

RESOLUTION 8-24

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

2024 RISK MANAGEMENT PLAN

Effective: JANUARY 1, 2024

BE IT RESOLVED that the following shall be the Fund’s Risk Management Plan for the 2024 Fund year:

1.) COVERAGE OFFERED

Medical

The medical plans offered by the Fund include standard “preferred provider organization”, “traditional”, “point of services”, and “health maintenance organization” plan designs. These plans have both in network and out of network benefits and are customized to the needs and specifications of the members. The Fund also offers “low cost plans” to allow members options to comply with contribution requirements under Chapter 78 and for those covered under Chapter 44. Included as options are: a health savings account, a core PPO program, and a buy up PPO program, an HMO program, a Consumer Directed Health Plan and the plans for those covered under Chapter 44. The Fund will also offer Medicare Advantage programs. See Exhibit “A” for a list of provided coverage/plans.

Dental

The Fund offers customized dental plans as required by the members.

Prescription

The Fund offers customized prescription plans as required by the members including plans that are coordinated with the low cost medical plans.

Vision

The Fund offers customized vision plans as required by the members.

2.) LIMITS OF COVERAGE

Limits of coverage vary by member and plan design.

3.) RISK RETAINED BY THE FUND

The Fund takes no risk on Medicare Advantage and Employer Group Waiver Plan fully-insured policies purchased for Medicare retirees.

Pre-Medicare retirees and active employees and their dependents are covered by self-insured plans. Risk retained by the Fund for these plans is summarized as follows:

Medical and Prescription:

Specific Coverage: The Fund self-insures for **the first \$450,000 per person** per agreement year and obtains reinsurance through its membership in the Municipal Reinsurance Health Insurance Fund "MRHIF" for claims in excess of its self-Insured Retention "SIR" to an unlimited maximum per person per contract period (incurred in 12 months paid in 24 months).

Specific Limit Unlimited

Basis: Incurred 12 months, paid 24 months.

Extra contractual claims are excluded from reinsurance coverage.

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The Fund complies with statutory accounting standards and establishes reserves on the probable total claim costs at the conclusion of the Fund Year. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted based on earned underwriting income and the number of months since the inception of the Fund Year. This accrual is periodically adjusted, but not less frequently than annually, in accordance with the actuary's certifications.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the Fund Year, the Fund adopts a budget for the upcoming year based on the most recent census, the claims experience for the current Fund Year and other applicable accounting and actuarial factors. Per employee rates are computed for each line of coverage for each Fund member, and are approved by the Fund as a part of the budget adoption process. These rates are used to compute the members' monthly assessment based on the updated census, and monthly billings are mailed to the members approximately 15 days before the beginning of the month. The billing also includes the member's updated census for verification each month by the local entity. Retroactive adjustments for enrollment changes are limited to 2 months. Former employees (COBRA, Conversion and some Retirees) are billed directly by the Fund.

Members that renew on January 1 have the option of taking a payment deferment by paying their December assessment in the subsequent month of January. Members that renew on July 1 have the option of taking a payment deferment by paying their June assessment in the subsequent month of July. Members that choose to take such deferments shall advise the Fund Executive Director's office in writing at least one month prior to taking the deferment

6.) COVERAGE PURCHASED FROM INSURERS AND PARTICIPATION IN THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND (MRHIF)

The Fund provides coverage on a self-insured basis, and secures excess insurance to cap the Funds' specific (i.e. per enrolled covered person per policy year) retention and aggregate retention. The Fund is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The MRHIF retains claims above the Fund's local specific retention and purchases an excess insurance policy that is filed with the Department of Banking and Insurance in accordance with the applicable regulations. The MRHIF also purchases an aggregate excess insurance policy on behalf of the Fund and the other members.

7.) REINSURANCE

Reinsurance will be provided by the Fund obtaining membership in the Municipal Reinsurance Health Insurance Fund. Risk will be retained by the Fund in accordance with Section 3.) above.

8.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, a prospective member's benefit program is reviewed by the actuary to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

- a.) age/sex factor as compared to the average for the existing Fund membership;
- b.) the plan of benefits for the prospective member; and
- c.) loss data if available.

The actuary then recommends a relativity factor to either the Fund's base rates or to the rates being paid by the entity. This recommendation requires Fund approval before the prospective member is admitted to the Fund.

Rates for all members are adjusted at the beginning of each Fund year to reflect the new budget. The adjustment reflects the overall cash flow needs of the Fund, and actuarial factors needed to assure that individual entity rates reflect the risk profile of the member. The Fund may implement individual entity loss ratio adjustments based upon recommendations from the Fund actuary. The Fund may also adopt mid Fund year rate changes to reflect changes in plan design, participation in lines of coverage, or a budget amendment. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the other lines of coverage may be adjusted and the member shall not be eligible for membership in the dropped line of coverage for a three year period. Loss experience data used by the Fund to determine loss ratio adjustments will be made available twice per year to members at no additional cost. "Loss experience data" is defined as monthly claims and assessments for a three year period including de-identified specific claims at 50% of the Fund's self-

insured retention. Requests for additional claims data from Fund members will be considered based upon the availability of data, the feasibility of extracting the data, and conditioned upon the member reimbursing the Fund or its vendors for data extraction and formatting costs.

9.) RATING PERIODS

All rating periods for municipal members coincide with the Fund (calendar) year while rating periods for school members can either coincide with their fiscal year (July 1 to June 30) or the Fund year. The Fund offers school entities the option of either Fund year or fiscal year renewals.

10.) FACTORS IF RATES FOR MEMBERS JOINING THE FUND DURING A FUND YEAR ARE TO BE ADJUSTED.

Unless otherwise authorized as part of the offer of membership, where a member joins during a Fund year, the member's initial rates are only valid through the end of that Fund year or, for schools, fiscal year, at which time the rates are adjusted for all members to reflect the new budget. Former members of the Fund cannot rejoin the Fund for a period of three (3) years after the date of the termination of their membership in the Fund.

11.) PROVISION FOR PPOs AND ALTERNATIVE PLAN DESIGNS

The Fund offers employees the option of selecting various plans depending upon member bargaining agreements. Generally, it is the policy of the Fund to encourage selection of lower cost plan designs as opposed to traditional indemnity plans, and the Fund provides promotional material to assist members in employee communication programs concerning optional plan designs.

12.) OPEN ENROLLMENT PROCEDURES

All members have an open enrollment period no later than the first month of their joining the Fund. Participating employees also have an open enrollment period in the fall or at other times designated by the Fund before the beginning of each calendar year during which they may switch between plan options. The changes shall be effective at the beginning of the Fund Year.

Open enrollment periods shall be scheduled by the Fund at least yearly for each member and as is otherwise required to comply with plan document requirements and to effectuate plan design, network changes, and plan migrations.

13.) COBRA AND CONVERSION OPTIONS

The Fund provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The Fund has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. Where provided for in a member's plan document, the Fund provides a conversion option at rates established by the Fund. Unless otherwise specified in the member's plan document, the conversion option duplicates the conversion option offered by the SHBC. The Fund's coverage for individuals covered under COBRA or conversion options shall terminate effective the date the member withdraws from the Fund, or otherwise ceases to be a member of the Fund or in the event of nonpayment of applicable charges.

14.) DISCLOSURE OF BENEFIT LIMITS

The Fund discloses benefit limits in plan booklets provided to all covered employees.

15.) PARTICIPATION RULES WHEN ALL OR PART OF THE PREMIUM IS DERIVED FROM EMPLOYEE CONTRIBUTIONS

All assessments, including additional assessments and dividends are the responsibility of the member, not the employee or former employee. Employee contributions, if any, are solely an internal policy of the member which shall not impact on the member's obligations to the Fund or confer any additional rights to the employees. Where the Fund directly bills an employee, (i.e. COBRA, etc.), this shall be considered as a service to reduce the member's administrative burden, and the member shall be responsible in the event of non-payment.

16.) RETIREES

The Fund duplicates coverage for eligible retirees and uses the rates established by the Fund actuary. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund, or otherwise ceases to be a member of the Fund or in the event of nonpayment of applicable charges.

17.) NEWBORN CHILDREN

All plan documents will have the following language:

"You may remove family members from the policy at any time, but you may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is your responsibility to notify your employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until you have formally requested that change. Newborn children, but not grandchildren of an eligible employee, shall be automatically covered from birth for (60) days, even if not enrolled within the required sixty (60)

days. In the event of an eligible dependent giving birth to a child, (a grandchild) benefits for any hospital length of stay in connection with childbirth for the mother or newborn grandchild will apply for up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn grandchild's attending provider, after consulting with the mother, may discharge the mother or her newborn grandchild earlier than 48 hours (or 96 hours as applicable)."

18.) PLAN DOCUMENT

The Fund prepares a plan document and benefit plan booklets for each member local unit (or each employee bargaining group within a member local unit as the case may be), and an employee handbook provides a summary of the coverage provided by the plan. Each booklet (or certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

A.) General Information

Enrollment procedures and eligibility;

Dependent eligibility;

When coverage begins;

When coverage may be changed;

When coverage ends;

COBRA provisions;

Conversion privileges; and

Enrollment forms and instructions.

B.) Benefits

Definitions;

Description of each benefit, inclusive of;

Eligible services and supplies;

Deductibles and co-payments; and

Examples as needed;

Exclusions.

Retiree coverage, before age 65 or after (if any).

C.) Claims Procedures

Submission of claim. In accordance with plan document.

Proof of loss. In accordance with plan document

Appeal procedures. Shall be in accordance with applicable law. See Plan Document and Fund Bylaws

D.) Cost Containment Programs - In accordance with plan document.

Pre-admission.

Second surgical opinion.

Other cost containment programs.

Application and level of employee penalties.

19.) BENEFITS CURRENTLY PROVIDED TO COVERED EMPLOYEES BY EACH MEMBER AND BENEFITS PROPOSED TO BE PROVIDED BY THE FUND.

SEE PLAN DOCUMENT OF EACH MEMBER ENTITY

20.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately six months after the end of a Fund year, the Fund evaluates the results to determine if dividends or additional assessments are warranted. Most claims are paid within twelve months of year end, and at that time the Fund begins to consider closing the year, unless excess insurance recoveries are pending or litigation is likely. The Fund has determined that maintaining and retaining a surplus equal to two and a half (2.5) months of the current year claim expenses is a benchmark prior to a dividend being declared from surplus generated by claims operations.

Fully insured plans are not considered in surplus retention. Entities with only Medicare Advantage/Employer Group Waiver Programs are not included in closed year balance shares.

When the Fund determines that a Fund year should be closed:

A reserve is established by the actuary to cover any unpaid claims or IBNR

The Fund decides on the final dividend or supplemental assessment.

A closure resolution is adopted transferring all remaining assets and liabilities of that Fund year to the "Closed Fund Year/Contingency Account".

Each member's pro rata share of the residual assets are computed and added to its existing balance in the Closed Fund Year/Contingency Account. Any member who has withdrawn from the Fund shall receive its remaining share of the Closed Fund Year/Contingency Account six years after the date of its withdrawal.

- Any member that has withdrawn from the Coastal Fund shall receive its remaining share of the Closed Fund Year/Contingency Account on the following schedule:
 - 3rd year after withdrawal - 25% of balance
 - 4th year after withdrawal - 25% of balance
 - 5th year after withdrawal - 25% of balance
 - 6th year after withdrawal - Remaining balance

21.) MAXIMUM APPROVAL AMOUNT FOR CERTIFYING & APPROVING OFFICER

1. The Fund Treasurer may issue checks or initiate wire transfers in payment of medical claims, as submitted by the third party administrator responsible for handling the Fund's medical claims, as necessary in order to fulfill the Fund's claim funding obligations under the applicable service provider contract between the Fund and the third party administrator. The certifying and approving officer shall prepare a report of all claims approved by him or her since the last report, detailing the nature and amount of the claim, the payee, the reasons supporting payment and any other pertinent information. This report shall be submitted to the Executive Committee of the Fund at their next scheduled meeting. The Executive Committee shall review and approve the actions of the certifying and approving officer. In the event a claim approved and paid by the certifying and approving officer is not approved by the Executive Committee, they shall direct appropriate action to be taken.

2. Delta Dental shall issue checks for the payment of dental claims in the amount of \$.0 to \$5,000 on the adjudication and signature solely of duly authorized Delta Dental personnel.

3. All dental claims, if any, in excess of \$5,000 shall require the approval, at a regularly scheduled meeting, of the Executive Committee of the Fund after obtaining appropriate certifications and making such other inquiries as are reasonable. Checks issued pursuant to any such approval shall be countersigned by a duly authorized representative of the Executive Director.

4. The terms "claims" as herein utilized shall refer to the issuance of any particular check, provided however that no bills shall be split for the purpose of avoiding the requirements hereof.

5. In addition to the claim payment procedure, Delta Dental shall also notify the Executive Committee in writing whenever the cumulative payments to any covered person for a single illness or injury (including related illnesses and injuries) exceeds \$30,000.

22.) "RUN-IN" or "RUN-OUT" LIABILITY

The Fund covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former Fund member during the period it was a member. Upon approval of the Executive Committee, the Fund may also cover the run-in liability of a perspective member (i.e., the liability for claims incurred but not reported by a prospective member in connection with the provision of health benefits during the period prior to joining the Fund). When the Fund covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the Fund's actuary and approved by the Executive Committee. The assessment shall be paid entirely within the Fund Year the member joined the Fund.

23.) CLAIM AUDIT

The Fund retains a claim auditor experienced in auditing self-insured health plans. The audit will be conducted upon completion of the first Fund Year after the Fund's inception and at least once every three years thereafter. The Fund can conduct this audit on its own, or in a cooperative effort with other Funds through the Municipal Reinsurance Health Insurance Fund.

24.) AUTHORITY OF CLAIM APPEAL COMMITTEE AND INDEPENDENT REVIEW ORGANIZATIONS

The TPA shall initially review all appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

The TPA shall provide the Program Manager, Executive Director and the Fund Attorney with a copy of the memo, which has been prepared concerning the appeal.

The TPA, Program Manager, Executive Director and Fund Attorney shall confer concerning the merits of an appeal and they shall render a decision concerning the appeal provided that the appeal is

(a) In an amount not greater than \$5,000.00 and/or

(b) Has been reviewed and recommended for approval by an independent, third party medical review consultant.

If the decision of the TPA, Program Manager, Executive Director and Fund Attorney is to pay the claim, then the TPA is hereby authorized to issue the necessary check in payment of the claim.

The Executive Committee of the Fund shall formally confirm the decision of the TPA, Program Manager, Executive Director and Fund Attorney to pay the claim and ratify the payment issued pursuant to that decision at the next meeting of the Executive Committee.

- If the decision of the TPA, Program Manager, Executive Director and Fund Attorney is to deny the claim, the appeal shall be subject to the “adverse benefit determination” appeal process that is required pursuant to applicable law. The plan participant (hereinafter sometimes referred to as “claimant”) shall at that time be advised that the adverse benefit determination may be appealed to the Fund's Independent Review Organization (“IRO”). The claimant's identity shall be revealed only upon the written request of the claimant. A copy of such written request with respect to disclosure of the claimant's name shall be sent to the Program Manager.

- a. An appeal of an adverse benefit determination must be filed by the claimant within four (4) months from the date of receipt of the notice of the adverse benefit determination. The claimant shall submit a written request to the Program Manager to appeal an adverse benefit determination and/or final internal adverse benefit determination made by the TPA and the written request shall be accompanied by a copy of the determination letter issued by the TPA.

1. The Program Manager will conduct a preliminary review within five (5) business days of the receipt of the request for an external review. There is no right to an external review by the IRO if (i) the claimant is or was not eligible for coverage at the time in question or (ii) the adverse benefit determination or final internal adverse benefit determination is based upon the failure of the claimant or covered person to meet requirements for eligibility under the Plan or (iii) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit. The Program Manager shall notify the claimant if (a) the request is not eligible for external review; (b) that additional information is needed to make the request complete and what is needed to complete the request; or (c) the request is complete and is being forwarded to the IRO.

2. The Program Manager shall then forward an eligible, complete request for external review to the IRO designated by the Fund who shall be required to conduct its review in an impartial, independent and unbiased manner and in accordance with applicable law.

3. The assigned IRO will provide timely written notice to the claimant of the receipt and acceptance for external review of the claimant’s request and shall include a statement that the claimant may submit, in writing and within ten (10) business days of the receipt of the notice,

additional information which shall be considered by the IRO when conducting the external review. Upon receipt of any information submitted by the claimant, the IRO, within one (1) business day, shall forward the information to the Program Manager who may reconsider the adverse benefit determination or final internal adverse benefit determination and, as a result of such reconsideration, modify the adverse benefit determination or final internal adverse benefit determination. The Program Manager shall provide prompt written notice of any such modification to the claimant and the IRO.

4. The Program Manager, within five (5) business days of the assignment of the IRO, shall deliver to the IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. The IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination if the Program Manager does not provide such information in a timely manner. In such event, the IRO shall notify the claimant and the Program Manager of the decision within one (1) business day.

5. The IRO shall complete the external review and provide written notice of its final external review decision within forty-five (45) days of the receipt of the request for the external review. In the case of a request for expedited external review of an adverse benefit determination or final internal adverse benefit determination where delay would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, the IRO shall provide notice of the final external review decision as expeditiously as possible but in no event more than 72 hours after the receipt of the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Program Manager within 48 hours after providing that notice in the case of an expedited external review. The IRO shall deliver notice of its final external review decision to both the claimant and the Program Manager for all external reviews conducted. The notice of decision shall contain:

(i) a general description of reason for the external review with sufficient information to identify the claim, claim amount, diagnosis and treatment codes and reason for previous denial;

(ii) the date the IRO was assigned and date of the IRO's decision;

(iii) references to the documentation/information considered;

(iv) a discussion of the rationale for the IRO's decision and any evidence-based standards relied upon in making the decision;

(v) a statement that the decision is binding on the claimant and the Fund subject to the claimant's right to seek judicial review of the same; and

(vi) that the claimant may contract the New Jersey health insurance consumer assistance office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625, phone

(800) 446-7467 or (888) 393-1062 (appeals) website: <http://www.state.nj.us/dobi/consumer.htm> e-mail address: ombudsman@dobi.state.nj.us/

25.) ENROLLMENTS AND TERMINATIONS PAST 60 DAYS

Enrollments and terminations can be processed up to 60 days in the past. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the financial impact to the Fund. The Committee will approve/deny the request within 45 days.

26.) PARTIAL MONTH ENROLLMENTS

When processing enrollments and terminations, the Fund will charge a member for a full month rate for an employee that is enrolled between the 1st and the 15th of the month, but will charge the member in the following month if an enrollment occurred between the 16th and the 31st of the month. If a member should term between the 1st and the 15th of the month, the Fund will not charge the member a rate for the enrollment, but will charge a full month rate if a member terms between the 16th and the 31st of the month.

27.) MEDICARE ADVANTAGE/EGWP ONLY

The Fund may offer retiree coverage with a fully insured Medicare Advantage and/or Employer Group Waiver Program membership to an entity that does not have its active members in the Fund. The carrier will provide the Fund with a per employee, per month cost for a plan that matches equal to, or better to the current retiree plan. The Fund may add additional expenses to the price per employee. The entity would be required to sign an Indemnity and Trust agreement.

ADOPTED: JANUARY 22, 2024

BY: _____
CHAIRPERSON

ATTEST:

SECRETARY