REVISED RESOLUTION NO. 8-16

BERGEN MUNICIPAL EMPLOYEES BENEFITS FUND
2016 RISK MANAGEMENT PLAN

NOW, THEREFORE, BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2016 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 offered "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. .

- 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

Specific Retention:	$225,000
Aggregate Retention:	$17,607,216 (118.2% 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 each quarter 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 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 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 participants (COBRA, Conversion and some retirees) and, in some cases, Dependents under age 31, 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. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the remaining lines of coverage may be adjusted and the entity shall not be eligible for membership in the dropped line of coverage for a three year period.

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.

8.) RATING PERIODS

All rating periods for municipal members coincide with the Fund year while rating periods for school members can 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. 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

Claim appeals shall be processed in accordance with the Fund by-laws. In addition, there is hereby established a Small Claims Committee that shall handle claims where the dollar amount is not greater than $1,000.00 or likely not to exceed a total of $2,500 in one rolling 12 month cycle, where the treatment or therapy in question is of a continuing nature. This responsibility will extend to out of network payments, within the above thresholds, that may be above standard schedules that may be justified or appealed due to continuity of care considerations.

. The Small Claims Committee shall consist of the following persons:

A. Representative from the T.P.A.
B. Three fund commissioners as designated by the Fund chairman.

The Small Claims Committee shall report on all claims approved, in accordance with a reporting form approved by Resolution of the Executive Committee, at the first meeting following any such determination unless made within ten (10) days of a scheduled meeting in which case it will be the subsequent meeting. No person whose claim has been reviewed by the Small Claims Committee will be deprived of their opportunity to have their claim appeal adjudicated by the entire Executive Committee if they choose to do so.

All Small Claims Committee decisions to pay claims shall be unanimous (except in the case of unavailability of a member of the Committee) in which case it will be required that the remaining members be unanimous and that no less than __3___ people on the Committee have reviewed the claim.

Claims appealed beyond the executive committee shall be processed by Independent Appeal organizations designated by the Fund.

ADOPTED:

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 13-16

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND

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

WHEREAS, The Bergen Municipal Employee Benefits Fund permits member entities that designate a producer or risk manager to represent them in dealings with the Fund through subcontracts with the Fund; 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 Bergen Municipal Employee Benefits Fund establishes the following producer plan for 2016;

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 Fund using the standard form of contract.

3. The following sub-producers with the designated compensation levels are approved for 2016:

Group Name	RMC Name	RMC Rate (PEPM)	Large Producer Incentive
BOROUGH OF HILLSDALE	Burton	$0.93	
BOROUGH OF WESTWOOD	Burton	$11.12	
TOWNSHIP OF MINE HILL	Fairview Insurance	$2.50	
TOWNSHIP OF FAIRFIELD	IMAC	$55.71	$0.84
FAIRFIELD BOE	IMAC	$52.15	$0.84
WANAQUE VALLEY REGIONAL S.A.	McCarthy & Forde	$2.43	
VILLAGE OF RIDGEFIELD PARK	Otterstedt	$36.30	
BOROUGH OF EMERSON	P. Weisbart/Vozza	$1.25	
BOROUGH OF ALPINE	Parsells Agency	$1.28	
TOWNSHIP OF SOUTH HACKENSACK	PIA	$17.39	$1.89
MAYWOOD BOROUGH	PIA	$3.06	$1.89
BOROUGH OF EAST RUTHERFORD	PIA	$1.09	$1.89
BOROUGH OF WALLINGTON	PIA	$10.59	$1.89
TOWNSHIP OF ROCHELLE PARK	PIA	$1.16	$1.89
EAST RUTHERFORD BOARD OF ED	PIA	$2.58	$1.89
CARLSTADT BOARD OF ED	PIA	$2.69	$1.89
BOROUGH OF FRANKLIN LAKES	PIA	$29.62	$1.89
BOROUGH OF MOONACHIE	PIA	$16.99	$1.89
BOROUGH OF CARLSTADT	PIA	$2.97	$1.89
BOROUGH OF LODI	PIA	$0.97	$1.89
BOROUGH OF MONTVALE	PIA	$14.00	$1.89
BOROUGH OF NORTH ARLINGTON	PIA	$0.95	$1.89
BOROUGH OF RUTHERFORD	PIA	$36.66	$1.89
BOROUGH OF WOOD-RIDGE	PIA	$0.77	$1.89
BOROUGH OF SADDLE RIVER	PIA	$13.01	$1.89
BOROUGH OF PARK RIDGE	Vozza	$4.04	
BOROUGH OF FT. LEE	Vozza	$4.04	
BOROUGH OF OAKLAND	Vozza	$35.53	

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

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND

ADOPTED: February 25, 2016

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 14-16

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
APPROVAL OF THE FEBRUARY 2016 BILLS LIST

WHEREAS, the **Bergen Municipal Employee Benefits Fund** held a Public Meeting on **February 25, 2016** 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 month of February 2016 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 **Bergen Municipal Employee Benefits Fund** hereby approve the Bills List for February 2016 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.

ADOPTED: FEBRUARY 25, 2016

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 15-16

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
APPROVAL OF CLAIMS PAYMENTS/IMPREST TRANSFERS
FOR FEBRUARY 2016

WHEREAS, the **Bergen Municipal Employee Benefits Fund** held a Public Meeting on **February 25, 2016** for the purposes of conducting the official business of the Fund; 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 **Bergen Municipal Employee Benefits Fund** hereby approve the Treasurers Report as furnished by the Treasurer of the Fund and concur with actions undertaken by the Treasurer, in accordance with the laws and regulations promulgated by the State of New Jersey for Municipal Health Insurance Funds.

ADOPTED: FEBRUARY 25, 2016

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 16-16

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND
APPROVAL OF EXECUTIVE SESSION

WHEREAS, the **Bergen Municipal Employee Benefits Fund** held a Public Meeting on **FEBRUARY 25, 2016** for the purposes of conducting the official business of the Fund; and

WHEREAS, the Meeting was properly advertised in accordance with the Open Public Meetings Act of the State of New Jersey; and

WHEREAS, it was determined by the Executive Committee of the Fund such issues relative to litigation require discussion by the Executive Committee; and

WHEREAS, proper notification was given that an Executive Session would be on the Agenda of the **FEBRUARY 25, 2016** meeting,

NOW, THEREFORE BE IT RESOLVED, the Commissioners of the Executive Committee of the **Bergen Municipal Employee Benefits Fund** hereby move to enter Closed Session for the purpose of discussing issues relating to litigation and authorizes the official record of the meeting of the Fund reflect same.

ADOPTED: FEBRUARY 25, 2016

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY