BURLINGTON COUNTY INSURANCE COMMISSION

HEALTH BENEFITS RISK MANAGEMENT PLAN

Effective: JANUARY 1, 2021

Adopted: JANUARY 7, 2021

BURLINGTON COUNTY INSURANCE COMMISSION

2021 HEALTH BENEFITS RISK MANAGEMENT PLAN

NOW, THEREFORE, BE IT RESOLVED that the following shall be the Commission's Risk Management Plan for the 2021 Commission year for health benefits:

1.) COVERAGE OFFERED

- Medical

  The Commission offers a "point of service" and "open access" plan designs. These plans have both in network and out of network benefit. The Commission can offer other plans as may meet the needs of the members. The Commission also offers "low cost plans" to allow members options to comply with contribution requirements under Chapter 78. The Commission also offers Medicare Advantage programs and/or Medicare Supplement programs.

- Dental

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

- Prescription

  The Commission offers customized prescription plans as required by the members, including plans that are coordinated with the low cost medical plan options.

- Vision

  The Commission plans to offer customized vision plans as required by the members but does not do so at this time.

2.) LIMITS OF COVERAGE

Limits of coverage vary by member and plan design.

3.) RISK RETAINED BY THE COMMISSION

Medical and Rx

Specific Retention:	$350,000 24/12 with following claims that are "lasered" at higher retentions:

Claimant 1 $500,000
Claimant 2 $750,000

Aggregating Specific Deductible	$450,000
Aggregate Retention:	Not applicable

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The Commission complies with statutory accounting standards and establishes reserves on the probable total claim costs as of the end of each Commission 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 Commission year. This accrual is then 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 Commission adopts a budget for the upcoming year based on the most recent census. Per employee rates are computed for each line of coverage for each Commission member, and are approved by the Commission 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 provided 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 participants (COBRA, Conversion, Dependents to Age 31 and some retirees) are billed directly by the Commission's enrollment vendor.

6.) COVERAGE PURCHASED FROM INSURERS

The Commission provides medical and Rx coverage on a self-insured basis, and secures excess insurance to cap the Commissions' specific (i.e. per enrolled covered person per policy year) retention and aggregate retention. The Commission also purchases Medicare Advantage and Employer Group Waiver Programs from the commercial market for Medicare retirees.

7.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Commission, 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 Commission 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 Commission's base rates or to the rates being paid by the entity. This recommendation requires Commission approval before the prospective member is admitted to the Commission.

Rates for all members are adjusted at the beginning of each Commission year to reflect the new budget. However, entities operating on a fiscal year basis (July 1 to June 30) have the option to receive rates that are certified for a period corresponding to their fiscal year. Rates reflect the overall cash flow needs of the Commission, and actuarial factors needed to assure that individual entity rates reflect the risk profile of the member. The Commission may implement individual entity loss ratio adjustments based upon recommendations from the Commission actuary. The Commission may also adopt mid Commission 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 Commission 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 Commission's self insured retention. Requests for additional claims data from Commission members will be considered based upon the availability of data, the feasibility of extracting the data, and conditioned upon the member reimbursing the Commission or its vendors for data extraction and formatting costs.

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

Unless otherwise authorized as part of the offer of membership, where a member joins during a Commission year, the member's initial rates are only valid through the end of that Commission year or, for schools, fiscal year, at which time the rates are adjusted for all members to reflect the new budget.

10.) PROVISION FOR PLAN DESIGN OPTIONS

The Commission offers employees the option of selecting various plans depending upon member bargaining agreements. Generally, it is the policy of the Commission to encourage selection of lower cost plan designs as opposed to traditional indemnity plans, and the Commission 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 each member entity 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.

12.) COBRA AND CONVERSION OPTIONS

The Commission provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The Commission has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. The Commission's coverage for individuals covered under COBRA shall terminate effective the date the member withdraws from the Commission, or otherwise ceases to be a member of the Commission.

13.) DISCLOSURE OF BENEFIT LIMITS

The Commission 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 Commission or confer any additional rights to the employees. Where the Commission 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

Fund duplicates coverage for eligible retirees not eligible or enrolled in a Medicare Advantage Plan. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund for a specific line of coverage 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)."

17.) PLAN DOCUMENT

Each member of the Commission contracts for the preparation of 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:

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 COMMISSION YEARS

Approximately six months after the end of a Commission year, the Commission 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 Commission begins to consider

closing the year, unless excess insurance recoveries are pending or litigation is likely. The Commission has determined that maintaining and retaining a surplus equal to two (2) months of the current year claim expenses is a benchmark prior to a dividend being declared from surplus generated by claims operations. A member entity will be eligible to participate in the dividend provided that its pro rata share of the Commission's surplus account is greater than two (2) months of said member entity's projected claims expense (the "retention amount") and shall be paid from amounts in excess of the established retention amount.

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

- A reserve is established by the actuary to cover any unpaid claims or IBNR
- The Commission decides on the final dividend or supplemental assessment.
- A closure resolution is adopted transferring all remaining assets and liabilities of that Commission year to the "Closed Commission Year/Contingency Account".
- Each member's pro rata share of the residual assets are computed and added to its existing balance in the Closed Commission Year/Contingency Account. Any member who has withdrawn from the Commission shall receive its remaining share of the Closed Commission Year/Contingency Account six years after the date of its withdrawal.

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

The Commission covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former Commission member during the period it was a member. Upon approval by the Commissioners, the Commission may also cover the run-in liability of a prospective 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 Commission). When the Commission covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the Commission's actuary and approved by the Commissioners.

20.) CLAIM AUDIT

The Commission may retain a claim auditor experienced in auditing self-insured health plans. The audit will be conducted every three years.

21.) CLAIMS APPEALS

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

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 met 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://wwww.state.nj.us/dobi/consumer.htm e-mail: ombudsman@dobi.state.nj.us/

ADOPTED:

BY: _____
CHAIR

ATTEST: _____