Southern Jersey FUND

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

AGENDA & REPORTS
MARCH 22, 2021
CONFERENCE CALL
6:00 PM

Join Zoom Meeting

https://permainc.zoom.us/j/95934689266

Meeting ID: 959 3468 9266

Dial by your location

+1 929 205 6099 US (New York)
+1 301 715 8592 US (Washington D.C)
+1 312 626 6799 US (Chicago)

Meeting ID: 959 3468 9266

STATEMENT OF COMPLIANCE WITH OPEN PUBLIC MEETINGS ACT

Pursuant to Executive Order Number 103 dated March 9, 2020, Governor Murphy declared a Public Health Emergency and a State of Emergency in New Jersey. On March 20, 2020 P.L. 2020 Chapter 11 amended the Open Public Meetings Act to allow local public bodies to conduct Remote Public Meetings by use of electronic communications technology during a period declared as a Public Health Emergency or a State of Emergency.

Adequate Notice and Electronic Notice of this meeting was given by:

1. Sending advance written notice to The Courier Post and the Burlington County Times

2. Filing advance written notice of this meeting with the Clerk/Administrator of each member.

3. Sending advance electronic mail notice of this meeting to the Clerk/Administrator of each member.

4. Posting electronic notice of this meeting on the Fund's website which notice provided the time, date and instructions for: (i) access to the Remote Public Meeting, (ii) how to provide public comment and (iii) how to access the agenda.

5. Posting a copy of the meeting notice on the public bulletin board of all members.

6. During the business session portion of this Remote Public Meeting the audio of all members of the public attending the meeting will be muted. At the end of the business session of the meeting, a time for public comment will be available. Members of the public who desire to provide comment shall raise their virtual hand in the Zoom application and/or submit a written comment via the text message section of the application. The meeting moderator will queue the members of the public that wish to provide comment and the Chairperson will recognize them in order. Public comment shall be concise and to the point and shall not contain abusive, defamatory, or obscene language.

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
AGENDA
MEETING: MARCH 22, 2021
CONFERENCE CALL
6:00 PM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ

FLAG SALUTE – MOMENT OF SILENCE

ROLL CALL OF 2021 EXECUTIVE COMMITTEE

Michael Mevoli, Chairman
Joseph Wolk, Secretary
Louis DiAngelo, Executive Committee Member
Terry Shannon, Executive Committee Member
Neal Rochford, Executive Committee Member
Edward Hill, Executive Committee Member
Robert Maybury, Executive Committee Member
Gary Passanante, Executive Committee Alternate

APPROVAL OF MINUTES: February 22, 2021 Open (**Appendix I)**

CORRESPONDENCE – None

REPORTS:

EXECUTIVE DIRECTOR (PERMA)
Monthly Report.....**Page 1**

PROGRAM MANAGER– (Conner Strong & Buckelew)
Monthly Report.....**Page 7**

TREASURER – (Michael Zambito/Verrill & Verrill)
March 2021 Voucher List (Resolution 15-21) ..... **Page 12**
Treasurers Report ..... **Page 14**
Resolution 15-21: March 2021 Bills List ..... **Page 17**
Confirmation of Claims Paid/Certification of Transfers
Ratification of Treasurers Report

ATTORNEY – (J. Kenneth Harris)
Monthly Report

NETWORK & THIRD PARTY ADMINISTRATOR – (Aenta)
Monthly Report..... **Page 18**

NETWORK & THIRD PARTY ADMINISTRATOR – (AmeriHealth)
Monthly Report..... **Page 22**

PRESCRIPTION ADMINISTRATOR – (Express Scripts)
Monthly Report..... **Page 30**

DENTAL ADMINISTRATOR – (Delta Dental)
Monthly Report

OLD BUSINESS

NEW BUSINESS

PUBLIC COMMENT

RESOLUTION - EXECUTIVE SESSION FOR CERTAIN SPECIFIED PURPOSES
PERSONNEL - CLAIMS – LITIGATION

MEETING ADJOURNED

Southern New Jersey Regional Employee Benefits Fund
Executive Director's Report
March 22, 2021

FINANCE AND CONTRACTS

PRO FORMA REPORTS

- **Fast Track Financial Report –** as of January 31, 2021 (page 2)

AMERIHEALTH (AHA) CONTRACT

The AHA contract with the SNJREBF has been updated with the most current public sector language requirements and to reflect more terms that are standard for AHA. The compensation amounts are unchanged. This new contract will cover the period from 1/1/2019 to 12/31/2021. The contract is included in Appendix II.

During contract discussions, it was determined that the Fund was overpaying for the CCBOSS lives which produced a small credit to the Fund.

Motion: Authorize Fund Chairman and Secretary to sign new AHA contract.

COBRA SUBSIDY LEGISLATION

Our Benefits Enrollment vendor has reviewed the EBSA Disaster Relief Notice 2021-01 that was released on 2/26 and is currently reviewing further to determine how this will impact our members. They will advise next steps soon. They did confirm that the Department of Labor will provide Model Notices within 30 days of the enactment of ARPA and within 45 days for the Notice that is required when the subsidy will be ending.

MEL/MR-HIF/ CEL EDUCATIONAL SEMINAR

The 2021 seminar will be held virtually on the mornings of Friday, May 14th and Friday, May 21st. The information on how to register is included in Appendix III. The agenda includes two ethics courses, and presentations on implicit bias, insurance market conditions, proposals to change the Workers' Compensation law and a discussion of proposed changes to the Affordable Care Act.

FINANCIAL DISCLOSURE FILINGS

Commissioners should anticipate the online filing of the Financial Disclosure forms as both a Southern New Jersey Regional Employee Benefits Fund Commissioner, as well as any municipal related position that requires filing and Joint Insurance Fund. It is expected the Division of Local Government Services will distribute a notice in April and forms will need to be filed by April 30th.

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF January 31, 2021

			THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
1.	**UNDERWRITING INCOME**		**3,633,455**	**3,633,455**	**1,273,863,797**	**1,277,497,253**
2.	**CLAIM EXPENSES**					
	Paid Claims		3,041,585	3,041,585	1,034,181,010	**1,037,222,595**
	IBNR		139,682	139,682	2,850,521	**2,990,203**
	Less Specific Excess		-	-	(19,184,698)	**(19,184,698)**
	Less Aggregate Excess		-	-	(1,807,360)	**(1,807,360)**
	TOTAL CLAIMS		**3,181,267**	**3,181,267**	**1,016,039,473**	**1,019,220,741**
3.	**EXPENSES**					
	MA & HMO Premiums		114,439	114,439	27,777,460	**27,891,898**
	Excess Premiums		60,217	60,217	47,663,208	**47,723,425**
	Administrative		213,557	213,557	115,823,339	**116,036,896**
	TOTAL EXPENSES		**388,212**	**388,212**	**191,264,007**	**191,652,219**
4.	**UNDERWRITING PROFIT (1-2-3)**		63,976	63,976	66,560,317	**66,624,293**
5.	**INVESTMENT INCOME**		8,737	8,737	3,368,595	**3,377,332**
6.	**DIVIDEND INCOME**		0	0	11,184,436	**11,184,436**
7.	**STATUTORY PROFIT (4+5+6)**		**72,713**	**72,713**	**81,113,348**	**81,186,061**
8.	**DIVIDEND**		0	0	69,760,072	**69,760,072**
9.	**Transferred Surplus**		0	0	0	**0**
	STATUTORY SURPLUS (7-8+9)		**72,713**	**72,713**	**11,353,275**	**11,425,988**
			SURPLUS (DEFICITS) BY FUND YEAR			
	Closed	**Surplus**	3,254	3,254	5,844,521	**5,847,775**
		Cash	(373,009)	(373,009)	11,354,628	**10,981,619**
	2019	**Surplus**	7,943	7,943	4,270,513	**4,278,456**
		Cash	7,943	7,943	4,270,273	**4,278,216**
	2020	**Surplus**	(124,410)	(124,410)	1,238,241	**1,113,831**
		Cash	(1,565,012)	(1,565,012)	3,052,930	**1,487,918**
	2021	**Surplus**	185,927	185,927		**185,927**
		Cash	(1,568,952)	(1,568,952)		**(1,568,952)**
	TOTAL SURPLUS (DEFICITS)		**72,713**	**72,713**	**11,353,275**	**11,425,988**
	TOTAL CASH		**(3,499,031)**	**(3,499,031)**	**18,677,832**	**15,178,801**
			CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS		**(97)**	**(97)**	**950,769,554**	**950,769,457**
	FUND YEAR 2019					
	Paid Claims		(4,346)	(4,346)	32,736,244	**32,731,899**
	IBNR		-	0	0	**0**
	Less Specific Excess		-	0	(691,587)	**(691,587)**
	Less Aggregate Excess		-	0	0	**0**
	TOTAL FY 2019 CLAIMS		**(4,346)**	**(4,346)**	**32,044,657**	**32,040,312**
	FUND YEAR 2020					
	Paid Claims		1,663,464	1,663,464	30,805,796	**32,469,261**
	IBNR		(1,537,071)	(1,537,071)	2,850,521	**1,313,450**
	Less Specific Excess		0	0	(431,054)	**(431,054)**
	Less Aggregate Excess		0	0	0	**0**
	TOTAL FY 2020 CLAIMS		**126,393**	**126,393**	**33,225,263**	**33,351,657**
	FUND YEAR 2021					
	Paid Claims		1,382,564	1,382,564		**1,382,564**
	IBNR		1,676,753	1,676,753		**1,676,753**
	Less Specific Excess		0	0		**0**
	Less Aggregate Excess		0	0		**0**
	TOTAL FY 2021 CLAIMS		**3,059,317**	**3,059,317**		**3,059,317**
	COMBINED TOTAL CLAIMS		**3,181,267**	**3,181,267**	**1,016,039,475**	**1,019,220,742**

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

Southern New Jersey Regional Employee Benefits Fund

CONSOLIDATED BALANCE SHEET

AS OF JANUARY 31, 2021

BY FUND YEAR

	SNJREBF 2021	SNJREBF 2020	SNJREBF 2019	CLOSED YEAR	FUND BALANCE
ASSETS					
Cash & Cash Equivalents	(1,568,952)	1,487,918	4,278,216	10,981,619	15,178,801
Assesstments Receivable (Prepaid)	3,433,468	(50,156)	9,381	119,957	3,512,650
Interest Receivable	-	60	(26)	(34)	0
Specific Excess Receivable	-	431,054	(555)	-	430,499
Aggregate Excess Receivable	-	-	-	-	-
Dividend Receivable	-	-	-	517,797	517,797
Prepaid Admin Fees	1,833	-	-	-	1,833
Other Assets	-	600,000	-	-	600,000
Total Assets	1,866,349	2,468,877	4,287,017	11,619,339	20,241,581
LIABILITIES					
Accounts Payable	-	-	-	-	-
IBNR Reserve	1,676,753	1,313,450	-	-	2,990,203
A4 Retiree Surcharge	-	-	-	-	-
Dividends Payable	-	-	-	5,771,571	5,771,571
Accrued/Other Liabilities	3,669	41,595	8,561	-	53,825
Total Liabilities	1,680,422	1,355,046	8,561	5,771,571	8,815,600
EQUITY					
Surplus / (Deficit)	185,927	1,113,831	4,278,456	5,847,767	11,425,981
Total Equity	185,927	1,113,831	4,278,456	5,847,767	11,425,981
Total Liabilities & Equity	1,866,349	2,468,877	4,287,017	11,619,339	20,241,581
BALANCE	-	-	-	-	-

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

Fund Year allocation of claims have been estimated.

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

RATIOS

INDICES	2020	JAN	FEB
Cash Position	18,677,832	$ 15,178,801	
IBNR	2,850,521	$ 2,990,203	
Assets	20,687,548	$ 20,241,581	
Liabilities	9,334,280	$ 8,815,600	
Surplus	11,353,268	$ 11,425,981	
Claims Paid -- Month	2,209,786	$ 3,041,585	
Claims Budget -- Month	2,870,280	$ 3,027,707	
Claims Paid -- YTD	32,769,858	$ 3,041,585	
Claims Budget -- YTD	34,443,363	$ 3,027,707	
RATIOS			
Cash Position to Claims Paid	8.45	4.99	
Claims Paid to Claims Budget -- Month	0.77	1.00	
Claims Paid to Claims Budget -- YTD	0.95	1.00	
Cash Position to IBNR	6.55	5.08	
Assets to Liabilities	2.22	2.3	
Surplus as Months of Claims	3.96	3.77	
IBNR to Claims Budget -- Month	0.99	0.99	

REGULATORY

Monthly Items	Filing Status
Budget	**Filed**
Assessments	**Filed**
Actuarial Certification	**Filed**
Reinsurance Policies	**Filed**
Fund Commissioners	**Filed**
Fund Officers	**Filed**
Renewal Resolutions	**Filed**
Indemnity and Trust	**Compliance List included on page 6**
New Members	**N/A**
Withdrawals	**N/A**
Risk Management Plan and By Laws	**Filed**
Cash Management Plan	**Filed**
Unaudited Financials	**12/31/2020 Filed**
Annual Audit	**12/31/2019 filed**
Budget Changes	**N/A**
Transfers	**N/A**
Additional Assessments	**N/A**
Professional Changes	**N/A**
Officer Changes	**N/A**
RMP Changes	**N/A**
Bylaw Amendments	**N/A**
Contracts	**File**
Benefit Changes	**N/A**

Professional	Contract Received	Insurance Received	Contract Term
Executive Director	Yes	Yes	1/1/2019 - 12/31/2021
Program Manager	Yes	Yes	1/1/2019 - 12/31/2021
Attorney	Yes	Yes	1/1/2021-12/31/2022
Treasurer	Yes	Yes	1/1/2021-12/31/2022
Auditor	Yes	Yes	1/1/2021-12/31/2022
Deputy Treasurer	in progress	Yes	1/1/2021-12/31/2022
Actuary	Yes	Yes	1/1/2021-12/31/2022
Aetna	Yes	in progress	*1 year renewal negotiated
AmeriHealth	Yes	in progress	*1 year renewal negotiated
Delta Dental	Yes		*1 year renewal negotiated
United Healthcare	Yes	in progress	1/1/2020-12/31/2021

INDEMNITY & TRUST AGREEMET COMPLIANCE

Member	I&T end date
TOWNSHIP OF WILLINGBORO	email sent 1/19/2021
BOROUGH OF BELLMAWR	email sent 1/19/2021
HADDONFIELD BOROUGH	12/31/2021
BOROUGH OF SOMERDALE	12/31/2021
BOROUGH OF BROOKLAWN	12/31/2021
BOROUGH OF MAGNOLIA	12/31/2021
BOROUGH OF MERCHANTVILLE	12/31/2021
BOROUGH OF LINDENWOLD	12/31/2021
BOROUGH OF MOUNT EPHRAIM	12/31/2021
BOROUGH OF WENONAH	12/31/2021
NORTH HANOVER TWP	12/31/2021
WINSLOW TWP FIRE DISTRICT #1	12/31/2021
PINE HILL BOROUGH	12/31/2021
MT. HOLLY MUNICIPAL UTILITIES AUTHO	12/31/2021
LUMBERTON TOWNSHIP	12/31/2021
BOROUGH OF RUNNEMEDE	12/31/2021
CAMDEN COUNTY BOARD OF SOCIAL SERVICES	12/31/2021
Township of Winslow	12/31/2021
WINSLOW TOWNSHIP	12/31/2021
PALMYRA	12/31/2021
BOROUGH OF BARRINGTON	12/31/2022
BOROUGH OF PAULSBORO	12/31/2022
BOROUGH OF GIBBSBORO	12/31/2022
TOWNSHIP OF BORDENTOWN	12/31/2022
TOWNSHIP OF MAPLE SHADE	12/31/2022
PENNSAUKEN TOWNSHIP	12/31/2022
BOROUGH OF HADDON HEIGHTS	12/31/2022
BOROUGH OF WESTVILLE	12/31/2022
CHESILHURST BOROUGH	12/31/2022
FRANKLIN TWP	12/31/2022
TOWNSHIP OF BERLIN	12/31/2022
GLOUCESTER CITY	12/31/2022
BOROUGH OF PITMAN	12/31/2022
TOWNSHIP OF WATERFORD	12/31/2022
PENNSAUKEN TOWNSHIP	12/31/2022
BOROUGH OF MEDFORD LAKES	12/31/2023
MANTUA TOWNSHIP	12/31/2023
GLOUCESTER TOWNSHIP	12/31/2023

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
PROGRAM MANAGERS REPORT
March 2021
Program Manager: Conner Strong & Buckelew
Online Enrollment Training: kkidd@permainc.com
Enrollments/Eligibility/Billing: southernnj_enrollments@permainc.com
Brokers: brokerservice@permainc.com

ONLINE ENROLLMENT SYSTEM TRAINING

PERMA offers a virtual training and a refresher class on the online enrollment system the third Wednesday of each month. The sessions provide an overview of the Fund's enrollment system and shows users how perform tasks in the system. To use the enrollment system, each HR user must complete a system access form. Please email Austin Flinn at aflinn@permainc.com and indicate which of the sessions below you would like to attend. Please include this information in the subject line: Training - Fund Name and Client Name.

- Wednesday, February 17th 10:00 am - 11:00 am
- Wednesday, March 17th 10:00 am - 11:00 am
- Wednesday, April 21st 10:00 am - 11:00 am
- Wednesday, May 19th 10:00 am - 11:00 am
- Wednesday, June 16th 10:00 am - 11:00 am
- Wednesday, July 14th 10:00 am - 11:00 am
- Wednesday, August 18th 10:00 am - 11:00 am
- Wednesday, September 15th 10:00 am - 11:00 am
- Wednesday, October 20th 10:00 am - 11:00 am
- Wednesday, November 17th 10:00 am - 11:00 am

ENROLLMENT & ELIGIBILITY CONTACT

Please continue to direct any eligibility, enrollment, billing or system related questions to our dedicated Southern NJ Enrollment Team. The team can be reached by email at southernnj_enrollments@permainc.com . Attached please find an updated SNJREBF Enrollment Contact Information sheet.

MONTHLY BILLING

As a reminder, please be sure to check your monthly invoice for accuracy. If you find a discrepancy, please report it to the SNJREBF enrollment team. The Fund's policy is to limit retro corrections, *including terminations,* to 60 days. We have noticed an increase in requests for enrollment changes, billing changes, terminations and additions well past the 60 day time frame. Moving forward, it is of the utmost importance to review bills for rate and enrollment accuracy on a monthly basis. If there is an error, please bring it to the enrollment team's attention.

BROKER CONTACT INFORMATION

Please direct any escalated claims, benefit coverages, prescription coverage, Medicare advantage or appeal related questions to our dedicated SNJREBF Client Servicing Team. The team can be reached by email at brokerservices@permainc.com.

CONNER STRONG COVID-19 RESOURCES

- Conner Strong & Buckelew has compiled a database of COVID-19 resources available to Fund members: https://www.connerstrong.com/insights/covid-19-resource-center/
- The State of NJ has a helpful COVID-19 website with up to date information including vaccine rollout: www.Covid19.nj.gov

COVID-19 Vaccination Benchmarking

The results of a recent Employer Benchmarking Survey regarding employee vaccination policies/concerns was conducted by the Society for Human Resources Management (SHRM) were distributed via email with the SNJREBF Executive Committee, Member-Entities and Brokers. Many companies are encouraging their employees to get the vaccine, but are not planning to require workers vaccinations before returning to work. There is strong divide among employees who believe that any worker eligible for the vaccine should be required to get it and employees who reported that they will NOT get vaccinated even if their employment will be terminated.

Key points from the survey include:

- ✓ 60 percent of organizations say they will not require the vaccinations
- ✓ 60% of workers will probably or definitely get the vaccine once it becomes available to them.
- ✓ 24% of employees who are not planning to get vaccinated would change their minds if their employer offered incentives such as cash bonuses or stipends, paid time off (PTO) or gift cards
- ✓ 12% of employees would be willing to get vaccinated only if they might otherwise lose their job
- ✓ 77% of government, public administration or military organizations were more likely to encourage employees to get vaccine
- ✓ SHRM Information on making "mandating" the vaccine: https://www.shrm.org/ResourcesAndTools/legal-and-compliance/employment-law/Pages/coronavirus-different-approaches-vaccinations.aspx
- ✓ CDC hub on vaccine policy and information: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/essentialworker/workplace-vaccination-program.html

AETNA UPDATE

Aetna Network - Negotiations with Deborah Heart and Lung Center

- Aetna is currently in negotiations with Deborah Heart and Lung Centers in Brown Mills, NJ. The contract is set to expire on May 16, 2021, through an extension provided. The facility will be out-of-network for both Medicare Advantage and non-Medicare Advantage SNJREBF members if settlement is not reached by that date.
- Both parties are continuing discussions in hopes of reaching an acceptable agreement.
- Within the past 12 months, 10 SNJ HIF members have used this facility.
- At this time, there are no member communications scheduled for distribution. We will keep you apprised if that changes.

ALTERNATE AREA HOSPITALS

Virtua Health - Willingboro Hospital 218A Sunset Road Willingboro, NJ 08046 *Burlington County*	**Virtua Health - Virtua Memorial Hospital** 175 Madison Avenue Mount Holly, NJ 08060 *Burlington County*
Virtua Health- Marlton Hospital 90 Brick Road Marlton, NJ 08053 *Burlington County*	**Hackensack Meridian Health-Southern Ocean Medical Center** 1140 Route 72 West Manahawkin, NJ 08050 *Ocean County*
Community Medical Center- Toms River 99 NJ-37 Toms River, NJ 08755 *Ocean County*	**RWJ Barnabas-Hamilton** One Hamilton Health Place Hamilton, NJ 08690 *Mercer County*
Trinity Health-St. Francis Medical Center 601 Hamilton Ave Trenton, NJ 08629 *Mercer County*	**Capital Health Regional Medical Center** 750 Brunswick Avenue Trenton, NJ 08638 *Mercer County*
Cooper Health System- Cooper University One Cooper Plaza Camden, NJ 08103 *Camden County*	**Kennedy Health- Stratford** 18 East Laurel Road Stratford, NJ 08084 *Camden County*
Virtua Health- Voorhees Hospital 100 Bowman Drive Voorhees Township, NJ 08043 *Camden County*	**Virtua Health- Our Lady of Lourdes** 1600 Haddon Avenue Camden, NJ 08103 *Camden County*
CentraState Healthcare System 901 West Main St Freehold, NJ 07728 *Monmouth County*	**Inspira Medical Center- Mullica Hill** 700 Mullica Hill Road Mullica Hill, NJ 08062 *Gloucester County*

LEGISLATIVE UPDATE

***American Rescue Plan* COBRA Subsidies –** The US House of Representatives recently passed a sweeping COVID relief package, which includes a provision regarding subsides for COBRA premiums. If the Senate passes the bill, individuals eligible for COBRA due to involuntary employment termination or reduction in hours may receive an 85% reduction of COBRA premiums.

Key provisions include:

- Subsidies to become available to impacted workers beginning on the first of the month following enactment date and remain available through 9/30/2021.
- Extends COBRA election period to allow workers who previously had a Qualified Life Event (QLE) to enroll in coverage.

- Requires employers to provide clear, understandable, written notices to workers.
- Establishes expedited review process for workers denied premium assistance.
- Provides a payroll tax credit to reimburse employers and plans for the full cost of COBRA premiums not paid by workers.

ADMINISTRATIVE AUTHORIZATIONS

There are currently no administrative authorizations to report.

Southern Jersey FUND

COVID-19 VACCINES

The COVID-19 vaccine situation is rapidly evolving. Eligibility requirements, appointment scheduling, distribution site information, and overall guidelines vary by state and are changing at a rapid pace. Listed below, you'll find links to updated information detailing vaccination protocol near you.

New Jersey

- **www.covid-19.nj.gov** - For up to date information, resources, and guidance on questions about getting testing for COVID-19, contact tracing and, traveling to or from the State of New Jersey.
- **www.covid19nj.gov/vaccine** - For up-to-the-minute information on vaccine distribution.

State of Pennsylvania

- **www.covidportal.health.pa.gov/s/Your-Turn** - For up-to-the-minute information on vaccine distribution.

Additional Resources

- Conner Strong & Buckelew has compiled a database of COVID-19 resources available to Fund members: **https://www.connerstrong.com/insights/covid-19-resource-center/**
- For more details regarding a particular state not listed above, visit the official CDC site: **www.cdc.gov/coronavirus/2019-ncov/vaccines**

QUESTIONS & ANSWERS

How much will I have to pay to get the vaccine?

Nothing! Your SNJREBF medical plan pays the cost of administering the vaccine with $0 cost-share regardless of what provider you use.

Is the vaccine safe?

The FDA has declared the vaccines as safe. Vaccines go through a rigorous testing protocol and approval process before they are distributed to the general population.

Can I get COVID-19 from the vaccine?

No. None of the vaccines currently in development or in use in the United States contain the live virus. The vaccines are meant to teach our immune systems to fight the virus that causes COVID-19. It takes about two weeks to build immunity after vaccination, so it's possible to still become infected during this time.

Are there any side effects?

Some individuals may experience mild side effects like soreness at the injection site, fever, fatigue, or headache, similar to those associated with the flu shot. These side effects should go away within several days. If you have experienced an allergic reaction to a vaccine previously, check with your physician for guidance on how to proceed.

Do I still need to get the vaccine if I've already had COVID-19 and recovered?

Yes. At this time, we're not sure how long someone is immune from re-infection after recovering from COVID-19. Natural immunity may not last very long, so health experts are suggesting individuals still opt for the vaccine. About 60-70 percent of the population will need to develop immunity in order to achieve community protection.

Even if you have been vaccinated, continue to protect yourself and others by wearing a mask and social distancing.

SOUTHERN NJ REGIONAL EMPLOYEE BENEFITS FUND
BILLS LIST

Resolution No. 15-21 **MARCH 2021**

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Southern NJ Regional Employee Benefit Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2020

Check Number	Vendor Name	Comment	Invoice Amount
002286			
002286	WELLNESS COACHES USA	WELLNESS COACHING - CCBOSS 12/20	6,032.00
			6,032.00
		Total Payments FY 2020	**6,032.00**

FUND YEAR 2021

Check Number	Vendor Name	Comment	Invoice Amount
002287			
002287	AETNA HEALTH MANAGEMENT LLC	MEDICARE ADVTG 3/21	114,096.67
			114,096.67
002288			
002288	UHC-MEDICARE ADVANTAGE	MEDICARE ADVTG 3/21	224,132.61
002288	UHC-MEDICARE ADVANTAGE	MEDICARE ADVTG 1/21	217,897.42
			442,030.03
002289			
002289	FLAGSHIP HEALTH SYSTEMS INC	DMO PREMIUMS 3/21	492.57
002289	FLAGSHIP HEALTH SYSTEMS INC	DMO PREMIUMS 3/21	29.89
			522.46
002290			
002290	DELTA DENTAL OF NEW JERSEY INC	DENTAL TPA 3/21	5,772.00
			5,772.00
002291			
002291	AETNA LIFE INSURANCE COMPANY	MEDICAL TPA 3/21	73,244.34
			73,244.34
002292			
002292	PERMA	POSTAGE 2/21	49.77
002292	PERMA	ADMIN FEES 3/21	38,982.39
			39,032.16
002293			
002293	J. KENNETH HARRIS, ATTY AT LAW	PLAN DOCUMENT PREP 3/21	2,070.00
002293	J. KENNETH HARRIS, ATTY AT LAW	ATTORNEY FEE 3/21	1,810.67
			3,880.67
002294			
002294	VERRILL & VERRILL, LLC	DEPUTY TREASURER FEE 3/21	770.91
			770.91
002295			
002295	MICHAEL S. ZAMBITO	TREASURER FEE 3/21	505.08
			505.08
002296			
002296	COURIER TIMES INC.	PROF APPTS & MTG SCHED 3/21	161.68
002296	COURIER TIMES INC.	BALANCE FORWARD 3/21	221.90
			383.58
002297			
002297	COURIER POST	ACCT# CHL-079881 - MTG - 02.07.2021	107.32
002297	COURIER POST	ACCT# CHL-079881 - PROF - 02.07.2021	79.60
			186.92

002298			
002298	CONNER STRONG & BUCKELEW	RX - PROG. MANAGER FEES 3/21	9,179.30
002298	CONNER STRONG & BUCKELEW	MEDICAL - PROG. MANAGER FEES 3/21	55,635.18
002298	CONNER STRONG & BUCKELEW	BROKER FEES 3/21	23,377.50
002298	CONNER STRONG & BUCKELEW	DENTAL - PROG. MANAGER FEES 3/21	5,087.50
002298	CONNER STRONG & BUCKELEW	HEALTH CARE REFORM 3/21	608.76
			93,888.24
002299			
002299	ALLSTATE INFORMATION MANAGEMNT	ACCT# 419 - ARC. AND STOR. - 1.31.21	93.61
			93.61
002300			
002300	WELLNESS COACHES USA	WELLNESS COACHING - CCBOSS 3/21	6,032.00
002300	WELLNESS COACHES USA	WELLNESS COACHING - CCBOSS 1/21	6,032.00
			12,064.00
002301			
002301	MUNICIPAL REINSURANCE HIF	REINSURANCE 3/21	60,181.12
			60,181.12
		Total Payments FY 2021	**846,651.79**
		TOTAL PAYMENTS ALL FUND YEARS	**852,683.79**

_____
Chairperson

Attest:
_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____
Treasurer

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED

Current Fund Year: 2021 **Month Ending: February**	**Med**	**Dental**	**Rx**	**Vision**	**Medicare Advantage**	**Reinsurance**	**Dividend Reserve**	**Future**	**Admin**	**TOTAL**
OPEN BALANCE	82,164.36	386,350.02	2,672,737.43	0.00	6,926,760.33	421,736.58	4,248,094.92	1,284,997.46	(844,048.26)	15,178,792.84
RECEIPTS										
Assessments	2,309,151.67	86,850.92	551,374.87	0.00	321,161.60	58,480.03	0.00	0.00	216,148.37	3,543,167.46
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	2,433.86	164.40	1,203.78	0.00	2,503.76	175.95	1,535.52	464.48	41.32	8,523.07
Invest Adj	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02
Subtotal Invest	2,433.88	164.40	1,203.78	0.00	2,503.76	175.95	1,535.52	464.48	41.32	8,523.09
Other *	26,949.41	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	26,949.41
TOTAL	2,338,534.96	87,015.32	552,578.65	0.00	323,665.36	58,655.98	1,535.52	464.48	216,189.69	3,578,639.96
EXPENSES										
Claims Transfers	2,358,955.35	97,525.82	612,034.41	0.00	0.00	0.00	0.00	0.00	0.00	3,068,515.58
Expenses	898,879.60	685.54	0.00	0.00	0.00	60,003.15	0.00	0.00	214,938.73	1,174,507.02
Other *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	25.00	25.00
TOTAL	3,257,834.95	98,211.36	612,034.41	0.00	0.00	60,003.15	0.00	0.00	214,963.73	4,243,047.60
END BALANCE	**(837,135.63)**	**375,153.98**	**2,613,281.67**	**0.00**	**7,250,425.69**	**420,389.41**	**4,249,630.44**	**1,285,461.94**	**(842,822.30)**	**14,514,385.20**

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS											
SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND											
ALL FUND YEARS COMBINED											
CURRENT MONTH	**February**										
CURRENT FUND YEAR	**2021**										
	Description:	**SNJ Inv.**	**Investors Bank**	**Parke Bank**	**Republic Bank**	**Republic Bank - General Account**	**Republic Bank - Admin Account**	**Ocean First Investment Account**	**New Jersey Cash Management**	**William Penn Bank Money Market Account**	
	ID Number:										
	Maturity (Yrs)										
	Purchase Yield:	**0.03**	**0.50**	**0.70**	**0.75**	**0.75**	**0.75**	**0.25**	**0.05**	**0.50**	
	TOTAL for All Accts & instruments										
Opening Cash & Investment Balance	**$15,178,792.83**	**$ 5,172.75**	**$ 2,336.05**	**$ 4,241,150.37**	**$ 2,500,375.22**	**$ 1,880,877.16**	**$ 39,785.14**	**$ 678,485.34**	**$ 54,657.39**	**$ 5,775,953.41**	
Opening Interest Accrual Balance	**$0.13**	**$ 0.13**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	
1	Interest Accrued and/or Interest Cost	-$0.01	-$0.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	Interest Accrued - discounted Instr.s	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	(Amortization and/or Interest Cost)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4	Accretion	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5	Interest Paid - Cash Instr.s	$8,523.09	$0.13	$0.90	$2,277.44	$1,853.47	$1,372.47	$499.19	$130.13	$1.93	$2,387.43
6	Interest Paid - Term Instr.s	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7	Realized Gain (Loss)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
8	Net Investment Income	$8,523.08	$0.12	$0.90	$2,277.44	$1,853.47	$1,372.47	$499.19	$130.13	$1.93	$2,387.43
9	Deposits - Purchases	$10,273,116.88	$0.00	$0.00	$0.00	$5,525,000.00	$3,570,116.88	$1,178,000.00	$0.00	$0.00	$0.00
10	(Withdrawals - Sales)	-$10,946,047.60	$0.00	$0.00	$0.00	-$1,178,000.00	-$3,068,515.58	-$1,174,507.02	$0.00	$0.00	-$5,525,025.00
			OK	OK	OK	OK	OK	OK	OK	OK	OK
Ending Cash & Investment Balance		$14,514,385.20	$5,172.88	$2,336.95	$4,243,427.81	$6,849,228.69	$2,383,850.93	$43,777.31	$678,615.47	$54,659.32	$253,315.84
Ending Interest Accrual Balance		$0.12	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Plus Outstanding Checks		$1,174,515.82	$0.00	$0.00	$0.00	$0.00	$0.00	$1,174,515.82	$0.00	$0.00	$0.00
(Less Deposits in Transit)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Balance per Bank		$15,688,901.02	$5,172.88	$2,336.95	$4,243,427.81	$6,849,228.69	$2,383,850.93	$1,218,293.13	$678,615.47	$54,659.32	$253,315.84

CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

Month	**February**
Current Fund Year	**2021**

Policy Year	Coverage	1. Calc. Net Paid Thru Last Month	2. Monthly Net Paid February	3. Monthly Recoveries February	4. Calc. Net Paid Thru February	5. TPA Net Paid Thru February	6. Variance To Be Reconciled	7. Delinquent Unreconciled Variance From	8. Change This Month
2021	Med	2,290,101.02	2,358,955.35	0.00	4,649,056.37	0.00	4,649,056.37	2,290,101.02	2,358,955.35
	Dental	72,911.21	97,525.82	0.00	170,437.03	0.00	170,437.03	72,911.21	97,525.82
	Rx	688,773.88	612,034.41	0.00	1,300,808.29	0.00	1,300,808.29	688,773.88	612,034.41
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	**3,051,786.11**	**3,068,515.58**	**0.00**	**6,120,301.69**	**0.00**	**6,120,301.69**	**3,051,786.11**	**3,068,515.58**

RESOLUTION NO. 15-21

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
APPROVAL OF THE MARCH 2021 BILLS LISTS

WHEREAS, the Southern New Jersey Regional Employee Benefits Fund held a Public Meeting on **March 22, 2021** 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 February 2021 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 Southern New Jersey Regional Employee Benefits Fund hereby approve the Bills List for March 2021 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 Southern New Jersey Regional 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: MARCH 22, 2021

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

Monthly Claim Activity Report

March 22, 2021

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

	MEDICAL CLAIMS + CAP PAID 2020	# OF EES	PER EE	MEDICAL CLAIMS + CAP PAID 2021	# OF EES	PER EE
JANUARY	$2,504,772	1,611	**$ 1,555**	$2,161,645	1,558	**$ 1,387**
FEBRUARY	$2,167,425	1,607	**$ 1,349**			
MARCH	$2,818,446	1,607	**$ 1,754**			
APRIL	$1,816,987	1,603	**$ 1,133**			
MAY	$1,579,035	1,602	**$ 986**			
JUNE	$2,691,735	1,585	**$ 1,698**			
JULY	$1,896,448	1,574	**$ 1,205**			
AUGUST	$2,210,069	1,577	**$ 1,401**			
SEPTEMBER	$1,983,530	1,577	**$ 1,258**			
OCTOBER	$2,646,583	1,567	**$ 1,689**			
NOVEMBER	$2,124,203	1,562	**$ 1,360**			
DECEMBER	$2,450,166	1,554	**$ 1,577**			
TOTALS	**$26,889,399**			**$2,161,645**		
				2020 Average	**1,558**	**$ 1,387**
				2019 Average	**1,586**	**$ 1,414**

Large Claimant Report (Drilldown) - Claims Over $50000

Plan Sponsor Unique ID :	All	**Paid Dates:**	01/01/2021 - 01/31/2021
Customer:	**SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND**	**Service Dates:**	01/01/2011 - 01/31/2021
Group / Control:	00737391,00866356,00866357,SI030217,SI416902,SI431318	**Line of Business:**	All
Subgroup / Suffix:	All	**Funding Category:**	All

	Billed Amt	**Paid Amt**
	$756,576.23	$141,223.26
	$402,414.30	$119,546.98
	$105,454.03	$65,092.93
	$84,699.81	$50,872.16
Total	**$1,349,144.37**	**$376,735.33**

aetna™

SNJ Regional Employee Benefits Fund
2/1/20 thru 1/31/21 (unless otherwise noted)

Medical Claims Paid:
January 2021 thru January 2021
Total Medical Paid per EE: **$1,387**

Network Discounts

Inpatient:	**66.9%**
Ambulatory:	**67.2%**
Physician/Other:	**61.6%**
TOTAL:	**65.3%**

Provider Network

% Admissions In-Network:	**99.6%**
% Physician Office:	**98.6%**

Aetna Book of Business:
Admissions 98.5%; Physician 92.6%

Top Facilities Utilized (by total Medical Spend)
- Cooper Hospital
- Virtua-West Jersey
- Kennedy Health
- Thomas Jefferson
- CHOP

Hospitals

Catastrophic Claim Impact
January 2021 – January 2021

Number of Claims Over $50,000: **4**
Claimants per 1000 members: **1.0**
Avg. Paid per Claimant: **$94,184**
Percent of Total Paid: **20.1%**
- **Aetna BOB- HCC account for an average of 39.5% of total Medical Cost**

Nurse Case Member Outreach:
Through Q4 2020
Unique Members Identified: **172**
Outreach Opportunities Identified: **241**
Outreach in Progress: **5**
Completed Outreach: **236**
Closed with Engagement: **104**
Unable to Reach: **132**
Member Declined: **0**

Teladoc Activity:
January 2021 – January 2021

Total Registrations: **4**
Total Online Visits: **6**
Total Net Claims Savings: **$1,786**
Total Visits w/ Rx: **3**

New

Mental Health Visits: **0**
Dermatology Visits: **1**

Allentown Service Center Performance: Metrics thru FEB 2021

Customer Service Performance

Call Quality: **(Q4 2020)**	**95.2%**
1st Call Resolution:	**95.2%**
Abandonment Rate:	**1.5%**
Avg. Speed of Answer:	**37.6 sec**

Claims Performance

Financial Accuracy: **(Q4 2020)**	**97.7%**
90% processed w/in:	**5.4 days**
95% processed w/in:	**7.5 days**

****

Performance Goals

Call Quality:	95%
1st Call Resolution:	90%
Abandonment Rate less than:	2.5%
Average Speed of Answer:	30 sec
Financial Accuracy:	99%
Turnaround Time	
90% processed w/in:	14 days
95% processed w/in:	30 days


AmeriHealth.
ADMINISTRATORS

2020 SNJ HIF				
	MEDICAL CLAIMS PAID 2020	TOTAL	# OF EES	PER EE
JANUARY	$ 124,253.00	$ 124,253.00	135	$ 920.39
FEBRUARY	$ 163,740.17	$ 163,740.17	135	$ 1,212.89
MARCH	$ 115,953.08	$ 115,953.08	135	$ 858.91
APRIL	$ 255,467.18	$ 255,467.18	135	$ 1,892.34
MAY	$ 181,114.61	$ 181,114.61	135	$ 1,341.58
JUNE	$ 147,203.50	$ 147,203.50	135	$ 1,090.39
JULY	$ 92,020.36	$ 92,020.36	142	$648.03
AUGUST	$ 98,771.91	$ 98,771.91	142	$ 695.57
SEPTEMBER	$ 94,904.00	$ 94,904.00	138	$ 687.71
OCTOBER	$ 103,050.79	$ 103,050.79	137	$752.18
NOVEMBER	$ 129,893.21	$ 129,893.21	137	$ 948.12
DECEMBER	$ 350,638.54	$ 350,638.54	138	$ 2,540.85
TOTALS	$ 1,857,010.35	$ 1,857,010.35		$ 1,132.41
		2020 Average	137	$ 1,132.41
		2019 Average	135	$1,361

2021 SNJ HIF				
	MEDICAL CLAIMS PAID 2021	TOTAL	# OF EES	PER EE
JANUARY	$ 108,744.80	$ 108,744.80	134	$ 811.75
FEBRUARY	$ 166,873.52	$ 166,873.52	135	$ 1,236.10
MARCH				
APRIL				
MAY				
JUNE				
JULY				
AUGUST				
SEPTEMBER				
OCTOBER				
NOVEMBER				
DECEMBER				
TOTALS				
		2021 Average	134	$ 1,023.93
		2020 Average	135	$ 1,360.98

SOUTHERN NEW JERSEY HIF - 0002096174

Claims Incurred between 3/1/2020 and 3/12/2021 and Paid between 3/1/2020 and 3/12/2021

COVID19 Claims currently are consider to be claims with Procedure codes 0001A, 0002A, 0011A, 0012A, 0202U, 0223U, 0224U, 0225U, 0226U, 0240U, 0241U, 86328, 86408, 86409, 86413, 86769, 87426, 87428, 87635, 87636, 87637, 87811, 91300, 91301, C9803, G2023, G2024, M0239, M0243, M0245, Q0239, Q0243, Q0245, U0001, U0002, U0003, U0004 or a Dx Code of B34.2, B97.29, U07.1, Z11.52, Z20.822

AGE BAND	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
<1	2	2	$178.00	$89.00	$2.66
1-5	5	6	$537.72	$89.62	$2.04
6-18	12	28	$2,087.88	$74.57	$3.56
19-25	20	45	$4,325.70	$96.13	$7.97
26-39	27	49	$4,252.42	$86.78	$5.06
40-64	48	99	$31,554.29	$318.73	$20.80
65+	4	12	$566.70	$47.22	$3.68
Unknown	0	0	$0.00	$0.00	$0.00

REL TO INS	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Employee	61	133	$34,109.27	$256.46	$19.33
Spouse	22	34	$3,034.56	$89.25	$3.77
Dependent	34	74	$6,358.88	$85.93	$4.54

GENDER	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Female	65	139	$11,813.35	$84.99	$5.78
Male	52	102	$31,689.36	$310.68	$16.44
Undisclosed	0	0	$0.00	$0.00	$0.00

ST CD	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
FL	1	1	$100.00	$100.00	$16.67
NJ	116	240	$43,402.71	$180.84	$11.00

Summary by Service Type - Outpatient and Professional Claims

Service Types are Limited to: Emergency Room, Pathology (Laboratory), Urgent Care, Retail Clinic, Telemedicine, Emergency Room, Pathology (Laboratory), Urgent Care, Retail Clinic, Telemedicine, Office Physician Visit, Other Physician Visit, Emergency Room With Observation Bed, and Observation Bed

SRVC TP DSC	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Emergency Room	5	5	$91.70	$18.34	$0.02
Emergency Room With Observation Bed	2	2	$0.00	$0.00	$0.00
Office Physician Visit	7	8	$970.11	$121.26	$0.24
Pathology (Laboratory)	100	178	$14,300.75	$80.34	$3.60
Telemedicine	11	14	$1,597.41	$114.10	$0.40
Urgent Care	9	11	$1,834.83	$166.80	$0.46

Inpatient Cost and Utlization by Age Band

AGE BAND	CLAIMANT COUNT	CLAIM COUNT	ADM CNT	NET PAY	ADM PER 1000	COST PER ADM	COST PMPM	AVG LOS
<1	0	0	0	$0.00	0	$0.00	$0.00	0
1-5	0	0	0	$0.00	0	$0.00	$0.00	0
6-18	0	0	0	$0.00	0	$0.00	$0.00	0
19-25	0	0	0	$0.00	0	$0.00	$0.00	0
26-39	0	0	0	$0.00	0	$0.00	$0.00	0
40-64	1	2	2	$21,973.27	15.6	$10,986.64	$14.48	4
65+	0	0	0	$0.00	0	$0.00	$0.00	0
Unknown	0	0	0	$0.00	0	$0.00	$0.00	0

TOP PROVIDERS(TOP 25 BY NET PAYMENT)

PROVIDER NAME	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Inspira Medical Center Mullica Hill	5	7	$22,624.10	$3,232.01	$5.70
Labcorp Raritan	54	72	$6,169.63	$85.69	$1.55
Hackensack University Medical Group PC	11	14	$1,491.98	$106.57	$0.38
ACUTIS DIAGNOSTICS INC	4	6	$1,264.31	$210.72	$0.32
Cooper University Hospital	16	22	$1,216.80	$55.31	$0.31
Inspira Health Network Medical Group PC	4	8	$1,112.79	$139.10	$0.28
Quest Diagnostics Inc	12	12	$1,052.62	$87.72	$0.27
PROHEALTH CARE ASSOC LLP	5	5	$990.00	$198.00	$0.25
Cooper Physician Offices PA	1	5	$861.74	$172.35	$0.22
KENNEDY UNIVERSITY HOSPITAL GAC	10	11	$491.40	$44.67	$0.12
THE COUNSELING AND CRITICAL INCIDENT DEBRIEFING CENTER LLC	1	1	$396.36	$396.36	$0.10
Accu Reference Medical Lab	2	2	$360.00	$180.00	$0.09
Penn Family and Internal Medicine Mt Laurel	1	2	$337.36	$168.68	$0.08
GENESIS LABORATORY MANAGEMENT	1	1	$300.00	$300.00	$0.08
Accurate Diagnostic Labs	2	2	$300.00	$150.00	$0.08
Patient Care Now	1	2	$300.00	$150.00	$0.08
Atlantic Diagnostic Lab Llc	2	3	$300.00	$100.00	$0.08
Alfred I Dupont Institute	2	3	$261.40	$87.13	$0.07
Leap Health and Wellness Center LLC	1	3	$225.42	$75.14	$0.06
Minute Clinic Diagnostic of New Jersey LLC	8	11	$218.02	$19.82	$0.05
THERANOSTIX INC	1	1	$200.00	$200.00	$0.05
Inspira Medical Center Vineland	1	1	$191.53	$191.53	$0.05
Presbyterian Medical Center	2	2	$189.72	$94.86	$0.05
AMMON ANALYTICAL LABORATOR	1	2	$187.00	$93.50	$0.05
Patient First Maryland Physicians Group Pc	1	1	$178.50	$178.50	$0.04

COVID19 Vaccine Claims with Procedure codes '0001A','0002A','0011A','0012A','91300', and '91301'

AGE BAND	1st Dose Vaccine CLAIMANT COUNT	2nd Dose Vaccine CLAIMANT COUNT	NET PAY	COST PER CLAIMANT
<1	0	0	$0.00	$0.00
1-5	0	0	$0.00	$0.00
6-18	0	0	$0.00	$0.00
19-25	1	1	$58.94	$29.47
26-39	4	2	$141.99	$23.66
40-64	3	1	$61.73	$15.43
65+	1	1	$148.20	$74.10
Unknown	0	0	$0.00	$0.00

COVID19 Claims for Urgent Care and Retail Clinics Only

Urgent Care

AGE BAND	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIMANT
<1	0	0	$0.00	$0.00
1-5	0	0	$0.00	$0.00
6-18	2	3	$500.00	$250,000.00
19-25	2	2	$216.33	$108,165.00
26-39	1	1	$200.00	$200,000.00
40-64	4	5	$918.50	$229,625.00
65+	0	0	$0.00	$0.00
Unknown	0	0	$0.00	$0.00

Retail Clinic

AGE BAND	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIMANT
<1	0	0	$0.00	$0.00
1-5	0	0	$0.00	$0.00
6-18	0	0	$0.00	$0.00
19-25	0	0	$0.00	$0.00
26-39	0	0	$0.00	$0.00
40-64	0	0	$0.00	$0.00
65+	0	0	$0.00	$0.00
Unknown	0	0	$0.00	$0.00

EXPRESS SCRIPTS®

Southern New Jersey Regional Employee Benefits Fund

Total Component/Date of Service (Month)	202001	202002	202003	2020Q1	202004	202005	202006	2020Q2	202007	202008	202009	2020Q3	202010	202011	202012	2020Q4	2020YTD
Average Member Age - 35																	
Membership	3,889	3,788	3,794	3,824	3,780	3,780	3,776	3,779	3,771	3,756	3,754	3,760	3,734	3,751	3,740	3,742	3,776
Total Days	169,970	150,658	179,452	500,080	156,055	145,520	155,440	457,015	158,385	146,270	159,965	464,620	149,628	143,870	162,071	455,569	1,877,284
Total Patients	1,624	1,518	1,538	2,295	1,333	1,288	1,317	1,927	1,409	1,341	1,378	2,024	1,327	1,289	1,359	1,962	2,810
Total Plan Cost	$580,262	$664,774	$676,969	$1,922,005	$584,910	$662,499	$526,766	$1,774,175	$748,422	$639,385	$551,083	$1,938,890	$773,236	$544,801	$564,387	$1,882,424	$7,517,495
Generic Fill Rate (GFR) - Total	84.1%	83.8%	82.9%	83.6%	81.9%	82.0%	83.7%	82.6%	83.7%	84.2%	83.4%	83.8%	84.1%	83.4%	84.2%	83.9%	83.5%
Plan Cost PMPM	$149.21	$175.49	$178.43	$167.55	$154.74	$175.26	$139.50	$156.51	$198.47	$170.23	$146.80	$171.87	$207.08	$145.24	$150.91	$167.70	$165.90
Total Specialty Plan Cost	$163,972	$244,876	$199,958	$608,805	$186,919	$298,965	$144,888	$630,772	$277,796	$255,041	$119,411	$652,248	$375,379	$151,239	$167,221	$693,840	$2,585,666
Specialty % of Total Specialty Plan Cost	28.3%	36.8%	29.6%	31.7%	32.0%	45.1%	27.5%	35.6%	37.1%	39.9%	21.7%	33.6%	48.5%	27.8%	29.6%	36.9%	34.4%

Total Component/Date of Service (Month)	202101	202102	202103	2021Q1	202104	202105	202106	2021Q2	202107	202108	202109	2021Q3	202110	202111	202112	2021Q4	2021YTD
Average Member Age - 35																	
Membership	3,808	3,825															
Total Days	148,128	142,617															
Total Patients	1,334	1,292															
Total Plan Cost	$697,953	$436,117															
Generic Fill Rate (GFR) - Total	84.8%	84.9%															
Plan Cost PMPM	$183.29	$114.02															
% Change Plan Cost PMPM	22.8%	-34.1%															
Total Specialty Plan Cost	$257,915	$76,616															
Specialty % of Total Specialty Plan Cost	37.0%	17.6%															

	PMPM
Jan - Feb 2020	$160.93
Jan - Feb 2021	$148.57
Trend Jan - Feb 2021	-7.7%

APPENDIX I

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
OPEN MINUTES
FEBRUARY 22, 2021
ZOOM MEETING
6:00 PM

Meeting of Executive Committee called to order by Chair Mevoli. Open Public Meetings notice read into record.

PLEDGE OF ALLEGIANCE AND MOMENT OF SILENCE

ROLL CALL OF THE 2021 EXECUTIVE COMMITTEE

Michael Mevoli, Chairman	Borough of Brooklawn	Present
M. Joseph Wolk, Secretary	Borough of Mt. Ephraim	Present
Louis Di Angelo	Borough of Bellmawr	Present
Terry Shannon	Borough of Barrington	Present
Neal Rochford	Haddonfield	Present
Edward Hill	CCBOSS	Present
Robert Maybury	Mt. Holly MUA	Present
Gary Passanate	Borough of Somerdale	Present

APPOINTED PROFESSIONALS PRESENT:

Executive Director/Adm.	PERMA Risk Management Services **Paul Laracy** **Emily Koval**
Program Manager	Conner Strong & Buckelew **Brandon Lodics**
Attorney	**J. Kenneth Harris, Esq.**
Medical TPA – AmeriHealth	**Kristina Strain**
Medical TPA – Aetna	**Jason Silverstein**
Express Scripts	**Kyle Colalillo** **Ken Rostkowski**
Treasurer	**Mike Zambito** **Lorraine Verrill**
Delta Dental	**Kim White** **Brian Remlinger**

PRESENT FUND COMMISSIONERS AND PROFESSIONALS:
Maggie Friel, Conner Strong & Buckelew
Jozsef Pfeiffer, Conner Strong & Buckelew
Patrick Keating, Gloucester City
Suzanne Wood, CBIZ
Kim Porter, CHB Group
Robert Weil, Conner Strong & Buckelew
Susan Danson, Township of Maple Shade

APPROVAL OF MINUTES: January 25, 2021 Open

MOTION TO APPROVE OPEN MINUTES OF JANUARY 25, 2021:

Moved:	Commissioner Wolk
Second:	Commissioner Shannon
Vote:	Unanimous

CORRESPONDENCE – None

EXECUTIVE DIRECTOR'S REPORT

Mr. Laracy said he is moving towards retirement in the next year and Ms. Koval and Mr. Lodics will be taking over.

FAST TRACK FINANCIAL REPORT – as of December 31, 2020 – Executive Director said the fast track for December shows a very profitable month well below our claims budget. She said the statutory surplus is a little over $11 million.

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND – Executive Director said the MRHIF met on February 10 to reorganize and took action on the following items:

1. Awarded a contract to ELMC to facilitate the PBM RFP process, perform 18 month market checks and the annual audits of the PBM contract.

2. Approved a release of an RFP for the PBM contract.

3. Approved a release of an RFP for the Medicare Advantage/EGWP policies. Further discussion will be brought to the local Funds in the next few months.

4. The State Wide contracts committee will be engaged in the above mentioned RFPs. Current committee is below. More Commissioners are welcome to join (no more than 3 per Fund):

MRHIF RFP/ Contracts Committee

Lorene Wright	NJHIF
Brian Brach	CJHIF

Donato Nieman	CJHIF
Lisa Giovanelli	SHIF
Tammy Smith	NJHIF

5. The Aetna Audit has been completed and will provide the report to each of the Funds in the next month.

PROGRAM MANAGERS REPORT

Mr. Lodics introduced Jozsef Pfeiffer from Conner Strong & Buckelew and noted that he will be stepping into more of a leadership role on the Program Managers team as he transitions to the Executive Directors side.

ONLINE ENROLLMENT SYSTEM TRAINING – Program Manager said the agenda includes a training schedule for anyone that may need a refresher on the benefit express enrollment system. They can reach out to Austin Flynn at Conner Strong.

COVID 19 RESOURCES – Program Manager said as a reminder Conner Strong & Buckelew has compiled a database of Covid-19 resources that are available at www.connerstrong.com/insights/covid-19-resource-center. The state of New Jersey also has a website available at www.covid19.nj.gov.

AETNA UPDATES – Program Manager said Aetna has begun a member communication campaign for Teladoc. Welcome letters for the 2021 plan year are being mailed to Aetna Members. Program Manager said Aetna is currently in negotiations with Salem Medical Center. She said the contract is set to terminate on March 29th. She said negotiations are ongoing however letters are not being released at this time. If letters are released the targeted mail date is February 12, 2021.

COVID-19 VACCINE UPDATES – Program Manager reviewed the legislative updates included in the agenda.

TREASURER'S REPORT – Fund Treasurer reviewed the bills list and treasurers report.

Resolution 14-21 – February 2021 Bills List

FY2019	**$1,065.49**
FY2020	**$5,286.33**
FY2021	**$605,893.20**
TOTAL	**$612,245.02**

MOTION TO APPROVE RESOLUTION 14-21 AND THE REMAINDER OF THE TREASURERS REPORT:

Moved: Commissioner DiAngelo
Second: Commissioner Shannon
Vote: 8 Ayes, 0 Nays

FUND ATTORNEY: Fund Attorney said we are currently in phase 1B for who is eligible for the vaccine. He said Governor Murphy signed 3 bills today that essentially legalize marijuana for non medical purposes. The Committee discussed how that may affect their employees.

AETNA: Mr. Silverstein reviewed the claims for December 2020. He said the average pepm was $1,577. He said there were 3 claims over $50,000 for the month of December. He reviewed the dashboard report and noted that all metrics continue to perform well however, the average speed of answer and financial accuracy are slightly below target and they are taking steps to correct that. He also reviewed the Covid-19 reporting included with the Agenda.

AMERIHEALTH: Ms. Strain reviewed the claims for January 2021. She said the average pepm was $811.75. She said there were no claims over $50,000 for this reporting period. She also reviewed the Covid-19 reporting included with the agenda.

EXPRESS SCRIPTS: Mr. Colalillo said the plan cost for January is about $168.20 which is a 12.7% increase from this time last year. He said the Fund did pick up 1 new specialty patient that they will continue to monitor and report back. He provided an update on the Covid vaccine and treatments.

DENTAL ADMINISTRATOR: None

OLD BUSINESS: None

NEW BUSINESS: None

PUBLIC COMMENT: None

MOTION TO ADJOURN:

Moved:	Commissioner DiAngelo
Second:	Commissioner Shannon
Vote:	Unanimous

MEETING ADJOURNED:
NEXT MEETING: MARCH 22, 2021

_____
Emily Koval , Assisting Secretary
for

_____
JOSEPH WOLK, SECRETARY

APPENDIX II

AMERIHEALTH ADMINISTRATORS
ADMINISTRATIVE AND NETWORK SERVICES CONTRACT

This Administrative and Network Services Contract, and any exhibits, schedules and appendices hereto (together, the "Contract"), made this first (1st) day of January 2019, by and between **AmeriHealth Administrators, Inc.**, a Pennsylvania corporation ("AmeriHealth Administrators"), and **Southern New Jersey Health Insurance Fund** (the "Plan Sponsor").

W I T N E S S E T H

WHEREAS, the Plan Sponsor has established an Employee Health Benefit Plan (the "Plan"), which is attached hereto and incorporated herein as Exhibit A; and

WHEREAS, the Plan Sponsor desires to engage the services of AmeriHealth Administrators for purposes of performing administrative and network services for the Plan; and

WHEREAS, AmeriHealth Administrators wishes to provide such services in accordance with the terms and conditions set forth in this Contract;

WHEREAS, the benefits under the Plan are entirely funded by the Plan Sponsor and AmeriHealth Administrators provides administrative and claims payment services only;

NOW, THEREFORE, the Plan Sponsor and AmeriHealth Administrators agree as follows:

Section I. Definitions.

1.1 Definitions. Whenever used in this Contract:

"Access Fee" means Network Access Fee which can be a dollar PEPM or percentage of claim and is shown in Exhibit D

"Account" means the checking account established by AmeriHealth Administrators for purposes of transmitting benefit payments under the plan.

"Administrative Fee" means fees paid by the Plan Sponsor to AmeriHealth Administrators for the agreed upon services AmeriHealth Administrators is to provide related to the Plan pursuant to the terms of this Agreement.

"Benefit Program" means the PPO program of health care benefits administered by AmeriHealth Administrators for the Plan Sponsor.

"Claim" means any claim by a Participant for benefits under the Plan that is submitted to AmeriHealth Administrators in the time and manner and including any proof prescribed by AmeriHealth Administrators.

"Claims Funding" means claims adjudicated and finalized that the Plan Sponsor is responsible for funding.

"Covered Expense" means the dollar amount of benefits payable under the Benefit Program, as calculated in this Contract.

"Covered Service" means a service or supply provided to a Participant that is determined to be covered under the Plan and this Contract.

"Determination" means, with respect to each Claim, a decision by AmeriHealth Administrators as to whether and to what extent such Claim shall be paid, subject to review and final determination by Plan Sponsor

"Effective Date" means January 1, 2019.

"Facility Provider" means an institution or entity licensed, where required, to provide care. Such facilities include: ambulatory surgical facility; birth center; free standing dialysis facility; free standing ambulatory care facility; home health care agency; hospice; hospital; non-hospital facility; psychiatric hospital; rehabilitation hospital; residential treatment facility; short procedure unit; and skilled nursing facility.

"Participant" means any person entitled to receive benefits under the Plan as a covered employee or dependent of a covered employee.

"PPN" means Preferred Provider Network.

"Preferred Facility Provider" means a Facility Provider that is a member of the PPN and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Participants.

"Preferred Professional Provider" means a Professional Provider that belongs to the PPN

"Professional Provider" means a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are: Audiologist; Nurse Midwife; Certified Registered Nurse; Optometrist; Chiropractor; Physical Therapist; Dentist; Physician; Independent Clinical Laboratory; Podiatrist; Licensed Clinical Social Worker; Psychologist; Master's Prepared Therapist; Speech-language Pathologist; and Teacher of the hearing impaired.

"Run-out Claim Processing" means the process for adjudicating claims and calculating the Administrative Fees paid to Claims Administrator for post-termination claims services under this Agreement. See Exhibit D.

Section II. Obligations, Duties and Compensation of AmeriHealth Administrators.

2.1 Administrative Service Agent and Named Claims Fiduciary.

AmeriHealth Administrators is hereby appointed administrative service agent by the Plan Sponsor of the Plan for purposes of providing administrative and claim services in connection with the Plan as are specified in Exhibit B to this Contract, which is attached hereto and incorporated herein by reference. AmeriHealth Administrators shall not be the administrator of the Plan for purposes of ERISA

2.2 The Account.

AmeriHealth Administrators shall provide a checking account through which benefit payments shall be made under the Plan. AmeriHealth Administrators shall have sole authority to sign checks on the Account. AmeriHealth Administrators shall notify the Plan Sponsor at reasonable intervals of the amount needed to cover Claims approved by AmeriHealth Administrators, and AmeriHealth Administrators shall pay such Claims as soon as is practical after the Plan Sponsor deposits such amount in the Account or provides the means for AmeriHealth Administrators to transfer funds electronically into the Account so that checks on the Account in such amount will be honored. Any balance in the Account shall be the property of the Plan or the Plan Sponsor if the Plan is unfunded. Any interest paid on the Account shall be retained by AmeriHealth Administrators as additional compensation for services hereunder.

AmeriHealth Administrators shall not have the obligation of paying Claims until funds are received from the Plan Sponsor. AmeriHealth Administrators shall apply funding to administrative fees, any applicable charges other than administrative fees or Claim payments, network provider Claim payments and non-network provider Claim payments, respectively.

Claims funding requests will be available by email notification and/or based on a mutually agreed upon method and on a weekly basis.

Funding not received within forty-eight (48) hours from when the claims funding request (invoice) is made available by email and/or the mutually agreed upon method will be considered delinquent.

Furthermore, if funding is not received by the 7thth calendar day after the date of the initial invoice, AmeriHealth Administrators will deliver a "**Notice of Failure To Remit Payment**" to the Plan Sponsor and hold all claims payments, (with the exception of Pharmacy claims), until all past due Claims Funding is paid in full. If all past due Claims Funding is not received by the 7th calendar day, AmeriHealth Administrators may deny all claims and inform members that the denied claims were ineligible for coverage due to the members employer's failure to fund past due claims. If after fourteen (14) calendar days from the initial invoice date, the Plan Sponsor is delinquent in the remittance of all claims funding, AmeriHealth Administrators may immediately terminate this contract. See, Section 4.2 of this Contract.

Administrative Fee invoice (entitled: "**Administrative Fees Billing Statement**") will be provided to the Plan Sponsor by the 25th of each month. Funding for the Administrative Fee is due on the first business day of the following month. Payment not received within 48 hours after the due date will be considered delinquent.

Plan Sponsor payment of monthly per employee per month fees shall be made in monthly installments, provided that AHA submits a duly authorized voucher to the Plan Sponsor/FUND's Executive Director/Administrator at least 10 days prior to the next regularly scheduled meeting of the FUND's Executive Committee. Furthermore, this payment schedule is subject to any rules and regulations promulgated by the New Jersey Department of Community Affairs.

If a Plan Sponsor self-accounts, funding for the Administrative fee is due by the first business day of each month. Plan Sponsors that self-account must ensure that Administrative Fees are accurate at the time of payment. Furthermore, AmeriHealth Administrators reserves the right to audit the Plan Sponsor's methodology for calculating its Administrative Fees to ensure that the correct amounts are being paid. Plan Sponsor shall comply with AmeriHealth Administrator's findings in such audits. Payment not received within 48 hours after the due date will be considered delinquent.

If a Plan Sponsor self-accounts, Past Due Administrative Fees will be based on an average of the Administrative Fees collected for the prior three months.

If Plan Sponsor is delinquent in Claims Funding and Administrative Fee funding, AmeriHealth Administrators will first apply any monies received toward the Administrative Fee bill, and then apply the balance towards the Claims Funding. If after fourteen (14) calendar days from the invoice due date, the Plan Sponsor is delinquent in the remittance of all administrative funding, AmeriHealth Administrators may immediately terminate this contract. See, Section 4.2 of this Contract.

Repeated delinquencies will require advanced deposits equal to the average monthly claim amount (medical and prescription drug) and may also result in termination of the Contract.

2.3 Advance Deposit. The Plan Sponsor will furnish AmeriHealth Administrators a deposit (the "Advance") to satisfy obligations of the Plan Sponsor under this Contract that are due, including, among others, Claims Expense. The Advance is intended to secure only the Plan Sponsor's obligations to AmeriHealth Administrators.

A. The Plan Sponsor will pay to AmeriHealth Administrators, on or before the effective date of this Contract, the Advance amount as set forth in Exhibit D. Failure to provide the Advance amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to fund the Advance for each day that the Advance remains unfunded.

B. During the term of this Contract, AmeriHealth Administrators may, upon mutual agreement, require a greater Advance amount from the Plan Sponsor upon renewal or upon any significant changes in membership and/or benefit design to secure the Plan Sponsor's obligations under this Contract. If AmeriHealth Administrators requires a greater amount, AmeriHealth Administrators will notify the Plan Sponsor of the required increase, which is due and payable within 20 days of the Plan Sponsor's receipt of such notice. Failure to provide the additional amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to increase the Advance for each day that the Advance is below the required amount.

C. AmeriHealth Administrators may at any time and in its discretion use amounts of the Advance to satisfy past due obligations owed by the Plan Sponsor to AmeriHealth Administrators under this Contract. Funds so used must be replenished by the Plan Sponsor within 10 days of the notification of AmeriHealth Administrators' use. Failure to provide the additional amount will result in the assessment by AmeriHealth Administrators of a fee of 12% per annum of the amount necessary to replenish the Advance for each day that the Advance is below the required amount.

D. If the Plan Sponsor fails to maintain the Advance as specified in this Contract, AmeriHealth Administrators may, in its discretion terminate this Contract or suspend the performance of its obligations as set forth in this Section II.

E. AmeriHealth Administrators' right to use the Advance survives the termination of this Contract.

2.4 Administration.

AmeriHealth Administrators shall provide administration services as set forth in Part I of Exhibit B to this Contract.

2.5 Claims Services.

AmeriHealth Administrators shall process Claims as set forth in Part II of Exhibit B to this Contract.

2.6 Overpayment of Benefits. If it is determined that any benefit payment has been made to or on behalf of an ineligible individual, including payments made as a result of the fraudulent acts or omissions of a Participant or a provider, or if it is determined that more than the correct amount has been paid by AmeriHealth Administrators, AmeriHealth Administrators will make a diligent attempt to recover the payment made to such ineligible person or overpayment, but AmeriHealth Administrators will not be required to initiate litigation for purposes of payment recovery.

2.7 Recoveries.

1. Whenever amounts recovered by AmeriHealth Administrators can be associated with a claim paid under the Benefit Program and result in a paid claim adjustment, Plan Sponsor will receive a credit against future paid claims costs in the

amount of the recovery, less the Recovery Fee[1] that is retained by AmeriHealth Administrators. AmeriHealth Administrators warrants that it will exercise reasonable efforts to determine whether a recovery is associated with a claim under the Benefit Program and adjust applicable paid claims. Nevertheless, Plan Sponsor understands and agrees that not all recoveries can be reasonably tied to a particular paid claim resulting in its adjustment; for example, when a recovery arises from a settlement based upon AmeriHealth Administrators' entire book of business with insufficient information to determine individual paid claim adjustments. In such settlements, AmeriHealth Administrators will retain the Recovery Fee associated with the respective recovery. AmeriHealth Administrators will make available details of such settlements and on an annual basis upon written request.

2. Except as otherwise provided in this Agreement, AmeriHealth Administrators has no obligation to pursue a recovery from providers or manufacturers of health care products or services on behalf of the Plan Sponsor for causes of action arising out of a product/service defect (including, but not limited to, fitness for use or product recalls), violations of antitrust law, fraud, and claims relating to fraud (including claims under the Racketeering Influenced and Corrupt Organizations Act).

2.8 Preparation of Materials.

AmeriHealth Administrators shall provide the Plan Sponsor with the materials listed in Part III of Exhibit B to this Contract.

2.9 Clinical Services.

AmeriHealth Administrators will provide the Plan Sponsor with Clinical Services as described in Exhibit G to this Contract. AmeriHealth Administrators' compensation for its services under this section shall be as set forth in Exhibit D to this Contract, under the listing "Utilization Management Fee".

2.10 Advice.

AmeriHealth Administrators shall, where it deems appropriate or upon the reasonable request of the Plan Sponsor, provide the Plan Sponsor with advice and information concerning the matters listed in Part IV of Exhibit B to this Contract.

2.11 Certification of Eligibility.

AmeriHealth Administrators shall, with the assistance of the Plan Sponsor, certify as to the eligibility of a Participant in the Plan when necessary for such Participant to receive services covered under the Plan.

2.12 COBRA.

[1] No Recovery Fees will be charged to Plan Sponsor in the event of overpayments being applied in error by AmeriHealth Administrators

AmeriHealth Administrators shall not provide administrative services for compliance with the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 except as described in Exhibit C to this Contract, which is attached hereto and incorporated herein by reference.

2.13 Miscellaneous.

In addition to the services specified in Sections 2.3 - 2.11, AmeriHealth Administrators may perform any and all optional services set forth in Exhibit C to this Contract.

2.14 Access to Files.

The Plan Sponsor shall have the right, upon reasonable request, to inspect AmeriHealth Administrators' records regarding the financial condition of the Account, payments from the Account, Claims, Determinations, Participants, and any of the optional services set forth in Exhibit C to this Contract provided with respect to the Plan under this Contract. This right to file access shall be subject to AmeriHealth Administrators' policy regarding external audits attached as Exhibit F to this Contract.

2.15 Responsibility of AmeriHealth Administrators

AmeriHealth Administrators shall make reasonable efforts to secure the reimbursement of funds disbursed from the account in error, however AmeriHealth Administrators shall itself only be liable for amounts paid or withdrawn from the Account by reason of the willful misconduct or gross negligence of any of its officers or employees. AmeriHealth Administrators shall bond each of its officers and employees who handle funds held in the Account. in an amount not less thanis indicated in Exhibit J.

AmeriHealth Administrators shall be entitled to rely upon representations made to it with respect to the Plan and any Participants thereunder by the President, Board of Directors, or Board of Trustees of the Plan Sponsor and any other officer or employee authorized in writing to make such representations to AmeriHealth Administrators by the President, Board of Directors, or Board of Trustees of the Plan Sponsor.

AmeriHealth Administrators shall not be responsible for investigating whether a Claim is payable, primarily or otherwise, under any plan or program other than the Plan, except for any plan or program identified as covering the Participant making such Claim in information provided to AmeriHealth Administrators by the Plan Sponsor and the Participant's own statements.

AmeriHealth Administrators shall not be responsible for pursuing the investigation of fraudulent or potentially fraudulent Claims, nor shall AmeriHealth Administrators be liable for any Claim payment which results from the fraudulent act or omission of any Participant or provider.

AmeriHealth Administrators shall not be responsible for conducting any utilization review other than that set forth in Exhibit G to this Contract or elsewhere in this Contract.

With the exception of those actions that fall within the terms of Section 8.2. (Defense of

Claims Litigation), AmeriHealth Administrators shall not be required to engage in any litigation or arbitration prior to the Plan Sponsor's agreement to indemnify AmeriHealth Administrators against the costs, and expenses that it might incur relating to such litigation.

2.16 Provision of Health Care

The Plan Sponsor acknowledges that: (i) AmeriHealth Administrators does not render medical services or care to Participants; (ii) AmeriHealth Administrators is not responsible for the provision of health care by health care providers; and (iii) network health care providers are independent contractors and are not the agents or employees of AmeriHealth Administrators.

2.17 Medicare Reporting.

AmeriHealth Administrators will comply with reporting requirements to the Centers for Medicare and Medicaid Services (CMS), as required by the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 as they apply to AHA. Plan Sponsor agrees to timely provide AmeriHealth Administrators with all data that AmeriHealth Administrators requests, and in an agreed upon format, to enable both parties to comply with the reporting requirements. AmeriHealth Administrators shall not be responsible for any noncompliance penalties incurred in connection with the Medicare reporting requirement.

Section III. Plan Sponsor's Obligations and Duties.

3.1 Plan Document.

The Plan Sponsor shall furnish AmeriHealth Administrators with a detailed description of the Plan and any and all amendments thereto, including all materials as shall be necessary to maintain the Plan in compliance with section 402 of ERISA and applicable provisions of the Internal Revenue Code, as well as all administrative manuals for the Plan. The Plan Sponsor shall provide notice of any change in benefits provided under the Plan prior to the date on which such change becomes effective. Retroactive benefit changes will only be accepted during the first fifteen (15) calendar days from the effective date of the Contract. All other benefit changes will require sixty (60) days' notice prior to the effective date of the change. If AmeriHealth Administrators prepares the benefit booklets AmeriHealth Administrators will provide the Plan Sponsor with a draft benefit booklet and will consider the draft benefit booklet to be final, and the terms and conditions set forth in the benefit booklet will become binding on Plan Sponsor and Plan if not approved by Plan Sponsor within fourteen (14) calendar days of delivery to the Plan Sponsor.

3.2 Plan Administrator and Named Fiduciary

The Plan Sponsor or its delegate shall be the plan administrator for purposes of section 3(16)(A) of ERISA and section 414(g) of the Internal Revenue Code. The Plan Sponsor or

its delegate, and not AmeriHealth Administrators, shall be the named claims fiduciary for purposes of section 402(a) of ERISA. The Plan Sponsor shall be responsible for complying with all reporting and disclosure requirements of Title I of ERISA, and the Internal Revenue Code. As the claims fiduciary, the Plan Sponsor retains the final discretionary authority regarding all decisions related to benefit determinations under the Benefit Program including, but not limited to, eligibility of Participant to receive benefits, payment of claims for services under the Benefit Program, the amount of payment due for claims, and Participant appeals. For purposes of initial benefit determinations and coordination of final benefit determinations with the Plan Sponsor, the Plan Sponsor will comply with the administrative policies of AmeriHealth Administrators regarding continuity of services involving concurrent review determinations including, but not limited to, behavioral health services. With the exclusive assumption of claims fiduciary responsibility, the Plan Sponsor shall have the authority to overturn or otherwise amend benefit determinations made by AmeriHealth Administrators. The Plan Sponsor also retains the final discretionary authority to determine who is eligible to participate in the Benefit Program and all other authority not specifically and expressly given to AmeriHealth Administrators in the Agreement.

Except as otherwise stated in this Agreement, the Plan Sponsor has sole responsibility for, and AmeriHealth Administrators has no liability whatever regarding, determining the applicability of, applying, administering, or undertaking any duties or responsibilities associated with continuation or conversion rights or obligations under state or other federal laws.

3.3 Information to AmeriHealth Administrators.

The Plan Sponsor shall provide AmeriHealth Administrators with all of the information required by AmeriHealth Administrators regarding the eligibility of Participants in the Plan and shall notify AmeriHealth Administrators on at least a monthly basis of all changes in participation in the Plan, whether by reason of termination, change in job classification, or otherwise. The Plan Sponsor shall furnish AmeriHealth Administrators with any other information that AmeriHealth Administrators reasonably requests for purposes of performing its claims processing and other administrative functions.

3.4 Deposits to Account.

The Plan Sponsor shall take all steps necessary to see that checks If Plan changes or changes in applicable law result in additional material costs for AHA, AHA will not be responsible for implementing such changes absent mutual agreement on the additional costs to be reimbursed to AHA in respect thereof. Written by AmeriHealth Administrators on the Account will be honored.

3.5 Fees and Expenses.

The Plan Sponsor shall pay AmeriHealth Administrators for the services rendered pursuant to this Contract in accordance with the terms set forth in Exhibit D to

this Contract, which is attached hereto and incorporated herein by reference. AmeriHealth Administrators reserves the authority to adjust the fee set forth in Exhibit D to this Contract as of the effective date of any amendment to or change in benefits provided under the Plan.

Amounts due AmeriHealth Administrators hereunder shall be charged against the Plan, and to the extent not paid by the Plan Sponsor, shall be paid by the Plan.

3.6 Plan Responsibility.

The Plan Sponsor shall have the responsibility for the Plan. AmeriHealth Administrators will act solely as an administrator to process and pay Claims with reasonable accuracy and utilizing due diligence as may be expected from an experienced benefit plan administrator. If it is determined that any benefit payment has been made to or on behalf of an ineligible individual, including payments made as a result of the fraudulent acts or omissions of a Participant or a provider, or if it is determined that more than the correct amount has been paid by AmeriHealth Administrators, AmeriHealth Administrators will make a diligent attempt to recover the payment made to such ineligible person or overpayment, but AmeriHealth Administrators will not be required to initiate litigation for purposes of payment recovery. AmeriHealth Administrators shall, however, notify the Plan Sponsor of such overpayment or payment to ineligible person as soon as reasonably possible following discovery of any such improper payment.

3.7 Subrogation and Other Third-Party Recovery. Plan Sponsor shall assist AmeriHealth Administrators in its subrogation and other third-party recovery efforts (hereinafter, collectively referred to as "Subrogation") by providing AmeriHealth Administrators (or its Subrogation management firm) with requested information and documentation. Plan Sponsor further represents and warrants that the Plan and/or Summary Plan Description provide for rights of subrogation and third-party recovery.

3.8 Subrogation, Coordination of Benefits and Other Claim Payment Recovery Services. AmeriHealth Administrators will provide appropriate subrogation, coordination of benefits and other claim payment recovery services. In connection with AmeriHealth Administrators' obligations under this Paragraph, the Plan Sponsor represents that the Benefit Program is a self-funded employee benefit plan, and subject to ERISA, if applicable, and authorizes AmeriHealth Administrators to advise third parties of this representation without liability to AmeriHealth Administrators.

i. AmeriHealth Administrators works with vendors to provide comprehensive subrogation and recovery services. A percentage of the amount collected, received and/or recovered ("Recovery Fee") by AmeriHealth Administrators, or the vendor of AmeriHealth Administrators on behalf of AmeriHealth Administrators, may be retained by AmeriHealth Administrators. This Recovery Fee is for AmeriHealth Administrators' vendor costs and internal administrative costs related to

subrogation, coordination of benefits and other claim payment recovery services. If no recovery is made, there is no charge to the Plan Sponsor for these services. The actual percentage for the Recovery Fee is set forth in Exhibit D to this Agreement.

ii. Subrogation. Unless otherwise directed by a Plan Sponsor, AmeriHealth Administrators is authorized by the Plan Sponsor to provide subrogation services for the Plan Sponsor. AmeriHealth Administrators may engage the services of subrogation vendors to assist with the identification and management of subrogation cases.

iii. Coordination of Benefits.

- Unless otherwise specified by the Plan Sponsor, AmeriHealth Administrators will follow the coordination provisions of the benefit booklet, as may be amended from time to time.

- AmeriHealth Administrators will work with state Medicaid agencies to the extent permitted by law by responding to data matching requests and making appropriate reimbursements based upon available paid claims information within its possession

- To the extent that AmeriHealth Administrators administers the payment of prescription drugs under this Agreement, Plan Sponsor acknowledges that coordination of benefits is not performed on such claims.

- AmeriHealth Administrators and its coordination of benefits and subrogation vendor(s) will undertake reasonable efforts on behalf of the Plan Sponsor to recover amounts from other accident and injury carriers (e.g., workers' compensation, automobile accident and other accident or injury insurers) to the extent insurance issued by such insurers were primarily liable for paid claims arising from an illness or injury suffered by a Participant.

iv. Other Claim Payment Recovery Services. AmeriHealth Administrators may engage the services of certain vendors for other claim payment recovery services.

Section IV. Termination of the Contract.

4.1 Plan Sponsor's Right to Terminate.

1. The Plan Sponsor may terminate this Contract or just the pharmacy benefit management services ("PBM Services") at the end of the initial Term or any renewal Term of Contract (as described below) by giving not less than 90 days' written notice of intention to terminate delivered to AmeriHealth Administrators prior to the end of the current Term. If Plan Sponsor terminates this Contract or the PBM Services with less than 90 days' written notice, Plan Sponsor shall pay the setup or other up-front costs that AmeriHealth Administrators actually spent for the succeeding Term. Notwithstanding the 90 days' written notice, the Plan Sponsor may also terminate this Contract or PBM Services, for the succeeding Term, during the 30-day notice period if any rate increase has been given for the succeeding Term. In the event of termination of this Contract or PBM Services, the Plan Sponsor shall continue to make payments for Claims for Covered Services incurred prior to termination. If a Plan Sponsor terminates PBM services only, then any bundling credit that was priced into the contract will become void on the effective date of termination.

2. The Plan Sponsor may terminate this Contract, upon fourteen (14) days' prior written notice to AmeriHealth Administrators, if, after giving AmeriHealth Administrators thirty (30) calendar days to cure any deficiency in AmeriHealth Administrators' performance of the obligations set forth in this Contract, AmeriHealth Administrators does not cure the deficiency.

3. **CONFLICT of INTEREST.** This contract may terminate this contract in accordance with the above provisions by the Executive Committee/FUND Commissioners if AmeriHealth Administrators fails to disclose an actual or potential conflict of interest as defined in the FUND's Bylaws, or in N.J.S.A. 40A: 9-22.1 et. seq. (the "Local Government Ethics Laws").

4.2 AmeriHealth Administrators' Right to Terminate.

1. AmeriHealth Administrators may terminate this Contract at the end of any Term of Contract by giving no less than 90 calendar days written "Notice of Intention To Terminate" delivered to the Plan Sponsor prior to the end of such Term.
2. Delinquency for Administrative Fees: If after fourteen ("14") calendar days from the

due date of the initial invoice, the Plan Sponsor is delinquent in the remittance of all administrative fees, AmeriHealth Administrators may immediately terminate the contract.

3. Delinquency for Claims Funding: If after fourteen (14) calendar days from the due date of the initial invoice, the Plan Sponsor is delinquent in the remittance of all claims funding, AmeriHealth Administrators may immediately terminate this Contract.
4. Repeated Delinquency: AmeriHealth Administrators also reserves the right to terminate this Contract at any time for reason of repeated delinquencies of fees.

4.3 General Rights to Terminate.

1. Either party may terminate this Contract upon written notice to the other party in the event that any of the following occur to the party requesting termination:
   a. the insolvency of the party,
   b. the appointment of a receiver or a trustee for the party,
   c. an assignment for the benefit of creditors of the party, or
   d. the commencement of any proceedings under bankruptcy or insolvency laws by or against the party.
2. This Contract will terminate immediately upon the termination, lapse, or cancellation of the Benefit Program.

4.4 Rights and Obligations of Parties Upon Termination of Contract. Upon termination of this Contract, or at the end of the Run-out period (see Exhibit D) if Run-out administration is elected, AmeriHealth Administrators shall deliver to the Plan, or to the Plan Sponsor if there is no trust under the Plan, any amounts held in the Account (other than interest due AmeriHealth Administrators) and an amount sufficient to cover uncashed checks.

Section V. Term and Amendment of Contract.

5.1 Term of Contract.

The term of this Contract shall be 36 MONTHS measured from the 01/01/19. Upon completion of the above term, AmeriHealth Administrators may amend the fee schedule, upon mutual consent, for the new term by providing the Plan Sponsor with at least 30 days' written notice prior to the beginning of such term.

5.2 Amendment of Contract.

Except as provided elsewhere in this Contract, the Plan Sponsor and AmeriHealth Administrators may amend the Contract only by their mutual consent.

Section VI. Provider Networks and Discount Arrangements.

6.1 For services by facility providers that participate in networks maintained by certain affiliates of AmeriHealth Administrators, covered expense is calculated as a fixed discount

applied to the provider's standard billed charge (a "Regional Affiliate Discount"). The Regional Affiliate Discounts in effect for this Contract as of the effective date are listed at Exhibit E to this Contract, which is attached hereto and incorporated herein by reference. Regional Affiliate Discounts are set by AmeriHealth Administrators and its affiliates based on market considerations and are not intended to result in discount pass-through arrangements based on AmeriHealth Administrators' payment to providers with respect to the Plan Sponsor's claims. Savings earned by AmeriHealth Administrators or its affiliates or payments in excess of Regional Affiliate Discounts as a result of its bulk purchasing arrangements with providers are for the sole benefit of and will remain the sole property or obligation of AmeriHealth Administrators or its affiliates. Neither the Plan Sponsor nor covered persons under the Plan nor anyone else is entitled to receive any portion of such savings, whether as part of any claims settlement or otherwise. Additional Regional Affiliate Discounts may be added to Exhibit E to this Contract, and the amount of each discount may be changed prospectively with thirty (30) days' notice to the Plan Sponsor.

6.2 For services by physician providers that participate in AmeriHealth Administrators' physician network, AmeriHealth Administrators' physician network discounts will be applied to provider standard billing charges with respect to the Plan Sponsor's Claims.

6.3 For services by a facility or physician provider that participates in a provider network that is not an Affiliate Network but that is identified as a "Directed Network," covered expense is the amount paid to the facility or physician provider for covered services. The Plan Sponsor agrees to pay AmeriHealth Administrators a fee equal to the PPO Access Fee as described in Exhibit D to this Contract. AmeriHealth Administrators will be solely responsible for payment of any network access fee to the Directed Network in connection with such discounts.

6.4 For a Claim from a Facility Provider or Physician Provider who does not participate in AmeriHealth Administrators' PPN but who participates in a facility and/or physician network through which AmeriHealth Administrators obtains a reduction in the amount charged by a Facility Provider or Physician Provider's for the Claim, Covered Expense is the amount paid by AmeriHealth Administrators to the Facility Provider or Physician Provider plus 25% of the reduction to the amount charged by the a Facility Provider or Physician Provider in the Claim.

6.5 The Prescription Drug Card program is an arrangement between AmeriHealth Administrators and a national prescription drug provider (PBM) to secure discounted prescriptions for its clients.

The Prescription Drug Card program includes a formulary program pursuant to which the person who prescribes a drug (doctor or pharmacist) selects from a list of preferred medications. Medications are included on the list based on cost and efficacy. Manufacturers of the preferred drugs pay a rebate with respect to their drugs that are included in the formulary program. AmeriHealth Administrators will retain any such rebates to offset administrative fees.

Section VII. Miscellaneous.

7.1 Successors. This Contract shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, personal representative, successors and assigns, Neither Party may assign or subcontract any or all of its rights or obligations under this Agreement without the other Party's prior written consent, such consent not to be unreasonably withheld or delayed. Notwithstanding the immediately preceding, AHA may assign or subcontract any or all of its rights or obligations under this Agreement to a subsidiary or affiliate of AHA, or pursuant to a company reorganization undertaken not as a result of insolvency or filing of a bankruptcy petition.

7.2 Entire Contract. This Contract contains the entire agreement among the parties relating to the subject matter hereof, and may not be altered, amended, modified or supplemented except by a writing signed by the parties hereto, provided that AmeriHealth Administrators reserves the authority to amend the fee schedule, and Exhibit E (which lists the Regional Affiliate Discounts), as provided herein.

7.3 Notices. Any notice, material, or information that AmeriHealth Administrators is required to provide to the Plan Sponsor under this Contract shall be deemed to have been given to the Plan Sponsor three days after mailing by regular or certified mail, postage prepaid, to the following address:

Southern New Jersey Health Insurance Fund
C/O PERMA Risk Management Services
9 Campus Drive, Suite 216
Parsippany, NJ 07054
Attn; Executive Director

7.4 No Contract of Insurance. Nothing in this Contract shall be construed as a contract of insurance. AmeriHealth Administrators shall be under no obligation to pay from its own funds or insure any benefits payable under the Plan. Any reference to an obligation of AmeriHealth Administrators to "pay" an amount hereunder shall refer to its obligation to pay on behalf of the Plan from the Account and shall not imply any liability on AmeriHealth Administrators with respect to its own funds.

7.5 Governing Law and Dispute Resolution. This Contract shall be governed by and construed and enforced in accordance with the laws of the state of New Jersey to the extent not superseded by ERISA.

a. If any Dispute arises between the parties in connection with this Agreement (a "Dispute"), the parties shall first attempt to resolve such Dispute by negotiation and consultation between themselves. In the event that the Dispute is not resolved on an informal basis within 30 days after one party notifies the other that a Dispute exists, the Dispute shall be presented to the executives of each party who have authority to settle the controversy and who

are at a higher level of management than the persons with direct responsibility for administration of this Agreement.

b. If a Dispute has not been resolved by the parties within 10 business days after each party becomes aware of the potential Dispute (or a longer period, as agreed to by the parties), the Dispute may be settled by arbitration. The arbitration will be conducted in accordance with the procedures in this document and the Arbitration Rules for Professional Accounting and Related Services Disputes of the AAA ("AAA RULES"). In the event of a conflict, the provisions of this document will control.

c. The arbitration will be conducted before a panel of three arbitrators, regardless of the size of the Dispute, to be selected as provided in the AAA Rules. Any issue concerning the extent to which any Dispute is subject to arbitration, or concerning the applicability, interpretation, or enforceability of these procedures, including any contention that all or part of these procedures are invalid or unenforceable, shall be governed by the Federal Arbitration Act and resolved by the arbitrators. No potential arbitrator may serve on the panel unless he or she has agreed in writing to abide and be bound by these procedures.

d. Unless provided otherwise in this Agreement, the arbitrators may not award non-monetary or equitable relief of any sort. They shall have no power to award (i) damages inconsistent with the Agreement or (ii) punitive damages or any other damages not measured by the prevailing party's actual damages, and the parties expressly waive their right to obtain such damages in arbitration or in any other forum. In no event, even if any other portion of these provisions is held to be invalid or unenforceable, shall the arbitrators have power to make an award or impose a remedy that could not be made or imposed by a court deciding the matter in the same jurisdiction.

e. No discovery will be permitted in connection with the arbitration unless it is expressly authorized by the arbitration panel upon a showing of substantial need by the party seeking discovery.

f. All aspects of the arbitration shall be treated as confidential. Neither the parties nor the arbitrators may disclose the existence, content or results of the arbitration, except as necessary to comply with legal or regulatory requirements. Before making any such disclosure, a party shall give written notice to all other parties and shall afford such parties a reasonable opportunity to protect their interests.

g. The result of the arbitration will be binding on the parties, and judgment on the arbitrators' award may be entered in any court having jurisdiction.

7.6 Set-off. If any undisputed financial consideration due AmeriHealth Administrators under this Agreement, including, but not limited to, amounts to be paid for administering the Benefit Program and amounts to be reimbursed for Covered Services, is unpaid by the Plan Sponsor 90 days after first being due, AmeriHealth Administrators may assign its rights to such consideration to any parent, subsidiary, or affiliate company of AmeriHealth Administrators (“AmeriHealth Administrators Affiliate”). The AmeriHealth Administrators

Affiliate to which AmeriHealth Administrators assigns such rights may collect the consideration due by any legal means, including set-off against amounts due to the Plan Sponsor from the AmeriHealth Administrators Affiliate under any contractual arrangement between the Plan Sponsor and the AmeriHealth Administrators Affiliate. Similarly, if AmeriHealth Administrators is assigned the right to collect amounts due any AmeriHealth Administrators Affiliate under any contractual arrangement between the Plan Sponsor and the AmeriHealth Administrators Affiliate, AmeriHealth Administrators may collect such amounts from the Plan Sponsor by any legal means, including set-off against amounts due to the Plan Sponsor from AmeriHealth Administrators under this Agreement.

7.7 Severability. If any provision of this Contract is held to be invalid or unenforceable for any reason, such provision shall be ineffective to the extent of such invalidity or unenforceability without invalidating the remaining portions hereof.

7.8 Acceptance. The Plan Sponsor may accept this Contract either by having an authorized individual or officer sign or by making required payment to AmeriHealth Administrators. Such acceptance renders all terms and provisions herein binding on the Plan Sponsor and AmeriHealth Administrators.

7.9 Affirmative Action. AmeriHealth Administrators has established a policy to ensure all qualified individuals are afforded equal employment opportunities in accordance with policies set forth in Exhibit H.

7.10 New Jersey Law. AmeriHealth Administrators is compliant with business registration requirements and applicable laws of the State of New Jersey as specified in Exhibit I.

7.11 Insurance. Except as provided elsewhere herein, AmeriHealth Administrators shall provide, at its own cost and expense, proof of insurance as described in Exhibit J.

7.12 Table of Exhibits. The following Exhibits are attached to and made a part of this contract unless otherwise indicated.

Exhibit A – Plan Document
Exhibit B – Administrative and Claim Services
Exhibit C – Optional Services
Exhibit D – Fees
Exhibit E – Regional Affiliate Discounts
Exhibit F – AmeriHealth Administrators' Audit Policy
Exhibit G – Clinical Services
Exhibit H – Affirmative Action
Exhibit I – New Jersey Law
Exhibit J - Insurance

Section VIII. Indemnification

8.1. Indemnification

a. AmeriHealth Administrators' Obligations.

1. With the exception of those actions that fall within the terms of Section 8.2 Defense of Claims Litigation, below, AmeriHealth Administrators shall indemnify the Plan, the Plan Sponsor and its officers, directors, employees (acting in the course of their employment, but not as Participants), agents, and subcontractors for that portion of any claim, lawsuit, action, loss, liability, damage, expense, judgment, settlement, cost, interest, fine or obligation (including attorney fees) that was caused directly by AmeriHealth Administrators' willful misconduct, criminal conduct, material breach of this Contract, fraud, or breach of its duty under federal or state law that relates to or arises out of the claims payment and benefit administration services provided by AmeriHealth Administrators under this Contract.

2. The indemnification obligations under this Section 8.1(a) do not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by, or resulting from, the acts or omissions of health care providers, whether network or non-network, with respect to Participants, including, but not limited to, fraud, negligence or malpractice, or to the fraudulent acts or omissions of Participants.

3. The indemnification obligations under this Section 8.1(a) shall not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by AmeriHealth Administrators' act or omission undertaken at the written direction of the Plan Sponsor (other than the services expressly set forth in this Contract).

b. Plan/Plan Sponsor's Obligations.

1. The Plan and/or Plan Sponsor shall indemnify AmeriHealth Administrators and its affiliated and parent companies, and their respective officers, directors, employees, agents, and subcontractors for that portion of any loss, liability, damage, expense, judgment, settlement, cost, interest, fine or obligation (including attorney fees):

(i) which was caused directly by the Plan Sponsor's willful misconduct, criminal conduct, material breach of this Contract, fraud or breach of fiduciary duty related to or arising out of the services provided by the Plan Sponsor under this Contract or the Plan;

(ii) arising out of or resulting from Southern New Jersey Health Insurance Fund's role as employer, Plan Administrator or Plan Sponsor, including its acts and/or omissions;

(iii) arising out of or resulting from acts and/or omissions of any other fiduciaries under the Plan;

(iv) resulting from taxes, surcharges, assessments and penalties incurred by AmeriHealth Administrators by reason of benefit payments made or services performed hereunder, and any interest thereon;

(v) in connection with the release or transfer of Participants individually identifiable information to the Plan Sponsor, the Plan, or a third party designated by the Plan or Plan Sponsor, or the use or further disclosure of such information by the Plan Sponsor, the Plan, or such third party; and/or

(vi) resulting from or arising out of claims, demands or lawsuits brought against AmeriHealth Administrators in connection with the services provided under this Contract, except as otherwise provided in this Contract.

2. The indemnification obligations under this Section 8.1(b) shall not apply to that portion of any loss, liability, damage, expense, settlement, cost, fine or obligation caused by the Plan Sponsor's act or omission undertaken at the written direction of AmeriHealth Administrators.

c. The party seeking to be indemnified under Section 8.1(a) or 8.1(b), above must notify the other party within a reasonable amount of time (not to exceed sixty (60) days) in writing of its receipt of the summons or suit to which it claims such indemnification applies. Failure to so notify the indemnifying party within this sixty (60) day period shall be deemed a waiver of all fees, costs and expenses incurred prior to the date of the notice. The parties will cooperate with regard to any claim or action brought by a third party against either party under this Contract. Neither party shall settle any such claim or action against it without the prior written consent of the indemnifying party, which consent shall not be unreasonably withheld.

d. The indemnification obligations under this Section 8.1 shall survive the expiration, termination, or cancellation of this Contract.

8.2 Defense of Claims Litigation. In the event of any legal action involving claims for benefits due under the Plan, AmeriHealth Administrators shall have the right to undertake the sole defense of such suit and have sole discretion over the resolution of such suit or action. If the Plan Sponsor is also named as a party to the lawsuit, AmeriHealth Administrators will defend the Plan Sponsor provided that such suit relates solely to AmeriHealth Administrators' provision of, or failure to provide, claims payment and benefit administration services under this Contract, and there is no conflict of interest between AmeriHealth Administrators and the Plan Sponsor. In all instances, the Plan Sponsor agrees to pay the amount of benefits due under the Plan which may be included in any judgment or settlement in such suit, but shall not be liable for any other part of such judgment or settlement, except to the extent provided in Section 8.1(b), above.

IN WITNESS WHEREOF, this Contract is executed in duplicate the day and year first above written.

SOUTHERN NEW JERSEY HEALTH INSURANCE FUND	**AMERIHEALTH ADMINISTRATORS, INC.**
By: _____	**By:** _____
Name: _____	**Name:** **Michael W. Sullivan**
Title: _____	**Title:** **President & CEO**
Date: _____	**Date:** _____

EXHIBIT A

(PLAN DOCUMENT)

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EXHIBIT B

Administrative and Claim Services

I. <u>Administration</u>. AmeriHealth Administrators shall provide administrative services to the Plan Sponsor as follows:

1. Eligibility maintenance.
2. Monthly eligibility listings.
3. Billing services by:
    a. Location
    b. Employee
    c. Line of coverage/benefit
    d. Administrative expenses
    e. Insurance premiums
4. Insurance carrier premium calculations and payment.
5. Explanation of benefit and check dispersal with postage.
6. 1099 Plan provider printing and dispersal with postage.
7. AmeriHealth Administrators shall make available a toll free telephone number to the Plan Sponsor and Participants for questions about administration and claim services.
8. Electronic Benefit Booklet[2,3]

[2] Upon Plan Sponsor's request, AmeriHealth Administrators will draft an electronic Benefit Booklet. This electronic Benefit Booklet will describe Plan Sponsor's medical plan based on information that Plan Sponsor provides to AmeriHealth Administrators. In preparing the electronic Benefit Booklet, AmeriHealth Administrators is acting only as a scrivener, not as a Plan Administrator. AmeriHealth Administrators assumes no fiduciary responsibilities under ERISA, and, by drafting the electronic Benefit Booklet, AmeriHealth Administrators is not providing legal advice with respect to the requirements of ERISA. Plan Sponsor should carefully review all of the information provided to AmeriHealth Administrators for inclusion in the electronic Benefit Booklet, before submitting the information to AmeriHealth Administrators for production, to ensure that it is accurate and meets the requirements of ERISA. Plan Sponsor should also review the information provided to AmeriHealth Administrators for inclusion in the electronic Benefit Booklet to ensure that it accurately reflects the benefits, terms, and conditions contained in Plan Sponsor's Summary Plan Description (SPD). Plan Sponsor should have its legal counsel review the electronic Benefit Booklet and provide a copy of its SPD and the electronic Benefit Booklet to its Stop-Loss carrier.

[3] If benefit booklet preparation is not requested, Plan Sponsor will be responsible for the preparation and provision of benefit booklets to its plan members. Plan Sponsor will be responsible for providing a copy of the benefit booklet.

II. Claim Services. AmeriHealth Administrators shall process eligible claims in accordance with the following procedures:

To the extent applicable and subject to Section 3.3, AmeriHealth Administrators will have the authority to exercise discretion to:

1. construe those terms of the Plan which are related to the health benefits to be administered by AmeriHealth Administrators under the Contract, and to make initial benefit Determinations on behalf of the Plan Sponsor;

2. administer standard first level Participants' appeals of Determinations under the Plan;

3. pay benefits, using funds from the Account, in accordance with Claim Determinations; and, to do all other things necessary to fulfill its obligations under this Contract.

4. in accordance with N.J.A.C. 11:15-3.26(c), AmeriHealth Administrators shall (unless the Plan Sponsor otherwise permits) handle to conclusion, process and pay to providers, or, if applicable, Participants, all eligible claims for Covered Services that are incurred by Participants while this Agreement is in effect, according to the terms of the Benefit Program.

The duties performed by AmeriHealth Administrators under this Section II do not alter or affect the Plan Sponsor's rights under Section 3.3. AmeriHealth Administrators has no responsibility or liability for the duties and obligations of the Plan Administrator.

III. Materials. AmeriHealth Administrators shall provide the Plan Sponsor with the following materials.

1. Identification cards for employees and their dependents who are eligible to receive coverage and benefits under the Plan.

2. AmeriHealth Administrators' claim service checks for payment of eligible claims made by Participants and eligible Plan providers.

3. AmeriHealth Administrators' explanation of benefit forms for consideration of non-payment claims of eligible Participants.

4. AmeriHealth Administrators' enrollment cards for employees and their dependents, who are eligible, to complete in order to receive coverage and benefits under the Plan.

5. A standard package of weekly, monthly and annual reports of coverage and benefit payments made to Participants and providers as well as fees and expenses paid from the Plan.

6. Participant claim forms.

IV. <u>Advice to Plan Sponsor</u>. AmeriHealth Administrators shall provide advice to the Plan Sponsor in accordance with Section 2.10 on the following matters:

1. Design features, funding alternatives, administrative procedures and cost savings mechanisms pertinent to the operation of the Plan. Advice with respect to funding alternatives shall include issues regarding the frequency of payments from Plan Sponsor to AmeriHealth Administrators and deposit requirements but shall not include Underwriting/Actuarial, tax, accounting or legal services.

2. Completion and submission of reports, forms or materials as may be required to comply with the reporting and disclosure obligations under applicable state or federal laws.

3. AmeriHealth Administrators assumes no fiduciary responsibilities under ERISA, and, by providing services stated in Sections 2.9 and Exhibit B (IV (1) and (2)) above, AmeriHealth Administrators is not providing legal advice with respect to the requirements of ERISA or any other federal or state laws.

AmeriHealth Administrators' compensation for Administration, Claim Services, Materials, and Advice to the Plan Sponsor shall be as shown in Exhibit D attached to this Contract, under the listing "Administration and Claims Service Fee."

EXHIBIT C

Optional Services

I. Utilization Review Procedures

AmeriHealth Administrators shall perform preadmission, concurrent and retrospective review of all facility admissions as requested by the Plan and the Plan Sponsor. Such services may include consultations with select physicians to review the attending physician's proposed treatment plans or practice patterns; coordination and facilitation of discharge planning; maintenance of a comparative data base of providers; and provision quarterly of summary of results. This overview process shall be directed towards the desired result of encouraging quality, cost efficient care while respecting the attending physicians' ultimate authority. AmeriHealth Administrators' compensation for its services under this section shall be as set forth in Exhibit D to the attached Contract, under the listing "Utilization Management Fee".

II. Documentation/Underwriting/Actuarial Services

If requested by the Plan Sponsor, AmeriHealth Administrators may furnish for review by the Plan Sponsor's counsel, a sample document necessary for the establishment and maintenance of the Plan. The Plan Sponsor shall review and, upon advice of legal counsel, adopt such document or take such other action, as it deems appropriate.

If requested by Plan Sponsor, AmeriHealth Administrators may review the documentation prepared by the Plan Sponsor for establishment and maintenance of the Plan. AmeriHealth Administrators will provide a written proposal setting forth the scope of such a review and the estimated time frame for completion. Provided however, that such review will not include Underwriting/Actuarial, tax, accounting or legal services.

If requested by the Plan Sponsor, AmeriHealth Administrators may also provide Underwriting/Actuarial services to the Plan Sponsor that the Plan Sponsor requests. If the Plan Sponsor requests such services, AmeriHealth Administrators will prepare a written proposal setting forth the scope of the services. Provided however, that such services will not include tax, accounting or legal services. Unless a written proposal is prepared at the request of the Plan Sponsor, AHA expects and assumes that the Plan Sponsor has obtained, or will obtain, advice and/or counsel from other persons or entities regarding Underwriting/Actuarial issues as needed and the Plan Sponsor is not relying on AHA for any such advice or counsel.

AmeriHealth Administrators' compensation for these services shall be as shown in Exhibit D to the attached Contract, under the listing "Documentation/Underwriting/Actuarial Services Fee".

III. Stop Loss Coordination Services[4,5]

Plan Sponsor agrees to complete the stop loss information form yearly and provide the details needed for stop loss services. On a monthly basis, AmeriHealth Administrators shall provide the following information, if applicable, to the Plan Sponsor's Stop Loss Carrier:

[4] Only claims received thirty (30) days prior to the end of the stop loss policy term are guaranteed to be paid and considered toward the stop loss contract term.

[5] AmeriHealth Administrator's audit policy also applies to aggregate accommodation stop loss audits.

- Early notifications (i.e., notice will be given if it is possible that the total claims paid plus the total amount charged for all pending claims will cause the claimant to exceed notification point);
- Fifty percent (50%) notifications;
- Notifications of specific excess claimants; and
- Aggregate spreadsheets which include census information.
- On the 1st and 16th of the month, the stop loss carrier will receive a large case notification report which reports on precertifications issued for trigger diagnoses and/or certain confinement criteria.
- High Dollar Claim notification will be provided upon receipt of high dollar claims with charges in excess of $25,000.

Upon notification of a specific excess claim, AmeriHealth Administrators will forward the following information, if applicable, to the Stop Loss Carrier:

Plan documents	COBRA information
Subrogation information	COB information
Proof of pre-certification	Enrollment documents
Screen prints of claim payments	Provider bills

Three (3) months prior to the end of a group's stop loss contract, AmeriHealth Administrators will provide appropriate information to the Stop Loss Carrier to assist in the renewal process.

IV. Disease Management and Decision Support Program

("DMDS Program") is a program designed to provide health information to Eligible Members and providers and to support Eligible Members in making informed decisions about their health care. The DMDS Program is not intended to be used for utilization management activities, including, but not limited to, coverage determinations, or to determine the level or type of care to be provided to Eligible Members.

The disease management component of the DMDS Program is designed to identify Eligible Members who are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. The disease management component of the DMDS Program may employ education, health coaching, provider feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Eligible Members who have one or more of the following five chronic conditions: chronic obstructive pulmonary disease ("COPD"), congestive heart failure ("CHF"), diabetes, coronary artery disease ("CAD"), and asthma.

The decision support component of the DMDS Program identifies Eligible Members who may be facing significant treatment options and offers them information to assist in making informed collaborative decisions with their providers. Decision support also includes the availability of general health information, general health coaching, and provider information.

EXHIBIT D

FEES AND TERMS

Effective Date: 01/01/2019 **Term: 36 Months**

AmeriHealth Administrator's Administration and Claims Service Fee

Lives: 125[6]

Administrative Fees

Effective Date 1/1/19	**36-month Term 1/1/19-12/31/21**
Medical/UM	$40.00 PEPM
Disease Management	$2.00
Wellness Program Credit	($1.25)
Total Base Medical Fee	$40.75

Additional Renewal Fees

PPO Access Fee	Amount AHA pays PPO access
Network Directories	Pass through cost from network, plus reasonable internal costs, if any
Recovery Fee	30% of the amount collected, received, or recovered
Advance Medical Deposit	$13,223[7]
Underwriting/Actuarial Services	$135.00 per hour plus expenses
Documentation	$135.00 per hour
Custom Programming	$150.00 per hour
Data/File exchange with outside vendor	Flat fee or PEPM
Early Termination	2 months of administrative fees
Run-out Claims Processing	4 months of administrative fees

[6] This Contract is based on 125 lives. A re-quote will be required if the actual number of lives varies by more than ten percent.
[7] In lieu of the individual payment amount for Southern New Jersey HIF, AHA has agreed to accept the collective amount for all four HIF groups.

Third-Party PBM Vendor Integration

If the client has chosen a third-party PBM and requests integration:

• Bi-directional feed to third-party PBM vendor.	$15,000 (minimum)
Set-up (one-time fee) actual cost, hourly charge.	$0.29 pepm

Ongoing Charge
(to accommodate the 2015 Medical/Rx Out-of Pocket Maximum requirements)

Our offering of this fee structure does not constitute a guarantee that we can accommodate feeds to all PBM's, nor can we guarantee that a requested feed timeline can be met.

Other Services

Any fees for services not listed in this Contract will be presented to Plan Sponsor and will include costs to AHA and vendor, if applicable.

Run-out Claim Processing

The Administrative Fees paid to Claims Administrator for post-termination claims services under this Agreement shall be calculated by the Claims Administrator based upon the following method for calculating Administrative Fees:

> **Per Contract holder.** Claims Administrator will charge one hundred (100%) of the per Employee Administrative Fee amount in effect immediately prior to termination, multiplied by the sum of the enrollment for the four (4) months prior to termination. This one time only fee will be billed and must be paid by the Group prior to the termination date.

Run-out claims will be processed for a period of 12 months following termination of the Contract.

The Plan Sponsor will reimburse AmeriHealth Administrators for any fees, services, benefits, payments, taxes, surcharges, non-compliance penalties or any other amounts imposed, increased, or adjudged due and attributable to the Plan by a lawful regulatory or governmental authority or its agents.

An Early Termination Charge will apply to clients who terminate our services prior to the end of the initial contract term or the subsequent amendment term. The Early Termination Charge is equal to 2 months of Administrative Fees.

The fees shown on this Exhibit D do not include costs associated with new or expanded

tasks that are required to be performed by AmeriHealth Administrators as a result of the requirements of The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Care Reform Law). If additional administrative costs are incurred by AmeriHealth Administrators because of changes imposed or required by the Health Care Reform Law or governmental or regulatory entities, AmeriHealth Administrators shall have the right to pass through the additional costs to the plan sponsor. AmeriHealth Administrators shall provide 60 days prior written notice of any such additional costs.

EXHIBIT E

Regional Network Discount	
The Philadelphia five-county area Discount (Includes the following counties: Philadelphia, Montgomery, Bucks, Chester and Delaware)	66%
New Jersey (	61%

EXHIBIT F

AmeriHealth Administrators Policy for Audits by Customers
And Other External Entities

PURPOSE

The purpose of this policy is to establish the necessary mechanism that will enable AmeriHealth Administrators (AHA) and external audit teams to conduct audits of relevant claims in an efficient and responsible manner.

SCOPE

This Policy applies to customers and their representatives who conduct an audit/review of relevant claims.

POLICY

The audit policy is as follows:

1. AHA written request shall be made on the requestor's letterhead. For audits by a group customer, an External Audit Questionnaire form (see below) must be completed by the audit/review requestor and returned to the Operations Compliance Department before an audit can begin.
2. The Operations Compliance Department must receive requests for onsite audits at least 90 days prior to the date the onsite work is requested to begin. Only one customer may conduct an audit at any time. Onsite audits will be conducted during normal business hours (8:30 a.m. to 5 p.m.).
3. The standard Confidentiality Agreement must be executed prior to the start of the audit.
4. Confidential and proprietary information (such as provider remittances and provider contracts) will not be released for an audit. Any medical records in the possession of AHA will not be released unless the patient signs a Member Authorization Form.
5. Online access to AHA's or its vendor's information systems will not be provided.
6. The audit scope period may go back no further than 18 months from the scheduled onsite audit date.
7. Audits shall be conducted by the requestor's internal audit staff or by a mutually agreeable third party. AHA will not allow audits to be conducted by contingency fee auditors/consultants.
8. Audits by a group customer are permitted only for self-funded groups. The following restrictions apply to all audits:

- An account must be current on its invoice payments prior to requesting an audit
- Standard audits are limited to a total of 250 claim samples

9. AHA reserves the right to assess a charge for the costs associated with fulfilling an audit request that does not meet the criteria listed in the preceding paragraph. The charge to the account will be $50 per claim. Charges may also be assessed for information system resources involved in providing the requested information.
10. Accounts that have terminated their coverage with AHA must request an audit within one (1) year of the effective date of the termination. If the request exceeds the one (1) year timeframe, charges of $50 per claim in addition to applicable information systems charges will be assessed and collected prior to fulfilling such requests.
11. Unless otherwise agreed to by AHA, claim errors found by external auditors/consultants cannot be extrapolated to calculate financial impact. AHA will identify and disclose the root cause, the volume of claims and the financial impact pertaining to a systemic related claim error.
12. The performance outcome from the audit will not result in specific payments by AHA for performance guarantees on claim performance.
13. The approved/final group health plan in effect will be the source of reference for an audit. Issues of intent/interpretation that are not specifically addressed in the Groups benefit documentation are to be mutually resolved between the Group, the auditor and AHA on a go forward basis and cannot be counted as errors against AHA operational audit performance results.
14. Unless otherwise agreed to by AHA, a final draft of the external auditor's report shall be submitted to AHA at least ten business days prior to the report being delivered to the audit requestor.
15. AHA shall receive a copy of the final report at the same time it is delivered to the audit/review requestor.

This Policy is subject to applicable state and federal laws/regulations. AHA has the final authority to interpret the scope and application of this Policy. Any questions concerning this Policy may be directed to the Director, Quality and Compliance.

AmeriHealth Administrators
EXTERNAL AUDIT QUESTIONNAIRE

Presented below is a series of questions regarding your proposed audit/review of AmeriHealth Administrators. Please complete the information requested and return it to the Operations Compliance Department within two weeks of your receipt. This information will enable us to make arrangements consistent with Plan Policy. After this document is returned to AmeriHealth Administrators, we will contact you to confirm the arrangements.

1. Name of account requesting review & group number(s) involved:

2. Number of contracts in the above account:

3. Purpose for audit:

4. Auditor's name, address and telephone #:

5. Time period to be covered in audit (not to exceed two years prior to most recent settlement or renewal date):

6. Line of business (check all applicable):

   a) Major Medical

   b) Hospitalization

   c) Medical/Surgical

   d) Vision

   e) Dental

   f) Prescription Drug

7. Describe sample size and methodology (use attachments if necessary):

   Sample size must comply with sections 7 and 8 of the audit policy.

8. We agree to comply with the terms and conditions of AmeriHealth Administrators' Policy for Audits by Customers and Other External Entities as attached.

   Requestor's Name:

   Requestor's Title:

   Signature:

   Date:

NOTE: Complete this section only if this is an on-site audit.

9. Anticipated field work start date:

10. Anticipated field work completion date:

11. Names, titles of auditors:

    a) Firm name (if applicable):

    b) In-charge:

    c) Staff:

12. Special facilities required:

13. Who should we contact if we have questions prior to auditor's arrival:

    Name:

    Title:

    Telephone #:

    Fax #:

EXHIBIT G

CLINICAL SERVICES

1. UTILIZATION REVIEW PROCESS

A basic condition of Southern New Jersey Health Insurance Fund**'s** benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. To assist Southern New Jersey Health Insurance Fund in making coverage determinations for requested health care services, AmeriHealth Administrators' delegate uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Participant's benefit plan is called utilization review.

Medically Appropriate/Medically Necessary (Or Medical Appropriateness/Medical Necessity) – a Health Intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. A Health Intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by AmeriHealth Administrator's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention." A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Participant.

C. It is known to be "effective" in improving "health outcomes." Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

Existing interv

professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. It is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a covered under the Plan or meet this Medically Appropriate/Medically Necessary definition.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by AmeriHealth Administrators to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider.

An example of such automatically approved services is an established list of services received in an emergency room which has been approved by AmeriHealth Administrators based on the procedure meeting emergency criteria and the severity of diagnosis reported. Other requested services, such as certain elective inpatient or outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based upon when the review is performed. When the review is required before a service is performed, it is called a precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. AmeriHealth Administrators follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by AmeriHealth Administrators or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Participant's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Participant in accordance with applicable law.

AmeriHealth Administrators' utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to AmeriHealth Administrators' or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither AmeriHealth Administrators nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

The precertification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Precertification is not a guarantee of eligibility for the

coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Participant being eligible, i.e., actively enrolled in the Plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the Plan that apply to the coverage request.

CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist AmeriHealth Administrators or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Participant's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests, and reduces practice variation among AmeriHealth Administrators' or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies: AmeriHealth Administrators and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines: A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

DELEGATION OF UTILIZATION MANAGEMENT ACTIVITIES AND CRITERIA

AmeriHealth Administrators, Inc., is a state licensed utilization review entity, where required, and a National Committee for Quality Assurance (NCQA) accredited utilization management program. In certain instances, AmeriHealth Administrators has delegated certain utilization review activities, including precertification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with AmeriHealth

Administrators' approval.

PRECERTIFICATION REVIEW

When required, precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Participant's benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. Precertification review may be initiated by a provider, however, it is the Participant's responsibility to obtain precertification review. Where precertification review is required, AmeriHealth Administrators' coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where precertification review is required for a procedure but is not obtained.

While the majority of services requiring precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, short procedure unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing Provider. Precertification review is not required for emergency services.

1. INPATIENT PRE-ADMISSION REVIEW

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be precertified in accordance with the standards of AmeriHealth Administrators' as to the Medical Appropriateness/Medical Necessity of the admission. The precertification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Participant is responsible to have the admission (other than an emergency or maternity admission) certified in advance as an approved admission.

2. EMERGENCY ADMISSION REVIEW

a. Participants are responsible for notifying AmeriHealth Administrators of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by AmeriHealth Administrators.

b. If the Participant elects to remain hospitalized after AmeriHealth Administrators and the attending doctor has determined that an inpatient level of care is not Medically Appropriate/Medically Necessary, the Participant will be financially liable for non-covered inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRENOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Participant and coordinates discharge planning. Concurrent review continues until the Participant is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an inpatient facility is paid based on a per case or diagnosis-related basis, or where an agreement with a facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when AmeriHealth Administrators has not been notified of a Participant's admission until after discharge, or where medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, AmeriHealth Administrators may determine coverage of certain procedures and other benefits available to Participants through prenotification as required by the Participant's benefit plan and discharge planning.

Pre-notification is advance notification to AmeriHealth Administrators of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Participants for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Participants who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Participant's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or skilled nursing facility placement. Discharge planning involves AmeriHealth Administrators' authorization of covered post-hospital services along with identifying and referring Participants for disease management or case management services.

CASE MANAGEMENT

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Participant's health needs through communication and available resources to promote quality, cost-effective outcomes.

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the Participant to ensure the efficient use of appropriate health care resources, link Participants with appropriate health care or support services, assist providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Participants. Case management supports Participants and providers by locating, coordinating, and/or evaluating

services for a Participant who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

Case management is a voluntary service. A Participant must provide their consent for enrollment into case management. There is no reduction in benefits if the Participant and the Participant's family choose not to participate.

AmeriHealth Administrators will provide case management services for those identified Participants that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and
- Reduction of preventable complications.

Participants may be identified for case management through the utilization review process or through claims review/predictive modeling. External referrals are also accepted from Participants' providers or family members. Participants referred to case management are screened and assessed prior to acceptance into the program. Only those Participants who meet the case management identification and screening criteria and who consent to case management will be accepted into the case management program. Case management will follow the utilization review process for review and authorization of services.

A case manager will consult with the Participant, the Participant's authorized representative, the caregiver and the attending doctor in order to develop a plan of care for approval by the patient's attending doctor and the Participant. This plan of care may include some or all of the following:

- personal support to the Participant;
- contacting the care giver to offer assistance and support;
- monitoring inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending doctor, the patient and the Participant's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, AmeriHealth Administrators may reimburse necessary expenses in the treatment plan, even if some expenses normally would not

be paid by the Plan.

A Participant's circumstances may determine the need to continue, decrease, or ultimately discontinue enrollment in case management services. AmeriHealth Administrators, in its sole discretion, will determine the most cost effective and appropriate case management interventions including discharge from case management.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

EXHIBIT H

Special Provision - Affirmative Action

AmeriHealth Administrators, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, AmeriHealth Administrators will take affirmative action to ensure that such applicants are recruited and employed, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such action shall include, but not limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. AmeriHealth Administrators agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this nondiscrimination clause.

AmeriHealth Administrators, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of AmeriHealth Administrators, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex.

AmeriHealth Administrators, where applicable, will send to each labor union or representative or workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer advising the labor union or workers' representative of AmeriHealth Administrators commitments under this act and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

AmeriHealth Administrators where applicable, agrees to comply with any regulations promulgated by the Treasurer pursuant to N.J.S.A. 10:5-31 et seq. as amended and supplemented from time to time and the Americans with Disabilities Act.

AmeriHealth Administrators agrees to make good faith efforts to employ minority and women workers consistent with the applicable county employment goals established in accordance with N.J.A.C. 17:27-5.2, or a binding determination of the applicable county employment goals determined by the Division, pursuant to N.J.A.C. 17:27-5.2.

AmeriHealth Administrators agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, labor unions, that it does not discriminate on the basis of age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

AmeriHealth Administrators agrees to revise any of its testing procedures, if necessary, to assure that all personal testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with the applicable employment goals, AmeriHealth Administrators agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

AmeriHealth Administrators shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

1. Letter of Federal Affirmative Action Plan Approval

2. Certificate of Employee Information Report

3. Employee Information Report Form AA302

AmeriHealth Administrators shall furnish such reports or other documents to the Division of Contract Compliance & EEO as may be requested by the Division from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Division of Contract Compliance & EEO for conducting a compliance investigation pursuant to Subchapter 10 of the Administrative Code at N.J.A.C.17:27.

Exhibit I

New Jersey Law

NEW JERSEY LAW. This Agreement shall be governed by, and construed in accordance with, the laws of the State of New Jersey. In addition:

1. BUSINESS REGISTRATION. AmeriHealth Administrators shall comply with business registration requirements of the State of New Jersey per N.J.S.A. 52:32-44.

2. MAINTENANCE OF CONTRACT RECORDS. (N.J.A.C. 17:44-2.2) Relevant records of private vendors or other persons entering into contracts with covered entities are subject to audit or review by OSC pursuant to N.J.S.A. 52:15C-14(d). AmeriHealth Administrators shall maintain all documentation related to products, transactions or services under this contract for a period of five years from the date of final payment. Such records shall be made available to the New Jersey Office of the State Comptroller upon request.

3. POLITICAL CONTRIBUTIONS: Compliance with the New Jersey Campaign Contributions and Expenditures Reporting Act. N.J.S.A. 19:44A-1 et seq. shall be a material term and condition of this contract and shall be binding upon the parties hereto upon execution of this Contract. The following provision only applies to AmeriHealth Administrators if the appointment was not made pursuant to a fair and open process in accordance with N.J.S.A. 19:44A-20.4 et. seq. By acceptance of this Agreement, AmeriHealth Administrators certifies that in the one year period preceding the date that this contract is legally authorized that neither AmeriHealth Administrators business entity nor any persons holding 10% or more of the issued and outstanding stock of AmeriHealth Administrators business entity or entitled to receive the benefit of 10% or more of the revenues and/or profits of AmeriHealth Administrators business entity have made any reportable contributions pursuant to N.J.S.A. 19:44A-1 et seq. that, pursuant to P.L. 2004, c.19 would bar the award of this contract. This includes any reportable contribution to any official, candidate, joint candidates committee or political party representing elected officials or candidates as defined pursuant to N.J.S.A. 19:44A-3(p), (q) and (r) of any member local unit insured by the Plan Sponsor. Further, AmeriHealth Administrators and all persons holding 10% or more of the issued and outstanding stock of AmeriHealth Administrators business entity or entitled to receive the benefit of 10% or more of the revenues and/or profits of AmeriHealth Administrators business entity shall not make such contributions during the period of this contract.

EXHIBIT J

Insurance

1.

Coverages. AHA shall at its sole cost maintain the following insurance coverage in full force and effect throughout the Term:

(a) Commercial General Liability – Insures against sums that must be paid because of bodily injury or property damage caused by an occurrence that takes place on property locations
   i. Each Occurrence- $1 million
   ii. Damage to rented premises (each occurrence)- $1 million
   iii. Medical Expenses (any one person)- $10k
   iv. Personal & Adv Injury- $1 million
   v. General Aggregate- $2 million
   vi. Products- Comp/Op Agg- $2 million

(b) Automobile Liability – Insures all Company owned/leased vehicles.
   i. Combined Single Limit (each accident) $1 million

(c) Umbrella Liability – Insures against all sums in excess of Primary General, Employee Benefits, Errors & Omissions, Automobile & Employers Liability.
   i. Each Occurrence- $1 million
   ii. Aggregate- $2 million

(d) Workers Compensation – Insures the Company against injury sustained by employees during the course or scope of their employment.
   i. Each Accident- $500,000
   ii. Disease Each Employee- $500,000
   iii. Disease Aggregate- $500,000

(e) Property/ All Risk includes EDP Boiler & Machinery – Covers real and business personal property. Also insures against loss of business income due to loss or damage to property.
   i. Personal Property- $1 million

(f) Managed Care Errors & Omissions – Insures the Company, Officers, Directors or Employees against claims made for wrongful acts in the rendering or failure to render professional (Managed Health Care) services.
   i. $10 million

(g) Group Medical Professional Liability- Insures against claims made for Bodily Injury caused by an act, error or omission directly resulting from the rendering or failure to render professional health care services.
   i. Physician's Professional Liability (PL)

i. Each Medical Incident- $500,000
ii. Annual Aggregate- $1,500,000

(h) Directors & Officers Liability (D&O) and Employment Practices Liability (EPL) – Insures individual Directors and Officers against personal losses and reimburses the Company for any loss arising from any claim made against any Directors and Officers. Also insures the Company and employees for loses and defense costs due to claims made for Wrongful Employment Acts.
   i. $5 million

(i) Crime/Employee Dishonesty – Insures against loss resulting directly from dishonest or fraudulent acts committed by an employee acting alone or in collusion with others.
   i. Each Occurrence- $10 million
   ii. Aggregate- $20 million

(j) Fiduciary Liability – Insures the Company and any Administrator and Fiduciary against any alleged wrongful act committed in the administration of any pension plan or welfare benefit plan.
   i. $10 million

(k) Cyber Risk Liability – Insures against claims made for First-Party and Third-Party losses that may occur because of Internet Operations and Privacy Injuries. Also insures against claims for actual or alleged wrongful acts in connection with the creation or dissemination of advertising material.
   i. $40 million

(l) Performance Bond: Valued at twenty five percent (25%) of the estimated value of the annual contract, with a minimum limit of $50,000.

APPENDIX III

2021 MEL, MRHIF & NJCE Educational Seminar

Virtual

Friday, May 14, 9:00 to Noon
Friday, May 21, 9:00 to Noon

The MEL (Municipal Excess Liability Joint Insurance Fund), MRHIF (Municipal Reinsurance Health Fund) and the NJCE (NJ Counties Excess Joint Insurance Fund) are sponsoring the 10th annual educational seminar for elected officials, commissioners, municipal, county and authority personnel, risk managers and other professionals. There is no cost to attend.

This seminar is eligible for the following continuing educational credits:

- CFO/CMFO, Public Works and Clerks:
- Insurance Producers and Purchasing Agents:
- Accountants (CPA's) and Lawyers (CLE):
- TCH Water Supply & Wastewater Licensed Operator Training:
- RPPO and QPA

Friday May 14th:

- Keynote: Combating Implicit Bias in Local Government
- Ethics Issue 1: NJ Local Officials Ethics Act
- Coverage Issues: Insurance Market Conditions and Cyber Risk Control

Friday, May 21st:

- Ethics Issue 2: Ethical Considerations in Drafting Personnel Policies and Procedures
- Legislative Issues: Proposals to Change the WC & Liability Statutes
- Benefits Issues: The Affordable Care Act under the New Administration.

REGISTRATION: Contact Jaine Testa @ jainet@permainc.com

MEL

MRHIF
Municipal Reinsurance Health Insurance Fund

NJCE
NEW JERSEY COUNTIES
EXCESS JOINT INSURANCE FUND