data that AmeriHealth Administrators requests, and in an agreed upon format, to enable both parties to comply with the reporting requirements. AmeriHealth Administrators shall not be responsible for any noncompliance penalties incurred in connection with the Medicare reporting requirement

**Section III. Plan Sponsor's Obligations and Duties.**

3.1 Plan Document.

The Plan Sponsor shall furnish AmeriHealth Administrators with a detailed description of the Plan and any and all amendments thereto, including all materials as shall be necessary to maintain the Plan in compliance with section 402 of ERISA and applicable provisions of the Internal Revenue Code, as well as all administrative manuals for the Plan. The Plan Sponsor shall provide notice of any change in benefits provided under the Plan prior to the date on which such change becomes effective. Retroactive benefit changes will only be accepted during the first fifteen (15) calendar days from the effective date of the Contract. All other benefit changes will require sixty (60) days' notice prior to the effective date of the change. If AmeriHealth Administrators prepares the benefit booklets AmeriHealth Administrators will provide the Plan Sponsor with a draft benefit booklet and will consider the draft benefit booklet to be final, and the terms and conditions set forth in the benefit booklet will become binding on Plan Sponsor and Plan if not approved by Plan Sponsor within fourteen (14) calendar days of delivery to the Plan Sponsor.

3.2 Plan Administrator and Named Fiduciary

The Plan Sponsor or its delegate shall be the plan administrator for purposes of section 3(16)(A) of ERISA and section 414(g) of the Internal Revenue Code. The Plan Sponsor or its delegate, and not AmeriHealth Administrators, shall be the named claims fiduciary for purposes of section 402(a) of ERISA. The Plan Sponsor shall be responsible for complying with all reporting and disclosure requirements of Title I of ERISA, and the Internal Revenue Code. As the claims fiduciary, the Plan Sponsor retains the final discretionary authority regarding all decisions related to benefit determinations under the Benefit Program including, but not limited to, eligibility of Participant to receive benefits, payment of claims for services under the Benefit Program, the amount of payment due for claims, and Participant appeals. For purposes of initial benefit determinations and coordination of final benefit determinations with the Plan Sponsor, the Plan Sponsor will comply with the administrative policies of AmeriHealth Administrators regarding continuity of services involving concurrent review determinations including, but not limited to, behavioral health services. With the exclusive assumption of claims fiduciary responsibility, the Plan Sponsor shall have the authority to overturn or otherwise amend benefit determinations made by AmeriHealth Administrators. The Plan Sponsor also retains the final discretionary authority to determine who is eligible to participate in the Benefit Program and all other authority not specifically and expressly given to AmeriHealth Administrators in the Agreement.

Except as otherwise stated in this Agreement, the Plan Sponsor has sole responsibility for, and AmeriHealth Administrators has no liability whatever regarding, determining the applicability of, applying,

administering, or undertaking any duties or responsibilities associated with continuation or conversion rights or obligations under state or other federal laws.

3.3 Information to AmeriHealth Administrators.

The Plan Sponsor shall provide AmeriHealth Administrators with all of the information required by AmeriHealth Administrators regarding the eligibility of Participants in the Plan and shall notify AmeriHealth Administrators on at least a monthly basis of all changes in participation in the Plan, whether by reason of termination, change in job classification, or otherwise. The Plan Sponsor shall furnish AmeriHealth Administrators with any other information that AmeriHealth Administrators reasonably requests for purposes of performing its claims processing and other administrative functions.

3.4 Deposits to Account.

The Plan Sponsor shall take all steps necessary to see that checks written by AmeriHealth Administrators on the Account will be honored.

3.5 Fees and Expenses.

The Plan Sponsor shall pay AmeriHealth Administrators for the services rendered pursuant to this Contract in accordance with the terms set forth in Exhibit D to this Contract, which is attached hereto and incorporated herein by reference. AmeriHealth Administrators reserves the authority to adjust the fee set forth in Exhibit D to this Contract as of the effective date of any amendment to or change in benefits provided under the Plan. If Plan changes or changes in applicable law result in additional material costs for AHA, AHA will not be responsible for implementing such changes absent mutual agreement on the additional costs to be reimbursed to AHA in respect thereof.

. Amounts due AmeriHealth Administrators hereunder shall be charged against the Plan, and to the extent not paid by the Plan Sponsor, shall be paid by the Plan.

3.6 Plan Responsibility.

The Plan Sponsor shall have the responsibility for the Plan. AmeriHealth Administrators will act solely as an administrator to process and pay Claims with reasonable accuracy and utilizing due diligence as may be expected from an experienced benefit plan administrator. If it is determined that any benefit payment has been made to or on behalf of an ineligible individual, including payments made as a result of the fraudulent acts or omissions of a Participant or a provider, or if it is determined that more than the correct amount has been paid by AmeriHealth Administrators, AmeriHealth Administrators will make a diligent attempt to recover the payment made to such ineligible person or overpayment, but AmeriHealth Administrators will not be required to initiate litigation for purposes of payment recovery. AmeriHealth Administrators shall, however, notify the Plan Sponsor of such overpayment or payment to ineligible person as soon as reasonably possible following discovery of any such improper payment.

3.7 Subrogation and Other Third-Party Recovery. Plan Sponsor shall assist AmeriHealth Administrators in its subrogation and other third-party recovery efforts (hereinafter, collectively referred to as "Subrogation") by providing AmeriHealth Administrators (or its Subrogation management firm) with requested information and documentation. Plan Sponsor further represents and warrants that the Plan and/or Summary Plan Description provide for rights of subrogation and third-party recovery.

3.8 Subrogation, Coordination of Benefits and Other Claim Payment Recovery Services. AmeriHealth Administrators will provide appropriate subrogation, coordination of benefits and other claim payment recovery services. In connection with AmeriHealth Administrators' obligations under this Paragraph, the Plan Sponsor represents that the Benefit Program is a self-funded employee benefit plan, and subject to ERISA, if applicable, and authorizes AmeriHealth Administrators to advise third parties of this representation without liability to AmeriHealth Administrators.

i. AmeriHealth Administrators works with vendors to provide comprehensive subrogation and recovery services. A percentage of the amount collected, received and/or recovered ("Recovery Fee") by AmeriHealth Administrators, or the vendor of AmeriHealth Administrators on behalf of AmeriHealth Administrators, may be retained by AmeriHealth Administrators. This Recovery Fee is for AmeriHealth Administrators' vendor costs and internal administrative costs related to subrogation, coordination of benefits and other claim payment recovery services. If no recovery is made, there is no charge to the Plan Sponsor for these services. The actual percentage for the Recovery Fee is set forth in Exhibit D to this Agreement.

ii. Subrogation. Unless otherwise directed by a Plan Sponsor, AmeriHealth Administrators is authorized by the Plan Sponsor to provide subrogation services for the Plan Sponsor. AmeriHealth Administrators may engage the services of subrogation vendors to assist with the identification and management of subrogation cases.

iii. Coordination of Benefits.

- Unless otherwise specified by the Plan Sponsor, AmeriHealth Administrators will follow the coordination provisions of the benefit booklet, as may be amended from time to time.

- AmeriHealth Administrators will work with state Medicaid agencies to the extent permitted by law by responding to data matching requests and making appropriate reimbursements based upon available paid claims information within its possession

- To the extent that AmeriHealth Administrators administers the payment of prescription drugs under this Agreement, Plan Sponsor acknowledges that coordination of benefits is not performed on such claims.

- AmeriHealth Administrators and its coordination of benefits and subrogation vendor(s) will undertake reasonable efforts on behalf of the Plan Sponsor to recover amounts from other accident and injury carriers (e.g., workers' compensation, automobile accident and other accident or injury insurers) to the extent insurance issued by such insurers were primarily liable for paid claims arising from an illness or injury suffered by a Participant.

iv. Other Claim Payment Recovery Services. AmeriHealth Administrators may engage the services of certain vendors for other claim payment recovery services.

**Section IV. Termination of the Contract.**

4.1 Plan Sponsor's Right to Terminate.

1. The Plan Sponsor may terminate this Contract or just the pharmacy benefit management services ("PBM Services") at the end of the initial Term or any renewal Term of Contract (as described below) by giving not less than 90 days' written notice of intention to terminate delivered to AmeriHealth Administrators prior to the end of the current Term. If Plan Sponsor terminates this Contract or the PBM Services with less than 90 days' written notice, Plan Sponsor shall pay the setup or other up-front costs that AmeriHealth Administrators actually spent for the succeeding Term. Notwithstanding the 90 days' written notice, the Plan Sponsor may also terminate this Contract or PBM Services, for the succeeding Term, during the 30-day notice period if any rate increase has been given for the succeeding Term. In the event of termination of this Contract or PBM Services, the Plan Sponsor shall continue to make payments for Claims for Covered Services incurred prior to termination. If a Plan Sponsor terminates PBM services only, then any bundling credit that was priced into the contract will become void on the effective date of termination.

2. The Plan Sponsor may terminate this Contract, upon fourteen (14) days' prior written notice to AmeriHealth Administrators, if, after giving AmeriHealth Administrators thirty (30) calendar days to cure any deficiency in AmeriHealth Administrators' performance of the obligations set forth in this Contract, AmeriHealth Administrators does not cure the deficiency.

3. **CONFLICT of INTEREST.** This contract may terminate this contract in accordance with the above provisions by the Executive Committee/FUND Commissioners if AmeriHealth Administrators fails to disclose an actual or potential conflict of interest as defined in the FUND's Bylaws, or in N.J.S.A. 40A: 9-22.1 et. seq. (the "Local Government Ethics Laws").

4.2 AmeriHealth Administrators' Right to Terminate.

1. AmeriHealth Administrators may terminate this Contract at the end of any Term of Contract by giving no less than 90 calendar days written "Notice of Intention To Terminate" delivered to the Plan Sponsor prior to the end of such Term.
2. Delinquency for Administrative Fees: If after fourteen ("14") calendar days from the due date of the initial invoice, the Plan Sponsor is delinquent in the remittance of all administrative fees, AmeriHealth Administrators may immediately terminate the contract.
3. Delinquency for Claims Funding: If after fourteen (14) calendar days from the due date of the initial invoice, the Plan Sponsor is delinquent in the remittance of all claims funding, AmeriHealth Administrators may immediately terminate this Contract.
4. Repeated Delinquency: AmeriHealth Administrators also reserves the right to terminate this Contract at any time for reason of repeated delinquencies of fees.

4.3 General Rights to Terminate.

1. Either party may terminate this Contract upon written notice to the other party in the event that any of the following occur to the party requesting termination:
   a. the insolvency of the party,

b. the appointment of a receiver or a trustee for the party,
c. an assignment for the benefit of creditors of the party, or
d. the commencement of any proceedings under bankruptcy or insolvency laws by or against the party.

2. This Contract will terminate immediately upon the termination, lapse, or cancellation of the Benefit Program.

4.4 Rights and Obligations of Parties Upon Termination of Contract. Upon termination of this Contract, or at the end of the Run-out period (see Exhibit D) if Run-out administration is elected, AmeriHealth Administrators shall deliver to the Plan, or to the Plan Sponsor if there is no trust under the Plan, any amounts held in the Account (other than interest due AmeriHealth Administrators) and an amount sufficient to cover uncashed checks.

**Section V. Term and Amendment of Contract.**

5.1 Term of Contract.

The term of this Contract shall be 36 MONTHS measured from 1/1/19. Upon completion of the above term, AmeriHealth Administrators may, upon mutual consent, amend the fee schedule for the new term by providing the Plan Sponsor with at least 30 days' written notice prior to the beginning of such term.

5.2 Amendment of Contract.

Except as provided elsewhere in this Contract, the Plan Sponsor and AmeriHealth Administrators may amend the Contract only by their mutual consent.

**Section VI. Provider Networks and Discount Arrangements.**

6.1 For services by a Facility or Physician Provider that participate in networks maintained by AmeriHealth Administrators or its affiliates, Covered Expenses are calculated by applying a network discount to the provider's or facility's standard billing charge. The Plan Sponsor's funding obligation will include the Covered Expense amount plus the Access Fee minus the Participant's obligations (deductible, copay, coinsurance).

6.2 For services by a Facility or Physician Provider that participates in a provider network that is not an affiliated Network but that is identified as a "Directed Network," Covered Expense is the amount paid to the Facility or Physician Provider for covered services. If the Plan Sponsor provides notice to AmeriHealth Administrators to provide the Plan's Participants with access to a Directed Network, the Plan Sponsor agrees to pay AmeriHealth Administrators a PPO Network Access Fee as described in Exhibit D. AmeriHealth Administrators will be solely responsible for payment of any Network Access Fee to the Directed Network in connection with such discounts.

6.3 For a Claim from a Facility Provider or Physician Provider who does not participate in AmeriHealth Administrators' PPN but who participates in a facility and/or physician network through which AmeriHealth Administrators obtains a reduction in the amount charged by a Facility Provider or Physician Provider's for the Claim, Covered Expense is the amount paid by AmeriHealth Administrators to the Facility Provider or Physician Provider plus 25% of the reduction to the amount charged by the a Facility Provider or Physician Provider in the Claim.

6.5 For a claim from a Preferred Facility Provider or a Preferred Professional Provider that participates in AmeriHealth Administrator's Integrated Provider Performance Incentive Program (IPPIP):

a. Covered Expense may generally include actual incentive payments and/or projected incentives that AmeriHealth Administrators anticipates it may pay to Preferred Facility Providers and/or Preferred Professional Providers pursuant to AmeriHealth Administrators' agreements with Preferred Facility Providers and/or Preferred Professional Providers.

Specifically, if a Preferred Facility Provider and/or Preferred Professional Provider participate in AmeriHealth Administrators' provider performance incentive program (IPPIP), the Covered Expense charged to the Plan Sponsor will include a projected percentage of the incentive payment that AmeriHealth Administrators anticipates it may pay to Preferred Facility Providers or Preferred Professional Providers that participate in AmeriHealth Administrators' IPPIP.

The projected incentive payment that AmeriHealth Administrators will charge the Plan Sponsor is based upon a projected percentage of the total eligible incentive payment AmeriHealth Administrators believes will be paid to the Provider at the completion of the Provider's annual measurement period. The calculation of this projected percentage will be based upon generally accepted actuarial principles so that the projected incentive payments charged to the Plan Sponsor over the course of the measurement period will be a projected equivalent to the total actual payment that AmeriHealth Administrators makes to such Provider at the end of the measurement period. This projected percentage will be reviewed by AmeriHealth Administrators at least quarterly during the measurement year to determine if the Preferred Facility Providers and Preferred Professional Providers, who are eligible for incentive payments, are meeting AmeriHealth Administrators' IPPIP program standards and/or metrics for receipt of incentive payments. This projected percentage may be prospectively decreased or increased to reflect the Preferred Facility Providers and Preferred Professional Providers' performance to-date as well as the Providers' anticipated performance for the annual measurement period under the Provider's agreement with AmeriHealth Administrators. AmeriHealth Administrators' quarterly review will be of the Provider's performance for AmeriHealth Administrators' commercial business collectively and will not be plan sponsor-specific. The IPPIP is designed to be revenue neutral to AmeriHealth Administrators.

In the event that the Preferred Facility Provider or the Preferred Professional Provider satisfies all requirements of the IPPIP such that the incentives payments by AmeriHealth Administrators to the Preferred Providers is greater than the projected percentage of incentive payments charged by AmeriHealth Administrators to the Plan Sponsor, AmeriHealth Administrators will be solely responsible for the payment of the amount of the provider incentive payment which is greater than the projected percentage of provider incentive payment charged by AmeriHealth Administrators to the Plan Sponsor.

In the event that the Preferred Facility Provider or the Preferred Professional Provider does not satisfy the requirements of the IPPIP, AmeriHealth Administrators will retain for its sole use that portion of the projected percentage of provider incentive payments charged to the Plan Sponsor by AmeriHealth Administrators which was not paid by AmeriHealth Administrators

as part of the incentive to the Preferred Facility Provider and/or the Preferred Professional Provider.

For claims for Preferred Facility Providers or Preferred Professional Provider that participate in AmeriHealth Administrators' incentive programs, including the IPPIP, Subscriber's Share will be calculated based upon Covered Expense, except Subscriber's Share will not include projected incentives that AmeriHealth Administrators anticipates it may pay to Preferred Facility Providers and/or Preferred Professional Providers pursuant to AmeriHealth Administrators' agreements with Preferred Facility Providers and/or Preferred Participating Providers.

**Section VII. Miscellaneous.**

7.1 Successors. This Contract shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, personal representative, successors and assigns. Neither Party may assign or subcontract any or all of its rights or obligations under this Agreement without the other Party's prior written consent, such consent not to be unreasonably withheld or delayed. Notwithstanding the immediately preceding, AHA may assign or subcontract any or all of its rights or obligations under this Agreement to a subsidiary or affiliate of AHA, or pursuant to a company reorganization undertaken not as a result of insolvency or filing of a bankruptcy petition.

7.2 Entire Contract. This Contract contains the entire agreement among the parties relating to the subject matter hereof, and may not be altered, amended, modified or supplemented except by a writing signed by the parties hereto, provided that AmeriHealth Administrators reserves the authority to amend the fee schedule as provided herein.

7.3 Notices. Any notice, material, or information that AmeriHealth Administrators is required to provide to the Plan Sponsor under this Contract shall be deemed to have been given to the Plan Sponsor three days after mailing by regular or certified mail, postage prepaid, to the following address:

Southern Coastal Regional Employee Benefits Fund
C/O PERMA Risk Management Services
9 Campus Drive, Suite 216
Parsippany, NJ 07054
Attn; Executive Director

7.4 No Contract of Insurance. Nothing in this Contract shall be construed as a contract of insurance. AmeriHealth Administrators shall be under no obligation to pay from its own funds or insure any benefits payable under the Plan. Any reference to an obligation of AmeriHealth Administrators to "pay" an amount hereunder shall refer to its obligation to pay on behalf of the Plan from the Account, and shall not imply any liability on AmeriHealth Administrators with respect to its own funds.

7.5 Governing Law and Dispute Resolution. This Contract shall be governed by and construed and enforced in accordance with the laws of the state of New Jersey to the extent not superseded by ERISA.

a. If any Dispute arises between the parties in connection with this Agreement (a "Dispute"), the

parties shall first attempt to resolve such Dispute by negotiation and consultation between themselves. In the event that the Dispute is not resolved on an informal basis within 30 days after one party notifies the other that a Dispute exists, the Dispute shall be presented to the executives of each party who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Agreement.

b. If a Dispute has not been resolved by the parties within 10 business days after each party becomes aware of the potential Dispute (or a longer period, as agreed to by the parties), the Dispute may be settled by arbitration. The arbitration will be conducted in accordance with the procedures in this document and the Arbitration Rules for Professional Accounting and Related Services Disputes of the AAA ("AAA RULES"). In the event of a conflict, the provisions of this document will control.

c. The arbitration will be conducted before a panel of three arbitrators, regardless of the size of the Dispute, to be selected as provided in the AAA Rules. Any issue concerning the extent to which any Dispute is subject to arbitration, or concerning the applicability, interpretation, or enforceability of these procedures, including any contention that all or part of these procedures are invalid or unenforceable, shall be governed by the Federal Arbitration Act and resolved by the arbitrators. No potential arbitrator may serve on the panel unless he or she has agreed in writing to abide and be bound by these procedures.

d. Unless provided otherwise in this Agreement, the arbitrators may not award non-monetary or equitable relief of any sort. They shall have no power to award (i) damages inconsistent with the Agreement or (ii) punitive damages or any other damages not measured by the prevailing party's actual damages, and the parties expressly waive their right to obtain such damages in arbitration or in any other forum. In no event, even if any other portion of these provisions is held to be invalid or unenforceable, shall the arbitrators have power to make an award or impose a remedy that could not be made or imposed by a court deciding the matter in the same jurisdiction.

e. No discovery will be permitted in connection with the arbitration unless it is expressly authorized by the arbitration panel upon a showing of substantial need by the party seeking discovery.

f. All aspects of the arbitration shall be treated as confidential. Neither the parties nor the arbitrators may disclose the existence, content or results of the arbitration, except as necessary to comply with legal or regulatory requirements. Before making any such disclosure, a party shall give written notice to all other parties and shall afford such parties a reasonable opportunity to protect their interests.

g. The result of the arbitration will be binding on the parties, and judgment on the arbitrators' award may be entered in any court having jurisdiction.

7.6 Set-off. If any undisputed financial consideration due AmeriHealth Administrators under this Agreement, including, but not limited to, amounts to be paid for administering the Benefit Program and amounts to be reimbursed for Covered Services, is unpaid by the Plan Sponsor 90 days after first being due, AmeriHealth Administrators may assign its rights to such consideration to any parent, subsidiary, or affiliate company of AmeriHealth Administrators ("AmeriHealth Administrators Affiliate"). The AmeriHealth Administrators Affiliate to which AmeriHealth Administrators assigns such rights may collect the consideration due by any legal means, including set-off against amounts due to the Plan Sponsor from the AmeriHealth Administrators Affiliate under any contractual arrangement between the Plan Sponsor and the AmeriHealth Administrators Affiliate. Similarly, if AmeriHealth Administrators is assigned the right to collect amounts due any AmeriHealth Administrators Affiliate under any contractual arrangement between the Plan Sponsor and the AmeriHealth Administrators Affiliate, AmeriHealth Administrators may collect such amounts from the Plan Sponsor by any legal means, including set-off against amounts due to the Plan Sponsor from

AmeriHealth Administrators under this Agreement.

7.7 Severability. If any provision of this Contract is held to be invalid or unenforceable for any reason, such provision shall be ineffective to the extent of such invalidity or unenforceability without invalidating the remaining portions hereof.

7.8 Acceptance. The Plan Sponsor may accept this Contract either by having an authorized individual or officer sign or by making required payment with the intent of accepting the contract, to AmeriHealth Administrators. Such acceptance renders all terms and provisions herein binding on the Plan Sponsor and AmeriHealth Administrators.

7.9 Affirmative Action. AmeriHealth Administrators has established a policy to ensure all qualified individuals are afforded equal employment opportunities in accordance with policies set forth in Exhibit G.

7.10 New Jersey Law. AmeriHealth Administrators is compliant with business registration requirements and applicable laws of the State of New Jersey as specified in Exhibit I.

7.11 Insurance. Except as provided elsewhere herein, AmeriHealth Administrators shall provide, at its own cost and expense, proof of insurance as described in Exhibit J.

7.12 Table of Exhibits. The following Exhibits are attached to and made a part of this contract unless otherwise indicated.

Exhibit A – Plan Document
Exhibit B – Administrative and Claim Services
Exhibit C – Optional Services
Exhibit D – Fees
Exhibit E – AmeriHealth Administrators' Audit Policy
Exhibit F – Clinical Services
Exhibit G – Affirmative Action
Exhibit H– New Jersey Law
Exhibit I - Insurance

**Section VIII. Indemnification**

8.1. Indemnification

a. AmeriHealth Administrators' Obligations.

1. With the exception of those actions that fall within the terms of Section 8.2 Defense of Claims Litigation, below, AmeriHealth Administrators shall indemnify the Plan, the Plan Sponsor and its officers, directors, employees (acting in the course of their employment, but not as Participants), agents, and subcontractors for that portion of any claim, lawsuit, action, loss, liability, damage, expense, judgment, settlement, cost, interest, fine or obligation (including attorney fees) that was caused directly by AmeriHealth Administrators' willful misconduct, criminal conduct, material breach of this Contract,

fraud, or breach of its duty under federal or state law that relates to or arises out of the claims payment and benefit administration services provided by AmeriHealth Administrators under this Contract.

2. The indemnification obligations under this Section 8.1(a) do not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by, or resulting from, the acts or omissions of health care providers, whether network or non-network, with respect to Participants, including, but not limited to, fraud, negligence or malpractice, or to the fraudulent acts or omissions of Participants.

3. The indemnification obligations under this Section 8.1(a) shall not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by AmeriHealth Administrators' act or omission undertaken at the written direction of the Plan Sponsor (other than the services expressly set forth in this Contract).

b. Plan/Plan Sponsor's Obligations.

1. The Plan and/or Plan Sponsor shall indemnify AmeriHealth Administrators and its affiliated and parent companies, and their respective officers, directors, employees, agents, and subcontractors for that portion of any loss, liability, damage, expense, judgment, settlement, cost, interest, fine or obligation (including attorney fees):

(i) which was caused directly by the Plan Sponsor's willful misconduct, criminal conduct, material breach of this Contract, fraud or breach of fiduciary duty related to or arising out of the services provided by the Plan Sponsor under this Contract or the Plan;

(ii) arising out of or resulting from Southern Coastal Regional Employee Benefits Fund's role as employer, Plan Administrator or Plan Sponsor, including its acts and/or omissions;

(iii) arising out of or resulting from acts and/or omissions of any other fiduciaries under the Plan;

(iv) resulting from taxes, surcharges, assessments and penalties incurred by AmeriHealth Administrators by reason of benefit payments made or services performed hereunder, and any interest thereon;

(v) in connection with the release or transfer of Participants individually identifiable information to the Plan Sponsor, the Plan, or a third party designated by the Plan or Plan Sponsor, or the use or further disclosure of such information by the Plan Sponsor, the Plan, or such third party; and/or

(vi) resulting from or arising out of claims, demands or lawsuits brought against AmeriHealth Administrators in connection with the services provided under this Contract, except as otherwise provided in this Contract.

2. The indemnification obligations under this Section 8.1(b) shall not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by the Plan Sponsor's act or omission undertaken at the written direction of AmeriHealth Administrators.

c. The party seeking to be indemnified under Section 8.1(a) or 8.1(b), above must notify the other party within a reasonable amount of time (not to exceed sixty (60) days) in writing of its receipt of the summons or suit to which it claims such indemnification applies. Failure to so notify the indemnifying party within this sixty (60) day period shall be deemed a waiver of all fees, costs and expenses incurred prior to the date of the

notice. The parties will cooperate with regard to any claim or action brought by a third party against either party under this Contract. Neither party shall settle any such claim or action against it without the prior written consent of the indemnifying party, which consent shall not be unreasonably withheld.

d. It is understood that as the named claims fiduciary, AmeriHealth Administrators may be deemed a co-fiduciary of other fiduciaries of the Plan. ERISA requires that, among other things, co-fiduciaries disclose information that they knew, or should have known, regarding another fiduciary's breach of its fiduciary obligations to the Plan. The parties acknowledge that, because AmeriHealth Administrators' involvement in the administration of the Plan is limited by the terms of this Contract, AmeriHealth Administrators will not be in a position to know of, monitor, and/or investigate the activities of other Plan fiduciaries. Therefore, the Plan and Plan Sponsor agree to hold AmeriHealth Administrators harmless using, if necessary, funds that are not Plan assets, from and against any and all liability that might attach due to AmeriHealth Administrators' failure to disclose information about the breach of the obligations of other co-fiduciaries of the Plan.

e. The indemnification obligations under this Section 8.1 shall survive the expiration, termination, or cancellation of this Contract.

8.2 Defense of Claims Litigation. In the event of any legal action involving claims for benefits due under the Plan, AmeriHealth Administrators shall have the right to undertake the sole defense of such suit and have sole discretion over the resolution of such suit or action. If the Plan Sponsor is also named as a party to the lawsuit, AmeriHealth Administrators will defend the Plan Sponsor provided that such suit relates solely to AmeriHealth Administrators' provision of, or failure to provide, claims payment and benefit administration services under this Contract, and there is no conflict of interest between AmeriHealth Administrators and the Plan Sponsor. In all instances, the Plan Sponsor agrees to pay the amount of benefits due under the Plan which may be included in any judgment or settlement in such suit, but shall not be liable for any other part of such judgment or settlement, except to the extent provided in Section 8.1(b), above.

**IN WITNESS WHEREOF, this Contract is executed in duplicate the day and year first above written.**

| | |
|---|---|
| **SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFIT FUND** | **AMERIHEALTH ADMINISTRATORS, INC.** |
| **By:** _____ | **By:** _____ |
| **Name:** _____ | **Name:** Michael W. Sullivan |
| **Title:** _____ | **Title:** President & CEO |
| **Date:** _____ | **Date:** _____ |

**EXHIBIT A**

**(PLAN DOCUMENT)**

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## EXHIBIT B

Administrative and Claim Services

**I. <u>Administration</u>.** AmeriHealth Administrators shall provide administrative services to the Plan Sponsor as follows:

1. Eligibility maintenance.
2. Monthly eligibility listings.
3. Billing services by:
    a. Location
    b. Employee
    c. Line of coverage/benefit
    d. Administrative expenses
    e. Insurance premiums
4. Insurance carrier premium calculations and payment.
5. Explanation of benefit and check dispersal with postage.
6. 1099 Plan provider printing and dispersal with postage.
7. AmeriHealth Administrators shall make available a toll free telephone number to the Plan Sponsor and Participants for questions about administration and claim services.
8. Electronic Benefit Booklet[2,3]

**II. <u>Claim Services</u>.** AmeriHealth Administrators shall process eligible claims in accordance with the following procedures:

To the extent applicable and subject to Section 3.3, AmeriHealth Administrators will have the authority to exercise

[2] Upon Plan Sponsor's request, AmeriHealth Administrators will draft an electronic Benefit Booklet. This electronic Benefit Booklet will describe Plan Sponsor's medical plan based on information that Plan Sponsor provides to AmeriHealth Administrators. In preparing the electronic Benefit Booklet, AmeriHealth Administrators is acting only as a scrivener, not as a Plan Administrator. AmeriHealth Administrators assumes no fiduciary responsibilities under ERISA, and, by drafting the electronic Benefit Booklet, AmeriHealth Administrators is not providing legal advice with respect to the requirements of ERISA. Plan Sponsor should carefully review all of the information provided to AmeriHealth Administrators for inclusion in the electronic Benefit Booklet, before submitting the information to AmeriHealth Administrators for production, to ensure that it is accurate and meets the requirements of ERISA. Plan Sponsor should also review the information provided to AmeriHealth Administrators for inclusion in the electronic Benefit Booklet to ensure that it accurately reflects the benefits, terms, and conditions contained in Plan Sponsor's Summary Plan Description (SPD). Plan Sponsor should have its legal counsel review the electronic Benefit Booklet and provide a copy of its SPD and the electronic Benefit Booklet to its Stop-Loss carrier.

[3] If benefit booklet preparation is not requested, Plan Sponsor will be responsible for the preparation and provision of benefit booklets to its plan members. Plan Sponsor will be responsible for providing a copy of the benefit booklet.

discretion to:

1. construe those terms of the Plan which are related to the health benefits to be administered by AmeriHealth Administrators under the Contract, and to make initial benefit Determinations on behalf of the Plan Sponsor;

2. administer standard first level Participants' appeals of Determinations under the Plan;

3. pay benefits, using funds from the Account, in accordance with Claim Determinations; and, to do all other things necessary to fulfill its obligations under this Contract.

4. in accordance with N.J.A.C. 11:15-3.26(c), AmeriHealth Administrators shall (unless the Plan Sponsor otherwise permits) handle to conclusion, process and pay to providers, or, if applicable, Participants, all eligible claims for Covered Services that are incurred by Participants while this Agreement is in effect, according to the terms of the Benefit Program.

The duties performed by AmeriHealth Administrators under this Section II do not alter or affect the Plan Sponsor's rights under Section 3.3. AmeriHealth Administrators has no responsibility or liability for the duties and obligations of the Plan Administrator.

**III. Materials.** AmeriHealth Administrators shall provide the Plan Sponsor with the following materials.

1. Identification cards for employees and their dependents who are eligible to receive coverage and benefits under the Plan.

2. AmeriHealth Administrators claim service checks for payment of eligible claims made by Participants and eligible Plan providers.

3. AmeriHealth Administrators explanation of benefit forms for consideration of non-payment claims of eligible Participants.

4. AmeriHealth Administrators enrollment cards for employees and their dependents, who are eligible, to complete in order to receive coverage and benefits under the Plan.

5. A standard package of weekly, monthly and annual reports of coverage and benefit payments made to Participants and providers as well as fees and expenses paid from the Plan.

6. Participant claim forms.

**IV. Advice to Plan Sponsor.** AmeriHealth Administrators shall provide advice to the Plan Sponsor in accordance with Section 2.10 on the following matters:

1. Design features, funding alternatives, administrative procedures and cost savings mechanisms pertinent to the operation of the Plan. Advice with respect to funding alternatives shall include issues regarding the frequency of payments from Plan Sponsor to AmeriHealth Administrators and deposit requirements but shall not include Underwriting/Actuarial, tax, accounting or legal services.

2. Completion and submission of reports, forms or materials as may be required to comply with the reporting and disclosure obligations under applicable state or federal laws.

3. AmeriHealth Administrators assumes no fiduciary responsibilities under ERISA, and, by providing services stated in Sections 2.9 and Exhibit B (IV (1) and (2)) above, AmeriHealth Administrators is not providing legal advice with respect to the requirements of ERISA or any other federal or state laws.

**AmeriHealth Administrators' compensation for Administration, Claim Services, Materials, and Advice to the Plan Sponsor shall be as shown in Exhibit D attached to this Contract, under the listing "Administration and Claims Service Fee."**

## EXHIBIT C

Optional Services

### I. Utilization Review Procedures

AmeriHealth Administrators shall perform preadmission, concurrent and retrospective review of all facility admissions as requested by the Plan and the Plan Sponsor. Such services may include consultations with select physicians to review the attending physician's proposed treatment plans or practice patterns; coordination and facilitation of discharge planning; maintenance of a comparative data base of providers; and provision quarterly of summary of results. This overview process shall be directed towards the desired result of encouraging quality, cost efficient care while respecting the attending physicians' ultimate authority. AmeriHealth Administrators' compensation for its services under this section shall be as set forth in Exhibit D to the attached Contract, under the listing "Utilization Management Fee".

### II. Documentation/Underwriting/Actuarial Services

If requested by the Plan Sponsor, AmeriHealth Administrators may furnish for review by the Plan Sponsor's counsel, a sample document necessary for the establishment and maintenance of the Plan. The Plan Sponsor shall review and, upon advice of legal counsel, adopt such document or take such other action, as it deems appropriate.

If requested by Plan Sponsor, AmeriHealth Administrators may review the documentation prepared by the Plan Sponsor for establishment and maintenance of the Plan. AmeriHealth Administrators will provide a written proposal setting forth the scope of such a review and the estimated time frame for completion. Provided however, that such review will not include Underwriting/Actuarial, tax, accounting or legal services.

If requested by the Plan Sponsor, AmeriHealth Administrators may also provide Underwriting/Actuarial services to the Plan Sponsor that the Plan Sponsor requests. If the Plan Sponsor requests such services, AmeriHealth Administrators will prepare a written proposal setting forth the scope of the services. Provided however, that such services will not include tax, accounting or legal services. Unless a written proposal is prepared at the request of the Plan Sponsor, AHA expects and assumes that the Plan Sponsor has obtained, or will obtain, advice and/or counsel from other persons or entities regarding Underwriting/Actuarial issues as needed and the Plan Sponsor is not relying on AHA for any such advice or counsel.

AmeriHealth Administrators' compensation for these services shall be as shown in Exhibit D to the attached Contract, under the listing "Documentation/Underwriting/Actuarial Services Fee".

## III. Stop Loss Coordination Services[4,5]

Plan Sponsor agrees to complete the stop loss information form yearly and provide the details needed for stop loss services. On a monthly basis, AmeriHealth Administrators shall provide the following information, if applicable, to the Plan Sponsor's Stop Loss Carrier:

- Early notifications (i.e., notice will be given if it is possible that the total claims paid plus the total amount charged for all pending claims will cause the claimant to exceed notification point);
- Fifty percent (50%) notifications;
- Notifications of specific excess claimants; and
- Aggregate spreadsheets which include census information.
- On the 1st and 16th of the month, the stop loss carrier will receive a large case notification report which reports on pre-certifications issued for trigger diagnoses and/or certain confinement criteria.
- High Dollar Claim notification will be provided upon receipt of high dollar claims with charges in excess of $25,000.

Upon notification of a specific excess claim, AmeriHealth Administrators will forward the following information, if applicable, to the Stop Loss Carrier:

| | | |
|---|---|---|
| Plan documents | COBRA information | Three (3) months prior to the end of a group's stop loss contract, |
| Subrogation information | COB information | |
| Proof of pre-certification | Enrollment documents | |
| Screen prints of claim payments | Provider bills | |

AmeriHealth Administrators will provide appropriate information to the Stop Loss Carrier to assist in the renewal process.

[4] Only claims received thirty (30) days prior to the end of the stop loss policy term are guaranteed to be paid and considered toward the stop loss contract term.

[5] AmeriHealth Administrator's audit policy also applies to aggregate accommodation stop loss audits.

## IV. Disease Management and Decision Support Program

("DMDS Program") is a program designed to provide health information to Eligible Members and providers and to support Eligible Members in making informed decisions about their health care. The DMDS Program is not intended to be used for utilization management activities, including, but not limited to, coverage determinations, or to determine the level or type of care to be provided to Eligible Members.

The disease management component of the DMDS Program is designed to identify Eligible Members who are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. The disease management component of the DMDS Program may employ education, health coaching, provider feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Eligible Members who have one or more of the following five chronic conditions: chronic obstructive pulmonary disease ("COPD"), congestive heart failure ("CHF"), diabetes, coronary artery disease ("CAD"), and asthma.

The decision support component of the DMDS Program identifies Eligible Members who may be facing significant treatment options and offers them information to assist in making informed collaborative decisions with their providers. Decision support also includes the availability of general health information, general health coaching, and provider information.

**EXHIBIT D**

**FEES AND TERMS**

**Effective Date: 1/1/2019** **36 Months-through 12/31/21**

**AmeriHealth Administrator's Administration and Claims Service Fee**

**Lives: 1241**[6]

**Administrative Fees**

| | |
|---|---|
| Medical/UM | $40.00 PEPM |
| Disease Management | $ 2.00[7] |
| Telemedicine | Included |
| Coastal Transparency Fee | $ 4.00 |
| Wellness Program Credit | ($1.25) |
| Stop Loss Coordination Fee | $ 0.00 |
| **Total Base Medical Fee** | $44.75 |

| | |
|---|---|
| PPO Access Fee | Amount AHA pays PPO access |
| Network Directories | Pass through cost from network, plus reasonable internal costs, if any |
| Recovery Fee | 30% of the amount collected, received, or recovered |
| Advance Medical Deposit | $104,720[8] |
| Underwriting/Actuarial Services | $135.00 per hour plus expenses |
| Documentation | $135.00 per hour |
| Custom Programming | $150.00 per hour |
| Early Termination | 2 months of administrative fees[9] |
| Run-out Claims Processing | 4 months of administrative fees |

**Third-Party PBM Vendor Integration:**
If the client has chosen a third-party PBM and requests integration:

[6] This Contract is based on 1241 lives. A re-quote will be required if the actual number of lives varies by more than ten percent.

[7] Diseases Management administered through Guardian Nurses effective 4/1/20.

[8] The cumulative amount for all four Health Insurance Funds is $420,522.00.

[9] An Early termination Charge will apply to clients who terminate our services prior to the end of the initial contract term or the subsequent amendment term. For convenience of the funds, amount is equal to 2 months of Administrative Fees in the event the term takes place inside CY 2021.

- Bi-directional feed to third-party PBM vendor. $15,000.00 (minimum)
  Set-up (one-time fee) actual cost, hourly charge. $ .29 pepm
  Ongoing Charge
  (to accommodate the 2015 Medical/Rx Out-of Pocket Maximum requirements)

Our offering of this fee structure does not constitute a guarantee that we can accommodate feeds to all PBM's, nor can we guarantee that a requested feed timeline can be met.

**Other Services**

Any fees for services not listed in this Contract will be presented to Plan Sponsor and will include costs to AHA and vendor, if applicable.

**Run-out Claim Processing**

The Administrative Fees paid to Claims Administrator for post-termination claims services under this Agreement shall be calculated by the Claims Administrator based upon the following method for calculating Administrative Fees:

> **Per Contract holder.** Claims Administrator will charge one hundred (100%) of the per Employee Administrative Fee amount in effect immediately prior to termination, multiplied by the sum of the enrollment for the four (4) months prior to termination. This one time only fee will be billed and must be paid by the Group prior to the termination date.

Run-out claims will be processed for a period of 12 months following termination of the Contract.

**The Plan Sponsor will reimburse AmeriHealth Administrators for any fees, services, benefits, payments, taxes, surcharges, non-compliance penalties or any other amounts imposed, increased, or adjudged due and attributable to the Plan by a lawful regulatory or governmental authority or its agents.**

**An Early Termination Charge will apply to clients who terminate our services prior to the end of the initial contract term or the subsequent amendment term. The Early Termination Charge is equal to 2 months of Administrative Fees.**

**The fees shown on this Exhibit D do not include costs associated with new or expanded tasks that are required to be performed by AmeriHealth Administrators as a result of the requirements of The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Care Reform Law). If additional administrative costs are incurred by AmeriHealth Administrators because of changes imposed or required by the Health Care Reform Law or governmental or regulatory entities, AmeriHealth Administrators shall have the right to pass through the additional costs to the plan sponsor. AmeriHealth Administrators shall provide 60 days prior written notice of any such additional costs.**

**EXHIBIT E**

AmeriHealth Administrators Policy for Audits by Customers
And Other External Entities

PURPOSE

The purpose of this policy is to establish the necessary mechanism that will enable AmeriHealth Administrators (AHA) and external audit teams to conduct audits of relevant claims in an efficient and responsible manner.

SCOPE

This Policy applies to customers and their representatives who conduct an audit/review of relevant claims.

POLICY

The audit policy is as follows:

1. AHA written request shall be made on the requestor's letterhead. For audits by a group customer, an External Audit Questionnaire form (see below) must be completed by the audit/review requestor and returned to the Operations Compliance Department before an audit can begin.
2. The Operations Compliance Department must receive requests for onsite audits at least 90 days prior to the date the onsite work is requested to begin. Only one customer may conduct an audit at any time. Onsite audits will be conducted during normal business hours (8:30 a.m. to 5 p.m.).
3. The standard Confidentiality Agreement must be executed prior to the start of the audit.
4. Confidential and proprietary information (such as provider remittances and provider contracts) will not be released for an audit. Any medical records in the possession of AHA will not be released unless the patient signs a Member Authorization Form.
5. Online access to AHA's or its vendor's information systems will not be provided.
6. The audit scope period may go back no further than 18 months from the scheduled onsite audit date.
7. Audits shall be conducted by the requestor's internal audit staff or by a mutually agreeable third party. AHA will not allow audits to be conducted by contingency fee auditors/consultants.
8. Audits by a group customer are permitted only for self-funded groups. The following restrictions apply to all audits:

    - An account must be current on its invoice payments prior to requesting an audit
    - Standard audits are limited to a total of 250 claim samples

9. AHA reserves the right to assess a charge for the costs associated with fulfilling an audit request that does not meet the criteria listed in the preceding paragraph. The charge to the account will be $50 per

claim. Charges may also be assessed for information system resources involved in providing the requested information.

10. Accounts that have terminated their coverage with AHA must request an audit within one (1) year of the effective date of the termination. If the request exceeds the one (1) year timeframe, charges of $50 per claim in addition to applicable information systems charges will be assessed and collected prior to fulfilling such requests.
11. Unless otherwise agreed to by AHA, claim errors found by external auditors/consultants cannot be extrapolated to calculate financial impact. AHA will identify and disclose the root cause, the volume of claims and the financial impact pertaining to a systemic related claim error.
12. The performance outcome from the audit will not result in specific payments by AHA for performance guarantees on claim performance.
13. The approved/final group health plan in effect will be the source of reference for an audit. Issues of intent/interpretation that are not specifically addressed in the Groups benefit documentation are to be mutually resolved between the Group, the auditor and AHA on a go forward basis and cannot be counted as errors against AHA operational audit performance results.
14. Unless otherwise agreed to by AHA, a final draft of the external auditor's report shall be submitted to AHA at least ten business days prior to the report being delivered to the audit requestor.
15. AHA shall receive a copy of the final report at the same time it is delivered to the audit/review requestor.

This Policy is subject to applicable state and federal laws/regulations. AHA has the final authority to interpret the scope and application of this Policy. Any questions concerning this Policy may be directed to the Director, Quality and Compliance.

AmeriHealth Administrators
EXTERNAL AUDIT QUESTIONNAIRE

Presented below is a series of questions regarding your proposed audit/review of AmeriHealth Administrators. Please complete the information requested and return it to the Operations Compliance Department within two weeks of your receipt. This information will enable us to make arrangements consistent with Plan Policy. After this document is returned to AmeriHealth Administrators, we will contact you to confirm the arrangements.

1. Name of account requesting review & group number(s) involved:

2. Number of contracts in the above account:

3. Purpose for audit:

4. Auditor's name, address and telephone #:

5. Time period to be covered in audit (not to exceed two years prior to most recent settlement or renewal date):

6. Line of business (check all applicable):

   a) Major Medical

   b) Hospitalization

   c) Medical/Surgical

   d) Vision

   e) Dental

   f) Prescription Drug

7. Describe sample size and methodology (use attachments if necessary):

   Sample size must comply with sections 7 and 8 of the audit policy.

8. We agree to comply with the terms and conditions of AmeriHealth Administrators' Policy for Audits by Customers and Other External Entities as attached.

Requestor's Name:

Requestor's Title:

Signature:

Date:

NOTE: Complete this section only if this is an on-site audit.

9. Anticipated field work start date:

10. Anticipated field work completion date:

11. Names, titles of auditors:

    a) Firm name (if applicable):

    b) In-charge:

    c) Staff:

12. Special facilities required:

13. Who should we contact if we have questions prior to auditor's arrival:

Name:

Title:

Telephone #:

Fax #:

## EXHIBIT F

## CLINICAL SERVICES

### 1. UTILIZATION REVIEW PROCESS

A basic condition of Southern Coastal Regional Employee Benefits Fund**'s** benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. To assist Southern Coastal Regional Employee Benefits Fund in making coverage determinations for requested health care services, AmeriHealth Administrators' delegate uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Participant's benefit plan is called utilization review.

**Medically Appropriate/Medically Necessary (Or Medical Appropriateness/Medical Necessity)** – a Health Intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. A Health Intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by AmeriHealth Administrator's medical director or physician designee, it meets all of the following criteria:

**A. It is a "Health Intervention."** A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

**B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Participant.**

**C. It is known to be "effective" in improving "health outcomes."** Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

**i. New interventions**: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

**D. It is cost-effective for this condition compared to alternative interventions, including no intervention.** "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a covered under the Plan or meet this Medically Appropriate/Medically Necessary definition.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by AmeriHealth Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider.

An example of such automatically approved services is an established list of services received in an emergency room which has been approved by AmeriHealth Administrators based on the procedure meeting emergency criteria and the severity of diagnosis reported. Other requested services, such as certain elective inpatient or outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based upon when the review is performed. When the review is required before a service is performed, it is called a precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. AmeriHealth Administrators follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by AmeriHealth Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Participant's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Participant in accordance with applicable law.

AmeriHealth Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to AmeriHealth Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither AmeriHealth Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

The precertification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Precertification is not a guarantee of eligibility for the

coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Participant being eligible, i.e., actively enrolled in the Plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the Plan that apply to the coverage request.

## CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

**Clinical Decision Support Criteria:** Clinical Decision Support Criteria is an externally validated and computer-based system used to assist AmeriHealth Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Participant's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests, and reduces practice variation among AmeriHealth Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

**Medical Policies:** AmeriHealth Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

**Internally Developed Guidelines:** A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

## DELEGATION OF UTILIZATION MANAGEMENT ACTIVITIES AND CRITERIA

AmeriHealth Administrators, Inc., is a state licensed utilization review entity, where required, and a National Committee for Quality Assurance (NCQA) accredited utilization management program. In certain instances, AmeriHealth Administrators has delegated certain utilization review activities, including precertification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse). In such instances, a formal delegation and

oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with AmeriHealth Administrators' approval.

## PRECERTIFICATION REVIEW

When required, precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Participant's benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. Precertification review may be initiated by a provider, however, it is the Participant's responsibility to obtain precertification review. Where precertification review is required, AmeriHealth Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where precertification review is required for a procedure but is not obtained.

While the majority of services requiring precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, short procedure unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing Provider. Precertification review is not required for emergency services.

### 1. INPATIENT PRE-ADMISSION REVIEW

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be precertified in accordance with the standards of AmeriHealth Administrators' as to the Medical Appropriateness/Medical Necessity of the admission. The precertification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Participant is responsible to have the admission (other than an emergency or maternity admission) certified in advance as an approved admission.

### 2. EMERGENCY ADMISSION REVIEW

a. Participants are responsible for notifying AmeriHealth Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by AmeriHealth Administrators.

b. If the Participant elects to remain hospitalized after AmeriHealth Administrators and the attending doctor has determined that an inpatient level of care is not Medically Appropriate/Medically Necessary, the Participant will be financially liable for non-covered inpatient charges from the date of notification.

## 3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRENOTIFICATION AND DISCHARGE PLANNING

**Concurrent review** may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Participant and coordinates discharge planning. Concurrent review continues until the Participant is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an inpatient facility is paid based on a per case or diagnosis-related basis, or where an agreement with a facility does not require such review.

**Retrospective/post-service review** occurs after services have been provided. This may be for a variety of reasons, including when AmeriHealth Administrators has not been notified of a Participant's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, AmeriHealth Administrators may determine coverage of certain procedures and other benefits available to Participants through prenotification as required by the Participant's benefit plan and discharge planning.

**Pre-notification** is advance notification to AmeriHealth Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Participants for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Participants who may benefit from case management programs.

**Discharge planning** is performed during an Inpatient admission and is used to identify and coordinate a Participant's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or skilled nursing facility placement. Discharge planning involves AmeriHealth Administrators' authorization of covered post-hospital services along with identifying and referring Participants for disease management or case management services.

## CASE MANAGEMENT

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Participant's health needs through communication and available resources to promote quality, cost-effective outcomes.

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the Participant to ensure the efficient use of appropriate health care resources, link Participants with appropriate health care or support services, assist providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Participants. Case management supports Participants and providers by locating, coordinating, and/or evaluating

services for a Participant who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

Case management is a voluntary service. A Participant must provide their consent for enrollment into case management. There is no reduction in benefits if the Participant and the Participant's family choose not to participate.

AmeriHealth Administrators will provide case management services for those identified Participants that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Participants may be identified for case management through the utilization review process or through claims review/predictive modeling. External referrals are also accepted from Participants' providers or family members. Participants referred to case management are screened and assessed prior to acceptance into the program. Only those Participants who meet the case management identification and screening criteria and who consent to case management will be accepted into the case management program. Case management will follow the utilization review process for review and authorization of services.

A case manager will consult with the Participant, the Participant's authorized representative, the caregiver and the attending doctor in order to develop a plan of care for approval by the patient's attending doctor and the Participant. This plan of care may include some or all of the following:

- personal support to the Participant;
- contacting the care giver to offer assistance and support;
- monitoring inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending doctor, the patient and the Participant's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, AmeriHealth Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not

be paid by the Plan.

A Participant's circumstances may determine the need to continue, decrease, or ultimately discontinue enrollment in case management services. AmeriHealth Administrators, in its sole discretion, will determine the most cost effective and appropriate case management interventions including discharge from case management.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

## EXHIBIT G

### Special Provision - Affirmative Action

AmeriHealth Administrators, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, AmeriHealth Administrators will take affirmative action to ensure that such applicants are recruited and employed, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such action shall include, but not limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. AmeriHealth Administrators agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this nondiscrimination clause.

AmeriHealth Administrators, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of AmeriHealth Administrators, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex.

AmeriHealth Administrators, where applicable, will send to each labor union or representative or workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer advising the labor union or workers' representative of AmeriHealth Administrators commitments under this act and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

AmeriHealth Administrators where applicable, agrees to comply with any regulations promulgated by the Treasurer pursuant to N.J.S.A. 10:5-31 et seq. as amended and supplemented from time to time and the Americans with Disabilities Act.

AmeriHealth Administrators agrees to make good faith efforts to employ minority and women workers consistent with the applicable county employment goals established in accordance with N.J.A.C. 17:27-5.2, or a binding determination of the applicable county employment goals determined by the Division, pursuant to N.J.A.C. 17:27-5.2.

AmeriHealth Administrators agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, labor unions, that it does not discriminate on the basis of age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

AmeriHealth Administrators agrees to revise any of its testing procedures, if necessary, to assure that all personal testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with the applicable employment goals, AmeriHealth Administrators agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression,

disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

AmeriHealth Administrators shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

1. Letter of Federal Affirmative Action Plan Approval
2. Certificate of Employee Information Report
3. Employee Information Report Form AA302

AmeriHealth Administrators shall furnish such reports or other documents to the Division of Contract Compliance & EEO as may be requested by the Division from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Division of Contract Compliance & EEO for conducting a compliance investigation pursuant to Subchapter 10 of the Administrative Code at N.J.A.C.17:27.

## Exhibit H

## New Jersey Law

**NEW JERSEY LAW.** This Agreement shall be governed by, and construed in accordance with, the laws of the State of New Jersey. In addition:

**1. BUSINESS REGISTRATION.** AmeriHealth Administrators shall comply with business registration requirements of the State of New Jersey per N.J.S.A. 52:32-44.

**2. MAINTENANCE OF CONTRACT RECORDS.** (N.J.A.C. 17:44-2.2) Relevant records of private vendors or other persons entering into contracts with covered entities are subject to audit or review by OSC pursuant to N.J.S.A. 52:15C-14(d). AmeriHealth Administrators shall maintain all documentation related to products, transactions or services under this contract for a period of five years from the date of final payment. Such records shall be made available to the New Jersey Office of the State Comptroller upon request.

**3. POLITICAL CONTRIBUTIONS:** Compliance with the New Jersey Campaign Contributions and Expenditures Reporting Act. N.J.S.A. 19:44A-1 et seq. shall be a material term and condition of this contract and shall be binding upon the parties hereto upon execution of this Contract. The following provision only applies to AmeriHealth Administrators if the appointment was not made pursuant to a fair and open process in accordance with N.J.S.A. 19:44A-20.4 et. seq. By acceptance of this Agreement, AmeriHealth Administrators certifies that in the one year period preceding the date that this contract is legally authorized that neither AmeriHealth Administrators business entity nor any persons holding 10% or more of the issued and outstanding stock of AmeriHealth Administrators business entity or entitled to receive the benefit of 10% or more of the revenues and/or profits of AmeriHealth Administrators business entity have made any reportable contributions pursuant to N.J.S.A. 19:44A-1 et seq. that, pursuant to P.L. 2004, c.19 would bar the award of this contract. This includes any reportable contribution to any official, candidate, joint candidates committee or political party representing elected officials or candidates as defined pursuant to N.J.S.A. 19:44A-3(p), (q) and (r) of any member local unit insured by the Plan Sponsor. Further, AmeriHealth Administrators and all persons holding 10% or more of the issued and outstanding stock of AmeriHealth Administrators business entity or entitled to receive the benefit of 10% or more of the revenues and/or profits of AmeriHealth Administrators business entity shall not make such contributions during the period of this contract.

## EXHIBIT I

### Insurance

Coverages. AHA shall at its sole cost maintain the following insurance coverage in full force and effect throughout the Term:

(a) Commercial General Liability – Insures against sums that must be paid because of bodily injury or property damage caused by an occurrence that takes place on property locations
   i. Each Occurrence- $1 million
   ii. Damage to rented premises (each occurrence)- $1 million
   iii. Medical Expenses (any one person)- $10k
   iv. Personal & Adv Injury- $1 million
   v. General Aggregate- $2 million
   vi. Products- Comp/Op Agg- $2 million

(b) Automobile Liability – Insures all Company owned/leased vehicles.
   i. Combined Single Limit (each accident) $1 million

(c) Umbrella Liability – Insures against all sums in excess of Primary General, Employee Benefits, Errors & Omissions, Automobile & Employers Liability.
   i. Each Occurrence- $1 million
   ii. Aggregate- $2 million

(d) Workers Compensation – Insures the Company against injury sustained by employees during the course or scope of their employment.
   i. Each Accident- $500,000
   ii. Disease Each Employee- $500,000
   iii. Disease Aggregate- $500,000

(e) Property/ All Risk includes EDP Boiler & Machinery – Covers real and business personal property. Also insures against loss of business income due to loss or damage to property.
   i. Personal Property- $1 million

(f) Managed Care Errors & Omissions – Insures the Company, Officers, Directors or Employees against claims made for wrongful acts in the rendering or failure to render professional (Managed Health Care) services.
   i. $10 million

(g) Group Medical Professional Liability- Insures against claims made for Bodily Injury caused by an act, error or omission directly resulting from the rendering or failure to render professional health care services.
   i. Physician's Professional Liability (PL)
      i. Each Medical Incident- $500,000
      ii. Annual Aggregate- $1,500,000

(h) Directors & Officers Liability (D&O) and Employment Practices Liability (EPL) – Insures individual Directors and Officers against personal losses and reimburses the Company for any loss arising from any claim made against any Directors and Officers. Also insures the Company and employees for loses and

defense costs due to claims made for Wrongful Employment Acts.

i. $5 million

(i) Crime/Employee Dishonesty – Insures against loss resulting directly from dishonest or fraudulent acts committed by an employee acting alone or in collusion with others.

i. Each Occurrence- $10 million
ii. Aggregate- $20 million

(j) Fiduciary Liability – Insures the Company and any Administrator and Fiduciary against any alleged wrongful act committed in the administration of any pension plan or welfare benefit plan.

i. $10 million

(k) Cyber Risk Liability – Insures against claims made for First-Party and Third-Party losses that may occur because of Internet Operations and Privacy Injuries. Also insures against claims for actual or alleged wrongful acts in connection with the creation or dissemination of advertising material.

i. $40 million

(l) Performance Bond: Valued at twenty five percent (25%) of the estimated value of the annual contract, with a minimum limit of $50,000.

# APPENDIX V

# *2021 MEL, MRHIF & NJCE Educational Seminar*

## Virtual

**Friday, May 14, 9:00 to Noon**
**Friday, May 21, 9:00 to Noon**

The MEL (Municipal Excess Liability Joint Insurance Fund), MRHIF (Municipal Reinsurance Health Fund) and the NJCE (NJ Counties Excess Joint Insurance Fund) are sponsoring the 10th annual educational seminar for elected officials, commissioners, municipal, county and authority personnel, risk managers and other professionals. There is no cost to attend.

This seminar is eligible for the following continuing educational credits:

- CFO/CMFO, Public Works and Clerks:
- Insurance Producers and Purchasing Agents:
- Accountants (CPA's) and Lawyers (CLE):
- TCH Water Supply & Wastewater Licensed Operator Training:
- RPPO and QPA

**Friday May 14th:**

- Keynote: Combating Implicit Bias in Local Government
- Ethics Issue 1: NJ Local Officials Ethics Act
- Coverage Issues: Insurance Market Conditions and Cyber Risk Control

**Friday, May 21st:**

- Ethics Issue 2: Ethical Considerations in Drafting Personnel Policies and Procedures
- Legislative Issues: Proposals to Change the WC & Liability Statutes
- Benefits Issues: The Affordable Care Act under the New Administration.

**REGISTRATION:** Contact Jaine Testa @ jainet@permainc.com

MEL

MRHIF
Municipal Reinsurance Health Insurance Fund

NJCE
NEW JERSEY COUNTIES
EXCESS JOINT INSURANCE FUND