RESOLUTION NO. 1-15

CENTRAL JERSEY HEALTH INSURANCE FUND
APPOINTING
PROFESSIONALS AND AWARDING CONTRACTS
FOR FUND YEAR 2015

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 30, 2014 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 15, 2014, and received and publicly opened resulting proposals on September 12, 2014 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 2015:

Central Jersey HIF	
Contract and Vendor	**2015 Fees**
Administrator - PERMA Risk Management Services	$8.14
Non Medical <1,001	$4.73
Non Medical >1,000	$3.44
Cobra	$0.81
GASB 45	$10,612
Med D & HIPAA	$18,374
Web Site Admin	$2,550.00
Annual Total	$247,870
Program Manager - Conner Strong & Buckelew	$19.05
Non Medical	$8.44
Health Care Reform	$0.83
Annual Total	$519,491
Actuary - John Vataha	$38,199
Attorney - Berry, Sahradnik, Kotzas & Benson	$34,329
Auditor - Holman & Frenia, PC	$22,185
Treasurer - Steven Mayer	$11,322
Dental TPA - Delta Dental	$3.05
Annual Total	$53,738
Rx Administrator - ESI - Medicare Part D Reporting	$5,000
Medical TPA - Aetna	
Medical	$48.55
Annual Total	$517,155
Medical TPA - Qualcare	
Network Fee - all Plans	$36.13
TPA - Vision Plan	$1.25
Multiplan	$25,153
Cost Containment	25% of saving
Annual Total	$ 205,566

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 16, Parsippany, NJ 07054;

CENTRAL JERSEY HEALTH INSURANCE FUND
ADOPTED: January 21, 2015

BY

_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 2-15

CENTRAL JERSEY HEALTH INSURANCE FUND
APPOINTING
PERMA RISK MANAGEMENT SERVICES
AS AGENT FOR THE FUND
FOR PROCESS OF SERVICE FOR THE YEAR 2015

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 16, Parsippany, NJ 07054, for the year 2015 or until its successor has be appointed and qualified.

ADOPTED: January 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 3-15

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 16, Parsippany, NJ 07054.

ADOPTED: January 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 4-15

CENTRAL JERSEY HEALTH INSURANCE FUND
DESIGNATING
THE ASBURY PARK PRESS AS
THE OFFICIAL NEWSPAPER FOR THE FUND YEAR 2015

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 2015 and that all official notices required to be published shall be published in this paper;

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.

ADOPTED: January 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 5-15

CENTRAL JERSEY HEALTH INSURANCE FUND
FIXING PUBLIC MEETING DATES
FOR THE YEAR 2015

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 2015 on the third Wednesday of the following months at 1:30 PM at the following locations:

DATE	**LOCATION**
March 18	Brielle Borough Hall
May 20	Brielle Borough Hall
July 15	Brielle Borough Hall
September 23	Brielle Borough Hall* 4th Wednesday
October 21	Brielle Borough Hall
November 18	Atlantic City Sheraton
January 20, 2016	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 21, 2015

BY:

_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 6-15

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 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 7-15

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 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 8-15

CENTRAL JERSEY HEALTH INSURANCE FUND
RESOLUTION ESTABLISHING INTEREST RATE
FOR DELINQUENT ASSESSMENTS

BE IT RESOLVED by the Central Jersey Health Insurance Fund that the rate of interest on delinquent assessments for the year 2015 shall be 10% per annum from the due date for any such assessment.

ADOPTED: January 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 9-15

CENTRAL JERSEY HEALTH INSURANC FUND
2015 RISK MANAGEMENT PLAN

NOW, THEREFORE, BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2015 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

Specific Retention: $225,000

Aggregate Retention: $40,304,640 (118.7% of budgeted claims)

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

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 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.

5.) 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.

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 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.) 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.

8.) 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).

9.) 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.

10.) 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.

11.) 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.

12.) 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.

13.) DISCLOSURE OF BENEFIT LIMITS

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

14.) 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.

15.) 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.

16.) 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."

17.) 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.

18.) 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.

19.) "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.

20.) 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.

21.) CLAIM APPEALS AND INDEPENDENT REVIWEW 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: JANUARY 21, 2015

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 10-15

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 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 11-15

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 2015;

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 2015:

Grinspec Consulting:
1) Neptune City – Fee $42.77 per employee, per month

Brown & Brown Metro:
1) Borough of West Long Branch – Fee $35.91 per employee, per month

Danskin Agency:
1) Borough of Englishtown – Fee $5.27 per dental employee, per month
2) Borough of Interlaken – Direct agreement with Borough
3) Borough of Allentown – Direct agreement with Borough
4) Borough of Keyport – Fee $2.28 per dental employee, per month

Fairview Insurance
1) Township of Brick - $.91 per prescription employee, per month

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

CENTRAL JERSEY HEALTH INSURANCE FUND

ADOPTED: JANUARY 21, 2015

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY