RESOLUTION NO. 1-17

CENTRAL JERSEY HEALTH INSURANCE FUND
APPOINTING
PROFESSIONALS AND AWARDING CONTRACTS
FOR FUND YEAR 2017

WHEREAS, the Central Jersey Health Insurance 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 of the Central Jersey Health Insurance Fund has deemed it necessary and appropriate to obtain certain professional and other extraordinary and unspecifiable services and, therefore, to make certain appointments and to authorize certain contracts for Extraordinary and Unspecifiable Services so that the work of the Central Jersey Health Insurance Fund may continue;

WHEREAS, the Fund resolved on July 15, 2015 to award contracts in accordance with a fair and open process pursuant to N.J.S.A. 19:44A-20.4 et. seq., the Fund advertised for such contracts on its official web site on August 3, 2015, and received and publicly opened resulting proposals on September 8, 2015 for all positions.

BE IT RESOLVED by the Executive Committee of the Central Jersey Health Insurance Fund that the following "fair and open" appointments and contract awards be and are hereby made for 2017:

CENTRAL JERSEY HEALTH INSURANCE FUND	
Contract and Vendor	**2017 Fees**
Administrator - PERMA Risk Management Services (PEPM)	$8.59
*inclusive of GASB45, Medicare Part D, Web Site Admin.	
Med D & HIPAA	
Web Site Admin	
Total	**$295,221.00**
Program Manager - Conner Strong & Buckelew (PEPM)	$19.63
Non Medical	$8.61
Health Care Reform	$0.83
Annual Total	**$706,618**
Actuary - John Vataha	$38,963
Attorney - Berry, Sahradnik, Kotzas & Benson	$35,016
Auditor - Holman & Frenia, PC	$22,400
Treasurer - Steven Mayer	$11,548
Dental TPA - Delta Dental (PEPM)	$3.10
Annual Total	**$62,236**
Rx Administrator - ESI - Medicare Part D Reporting	$5,000
Medical TPA - Aetna (PEPM)	
Medical	$50.31
Annual Total	**$591,042**
Medical TPA - Qualcare (PEPM)	
Network Fee - all Plans	$36.85
TPA - Vision Plan	$1.25
Multiplan - Out of network	$5.10
Cost Containment	25% of savings
Annual Total	**$ 112,008**

NOW THEREFORE BE IT RESOLVED that each of the above shall serve pursuant to a Professional Service Contract, which will be entered into and a copy of which will be on file in the Fund's office, located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054;

CENTRAL JERSEY HEALTH INSURANCE FUND

ADOPTED: January 18, 2017

BY

_____

CHAIRPERSON

ATTEST:

_____

SECRETARY

RESOLUTION NO. 2-17

CENTRAL JERSEY HEALTH INSURANCE FUND
APPOINTING
PERMA RISK MANAGEMENT SERVICES
AS AGENT FOR THE FUND
FOR PROCESS OF SERVICE FOR THE YEAR 2017

BE IT RESOLVED by the Executive Committee of the Central Jersey Health Insurance Fund that PERMA Risk Management Services is hereby appointed as agent for process of service upon the Fund, at its office located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054, for the year 2017 or until its successor has be appointed and qualified.

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 3-17

CENTRAL JERSEY HEALTH INSURANCE FUND
DESIGNATING CUSTODIAN OF FUND RECORDS

BE IT RESOLVED that _____, the Secretary of the Central Jersey Health Insurance Fund is hereby designated as the custodian of the Fund records, which shall be kept at the office of the Fund Administrator, located at 9 Campus Drive, Suite 216, Parsippany, NJ 07054.

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 4-17

CENTRAL JERSEY HEALTH INSURANCE FUND
DESIGNATING
THE ASBURY PARK PRESS AS
THE OFFICIAL NEWSPAPER FOR THE FUND YEAR 2017

BE IT RESOLVED by the Executive Committee of the Central Jersey Health Insurance Fund that the Asbury Park Press is hereby designated as the official newspaper for the Central Jersey Health Insurance Fund for the year 2017 and that all official notices required to be published shall be published in this paper and on the Fund website (www.cjhif.com)

BE IT FURTHER RESOLVED that in the case of special meetings or emergency meetings, the Secretary of the Central Jersey Health Insurance Fund shall give notice of said meetings to the Asbury Park Press and Fund website (www.cjhif.com)

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 5-17

CENTRAL JERSEY HEALTH INSURANCE FUND
FIXING PUBLIC MEETING DATES
FOR THE YEAR 2016

WHEREAS, under the Open Public Meetings Act of New Jersey, each public entity is required to publish the date and place for its public meetings;

NOW THEREFORE BE IT RESOLVED, by the Executive Committee of the Central Jersey Health Insurance Fund that the Fund shall hold public meetings during the year 2017 on the third Wednesday of the following months at 1:30 PM at the following locations:

DATE	**LOCATION**
March 15	Brielle Borough Hall
May 17	Brielle Borough Hall
July 19	Brielle Borough Hall
September 13	Brielle Borough Hall ** 2nd Wednesday
October 18	Brielle Borough Hall
November 15	Atlantic City Sheraton
January 17, 2018	Brielle Borough Hall

BE IT FURTHER RESOLVED that the Secretary of the Fund is hereby directed to publish a copy of this Resolution in Asbury Park Press.

ADOPTED: January 18, 2017

BY:

_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 6-17

CENTRAL JERSEY HEALTH INSURANCE FUND
DESIGNATING AUTHORIZED DEPOSITORIES FOR FUND ASSETS
AND ESTABLISHING A CASH MANAGEMENT PLAN

BE IT FURTHER RESOLVED that the attached Cash and Investment Management Plan, which includes the designation of authorized depositories, be and is hereby adopted.

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

CENTRAL JERSEY HEALTH INSURANCE FUND

2017 CASH MANAGEMENT AND INVESTMENT POLICY

1.) ***Cash Management and Investment Objectives***

The CENTRAL JERSEY HEALTH INSURANCE FUND (hereinafter referred to as the FUND) objectives in this area are:

a.) Preservation of capital.
b.) Adequate safekeeping of assets.
c.) Maintenance of liquidity to meet operating needs, claims settlements and dividends.
d.) Diversification of the FUND's portfolio to minimize risks associated with individual investments.
e.) Maximization of total return, consistent with risk levels specified herein.
f.) Investment of assets in accordance with State and Federal Laws and Regulations.
g.) Accurate and timely reporting of interest earnings, gains and losses by line of coverage in each Fund year.
h.) Where legally permissible, cooperation with other local municipal joint insurance funds, and the New Jersey Division of Investment in the planning and execution of investments in order to achieve economies of scale.
i.) Stability in the value of the FUND's economic surplus.

2.) ***Permissible Investments***

Investments shall be limited to the following:

a.) Bonds or other obligations of the United States of America or obligations guaranteed by the United States of America.
b.) Any federal agency or instrumentality obligation authorized by Congress that matures within 397 days from the date of purchase, and has a fixed rate of interest not dependent on any index or external factors.
c.) Bonds or other obligations of the local unit or bonds or other obligations of school districts of which the local unit is a part or within which the school district is located; or
d.) Bonds or other obligations, having a maturity date not exceeding 397 days, approved by the Division of Investment of the Department of Treasury for investment by local units.
e.) Debt obligations of federal agencies or government corporations with maturities not greater than five (5) years from the date of purchase, excluding mortgage backed obligations, providing that such investments are purchased through the New Jersey Division of Investment and are consistent the Division's own investment guidelines, and providing that the investment a fixed rate of interest not dependent on any index or external factors.

f.) Repurchase agreements of fully collateralized securities, subject to rules and conditions establish by the N.J. Department of Community Affairs.

No investment or deposit shall have a maturity longer than five (5) years from date of purchase.

3.) ***Authorized Depositories***

In addition to the above, the FUND is authorized to deposit funds in certificates of deposit and other time deposits in banks covered by the Governmental Unit Depository Protection Act, NJSA 17:9-14 et seq. (GUDPA). Specifically authorized depositories are as follows:

TD Bank
Ocean First
New Jersey Cash Management
Investors Bank
Wilmington Trust

4.) ***Authority for Investment Management***

The Treasurer is authorized and directed to make investments, with a maturity of three months or longer, through asset managers that may be selected by the Executive Board. Such asset managers shall be discretionary trustees of the FUND.

Their actions and decisions shall be consistent with this plan and all appropriate regulatory constraints.

In executing investments, asset managers shall minimize transaction costs by querying prices from at least three (3) dealers and purchasing securities on a competitive basis. When possible, federal securities shall be purchased directly from the US Treasury. Transactions shall not be processed through brokerages which are organizationally affiliated with the asset manager. Transactions may also be processed through the New Jersey Division of Investment by the Fund's asset managers.

5.) ***Preservation of Capital***

Securities shall be purchased with the ability to hold until maturity.

6.) ***Safekeeping***

Securities purchased on behalf of the FUND shall be delivered electronically or physically to the FUND's custodial bank, which shall maintain custodial and/or safekeeping accounts for such securities on behalf of the FUND.

7.) ***Selection of Asset Managers, Custodial Banks and Operating Banks***

Asset managers, custodial banks and operating banks shall be retained for contract periods of one (1) year. Additionally, the FUND shall maintain the ability to change asset managers and/or custodial banks more frequently based upon performance appraisals and upon reasonable notice, and based upon changes in policy or procedures.

8.) ***Reporting***

Asset managers will submit written statements to the treasurer and executive director describing the proposed investment strategy for achieving the objectives identified herein. Asset managers shall also submit revisions to strategy when justified as a result of changing market conditions or other factors. Such statements shall be provided to the Treasurer and Executive Director. The statements shall also include confirmation that all investments are made in accordance with this plan. Additionally, the Investment Manager shall include a statement that verifies the Investment Manager has reconciled and determined the appropriate fair value of the Funds portfolio based on valuation guidelines that shall be kept on file in the Executive Director's office.

The Treasurer shall report to the Executive Committee at all regular meetings on all investments. This report shall include information on the balances in all bank and investment accounts, and purchases, sales, and redemptions occurring in the prior month.

9.) ***Audit***

This plan, and all matters pertaining to the implementation of it, shall be subject to the FUND's annual audit.

10.) ***Cash Flow Projections***

Asset maturity decisions shall be guided by cash flow factors payout factors supplied by the Fund Actuary and reviewed by the Executive Director and the Treasurer.

11.) ***Cash Management***

All moneys turned over to the Treasurer shall be deposited within forty-eight (48) hours in accordance with NJSA 40A:5-15.

In the event a check is made payable to the Treasurer rather than the Fund, the following procedure is to be followed:

a.) The Treasurer endorses the check to the Fund and deposits it into the Fund account.

b.) The Treasurer notifies the payer and requests that in the future any check be made payable to the Fund.

The Treasurer shall minimize the possibility of idle cash accumulating in accounts by assuring that all amounts in excess of negotiated compensating balances are kept in interest bearing accounts or promptly swept into the investment portfolio.

The method of calculating banking fees and compensating balances shall be documented to the Executive Committee by the Treasurer at least annually.

Cash may be withdrawn from investment pools under the discretion of asset managers only to fund operations, claims imprest accounts, or approved dividend payments.

The Treasurer shall escheat to the State of New Jersey checks which remain outstanding for twelve or more months after the date of issuance. However, prior to implementing such procedures, the Treasurer, with the assistance of the claims agent, as needed, shall confirm that the outstanding check continues to represent a valid claim against the FUND.

The Central Jersey Health Insurance Fund that the rate of interest on delinquent assessments for the year 2017 shall be 10% per annum from the due date for any such assessment.

RESOLUTION NO. 7-17

CENTRAL JERSEY HEALTH INSURANCE FUND
RESOLUTION DESIGNATING
AUTHORIZED SIGNATURES FOR FUND BANK ACCOUNTS

BE IT RESOLVED by the Central Jersey Health Insurance Fund that all funds of the Central Jersey Health Insurance Fund shall be withdrawn from the official named depositories by check, which shall bear the signatures of at least two (2) of the following persons who are duly authorized pursuant to this Resolution.

_____	- Chairperson
_____	- Secretary
_____	- Alternate
Stephen Mayer	- Treasurer

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

CENTRAL JERSEY HEALTH INSURANCE FUND

RISK MANAGEMENT PLAN

Effective: JANUARY 1, 2017

Adopted: JANUARY 18, 2017

RESOLUTION NO. 8-17

CENTRAL JERSEY HEALTH INSURANCE FUND
2017 RISK MANAGEMENT PLAN

NOW, THEREFORE, BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2017 Fund year:

1.) COVERAGE OFFERED

- Medical

  The Fund offers a "point of services" and "open access" plan designs. These plans have both in network and out of network benefit. The Fund can offer other plans as may meet the needs of the members. Starting in 2012, the Fund also offers "low cost plans" to allow members options to comply with contribution requirements under Chapter 78. Included as options are a health savings account-consumer directed health plan, a core PPO program, a buy up PPO program, and an HMO plan. For Medicare aged retirees, the Fund also offers fully insured "Medicare Advantage" 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 plan options.

- Vision

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

2.) LIMITS OF COVERAGE

Limits of coverage vary by member plan design.

3.) RISK RETAINED BY THE FUND

Medical and Prescription – <u>For all members with such coverage except Lakewood Township:</u>

- Specific Retention: $250,000
- Aggregate Retention: $29,100,060 (132.4% of budgeted claims)

- Specific Limit Unlimited
- Aggregate Limit $10,000,000
- Basis: Incurred 12 months, paid 24 months.

Dental Aggregate Retention: None – Self insured with risk retained by Fund

Vision Aggregate Retention: None – Self insured with risk retained by Fund

Medical and Prescription coverage retentions will vary with census and can also vary depending upon the allocation of claims.

4.) RISK RETAINED BY LOCAL UNITS – APPLICABLE TO LAKEWOOD TOWNSHIP ONLY – NO RISK RETAINED BY HEALTH INSURANCE FUND (9/1/16-12/31/2017)

Medical and Prescription:

- Specific Retention: $200,000
- Aggregate Retention: $14,868,365 Medical and Rx
- Specific Limit Unlimited Medical Only
- Aggregate Limit $1,000,000, Medical and Rx
- Basis: Incurred 28 months, paid 16 months (run out claims and IBNR retained by Lakewood Township)
- No stop loss coverage is provided for Prescription coverage
- Stop Loss Carrier: Westport Insurance Corporation

Prescription Enrollees Without Self Insured Medical Coverage (Enrollees with fully insured Medicare Advantage Coverage)

- Risk fully retained by Lakewood Township – No Stop Loss Coverage or Reinsurance Purchased

5.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The Fund complies with statutory accounting standards and establishes reserves on the probable total claim costs at conclusion. 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 the adjusted at the end of the year in accordance with the actuary's projections.

6.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the year, the Fund adopts a budget for the upcoming year based on the most recent census. Per covered person 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 and rate certification process. These rates are used to compute the members' monthly assessment based on the updated census, and 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) and, in some cases, Dependent Age 31 participants, are billed directly by the Fund.

7.) 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 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.

8.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, the 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 the Fund's base rates. 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 Fund may also adopt mid Fund year rate changes to reflect changes in plan design, participation in lines of coverage, or a budget amendment. Loss experience 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 can be considered based upon the availability of

data, the feasibility of extracting the data, and the reimbursement to the Fund or its vendors of data extraction and formatting costs.. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, an increase may be applied to remaining lines of coverage, and it shall not be eligible for membership in the dropped line of coverage for a three year period.

9.) RATING PERIODS

All rating periods for municipal members coincide with the Fund year while rating periods for school members coincide with their fiscal year (July 1 to June 30).

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.

11.) PROVISION FOR PPOs, etc.

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

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 that may take place.

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.

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 provides "Medicare Advantage" plans for Medicare aged retirees. 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.

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 thirty-one (31) 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). Pursuant to N.J.A.C. 11:15-3.6 (d) 17, automatic coverage of a newborn child or an adopted child is provided for a period of 31 days from the date of birth or the date of adoption."

18.) PLAN DOCUMENT

The Fund prepares a detailed plan document 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 can coverage be changed.
- When does coverage end.
- COBRA provisions.
- Conversion privilege.

B.) Benefits

- Definitions.
- Description of benefits.

  Eligible services and supplies.
  Deductibles and co-payments.
  Examples as needed.
  Exclusions.
  Retiree coverage, before age 65 or after (if any).

C.) Claims Procedures

- Submission of claim.
- Proof of loss.
- Appeal procedures.

D.) Cost Containment Programs

- Pre-admission.
- Second surgical opinion.
- Other cost containment programs.
- Application and level of employee penalties.

19.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately every 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.

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.

20.) "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.

21.) CLAIM AUDIT

The Fund retains a claim auditor experienced in auditing self-insured health plans. The audit will be conducted every three years. The Fund can conduct this audit on its own, or in a cooperative effort with other Funds through the Municipal Reinsurance Health Insurance Fund.

22.) CLAIM APPEALS AND INDEPENDENT REVIEW ORGANIZATIONS

If an appeal to the Executive Committee results in a decision is to deny a 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 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 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 met requirements for eligibility under the Plan. 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://wwww.state.nj.us/dobi/consumer.htm e-mail: ombudsman@dobi.state.nj.us/

ADOPTED:

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 9-17

CENTRAL JERSEY HEALTH INSURANCE FUND
APPOINTING OF FUND COMMISSIONER AND ALTERNATE FUND COMMISSIONERS TO THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND

WHEREAS, The Central Jersey Health Insurance Fund has agreed to join the Municipal Reinsurance Health Insurance Fund; and

WHEREAS, by virtue of the conditions of membership contained in the by-laws of the fund, the Central Jersey Health Insurance Fund must appoint a Fund Commissioner and an Alternate;

NOW THEREFORE BE IT RESOLVED, Central Jersey Health Insurance Fund as follows:

1. That _____ is hereby appointed as Fund Commissioner.

2. That _____ is hereby appointed as Alternate.

CENTRAL JERSEY HEALTH INSURANCE FUND

ADOPTED JANUARY 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 10-17

CENTRAL JERSEY HEALTH INSURANCE FUND
ESTABLISHING PLAN FOR COMPENSATING PRODUCERS LICENSED PURSUANT TO N.J.S.A. 17:22A-1 ET SEQ AND REPRESENTING MEMBER ENTITIES

WHEREAS, The Central Jersey Health Insurance Fund permits member entities that designate a producer or risk manager to represent them in dealings with the Fund through subcontracts with the Program Manager; and

WHEREAS, Pursuant to N.J.A.C. 11:15-3.6 (e) 15, producer arrangements must be formally determined by the Fund and filed with the Department of Banking and Insurance; and

NOW THEREFORE BE IT RESOLVED, that the Central Jersey Health Insurance Fund establishes the following producer plan for 2017;

1. The Fund will include producer compensation in each entity's assessments using the compensation levels as disclosed to and approved by the member entity.

2. Each producer shall sub-contract with the Program Manager using the form of contract attached hereto.

3. The following sub-producers with the designated compensation levels are approved for 2017:

Group Name	Risk Manager	Dental Per/EE	New Member Per/EE
Brick Township	Fairview Insurance		$13.46
Englishtown Borough	Danskin Agency	$5.27	
Borough of West Long Branch	Brown & Brown Metro		$35.91
Borough of Keyport	Danskin Agency	$2.28	
Western Monmouth Utilities Authority	Danskin Agency	$5.26	
Borough of South River	Doyle Alliance		$26.96**
Housing Authority of Brick Township	Brown & Brown Metro		$14.80
** effective 2/1/2017			

4. This schedule may be amended upon written notification of each listed member entity.

CENTRAL JERSEY HEALTH INSURANCE FUND

ADOPTED: JANUARY 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 11-17

CENTRAL JERSEY HEALTH INSURANCE FUND
AUTHORIZING COMMISSION TREASURER TO PROCESS
CONTRACTED PAYMENTS AND EXPENSES

WHEREAS, the Executive Committee has deemed it necessary and appropriate to provide authorization to the Fund Treasurer to pay certain Fund contracted payments and expenses during the month(s) when the Commission does not meet; and

WHEREAS, payment by the Fund Treasurer of contracted payments and expenses for the month(s) in which the Fund does not meet shall be ratified by the Fund at its next regularly scheduled meeting; now, therefore,

BE IT RESOLVED by the Executive Committee of the Central Jersey Health Insurance Fund that the Fund Treasurer is hereby authorized to process the contracted payments and Fund expenses for all months in which the Fund does not meet during the year 2017.

BE IT FURTHER RESOLVED that the Executive Committee of the Central Jersey Health Insurance Fund shall ratify the contracted payments and Fund expenses so paid by the Fund Treasurer pursuant to the Resolution at its next regularly scheduled monthly meeting.

ADOPTED by Central Jersey Health Insurance Fund at a properly noticed meeting held on January 18, 2017.

ADOPTED:

BY:_____
Chairperson

ATTEST:

_____

Secretary

RESOLUTION NO. 12-17

CENTRAL JERSEY HEALTH INSURANCE FUND
ADOPTING 2017 WELLNESS GRANT PROGRAMS

WHEREAS, the Central Jersey Health Insurance 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 members for the Fund year through December 31, 2017. This budget includes $100,000 for individual member wellness grants;

WHEREAS, the Executive Committee requested grant applications from Fund members which were received and reviewed by the Committee;

WHEREAS, on January 18, 2017 the Executive Committee of the Central Jersey Health Insurance Fund approved Wellness Grant Programs for the following members:

CENTRAL JERSEY HEALTH INSURANCE FUND

ADOPTED: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 13-17

CENTRAL JERSEY HEALTH INSURANCE FUND
RESOLUTION TO OFFER MEMBERSHIP TO THE
THE BRICK TOWNSHIP HOUSING AUTHORITY

WHEREAS, a number of local public entities in the state of New Jersey have joined together to form a Joint Insurance Fund, entitled the Fund, (the "Fund") as permitted by chapter 372 Laws of 1983 (40A: 10-36); and

WHEREAS, the Fund held a Public Meeting on **January 18, 2017** for the purposes of conducting the official business of the Fund; and

WHEREAS, effective January 1, 2017, the Brick Township Housing Authority became independent of an existing Fund member, Brick Township, of which its experience has already been included and underwritten within the Fund.

WHEREAS, it appears that including Brick Township Housing Authority in the Fund as its own entity would be in the best interests of the Fund and the inclusion of the entity in the Fund is consistent with the Fund's By-laws; now, therefore,

BE IT RESOLVED, that the Central Jersey Health Insurance Fund hereby offers membership to the Brick Township Housing Authority on or about January 1, 2017 for prescription coverage, contingent upon receipt of the Fund's authorizing resolution to join the Fund and its executed Indemnity and Trust agreement.

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

CENTRAL JERSEY HEALTH INSURANCE FUND
APPROVAL OF THE DECEMBER 2016 AND JANUARY 2017 BILLS LISTS

WHEREAS, the Central Jersey Health Insurance Fund held a Public Meeting on **January 18, 2017** 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 December 2016 and January 2017 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 December 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 Central Jersey Health Insurance Fund hereby approve the Bills List for December 2016 and January 2017 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 Central Jersey Health Insurance 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: January 18, 2017

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY