SCHOOLS HEALTH INSURANCE FUND

www.schoolshif.com

AGENDA & REPORTS

MARCH 24, 2021

12:00 PM

CONFERENCE CALL

Join Zoom Meeting

https://permainc.zoom.us/j/5455080980

Meeting ID: 545 508 0980

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Meeting ID: 545 508 0980

SCHOOLS HEALTH INSURANCE FUND
MEETING: MARCH 24, 2021
12:00 PM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ BY FUND CHAIR

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 Burlington County Times, The Times of Trenton and the Star Ledger

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.

FLAG SALUTE

ROLL CALL OF 2020-2021 BOARD OF TRUSTEES

Officers
Joseph Collins, Delsea Regional BOE-Chairman
Beth Ann Coleman, Collingswood BOE

Board of Trustees
Lisa Giovanelli, Rancocas Valley BOE
Michael Colling, Medford Lakes BOE
Christopher Lessard, Frankford Twp BOE
Evon Digangi, Mt. Holly BOE
Nicholas Bice, Burlington Twp BOE
Marie Goodwin, Medford Township Public Schools
Jason Schmipf, Kingsway Regional School District
Helen Haley, Voorhees Township BOE

Fund Attorney swears in Trustee Sekelskly

OPEN MINUTES: February 24, 2021 (**Appendix I)**

PUBLIC COMMENT – For Agenda items only

REPORTS:

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

PROGRAM MANAGER– (Conner Strong & Buckelew)
Monthly Report**.....Page 25**

GUARDIAN NURSES -
Monthly Report **.....Page 29**

TREASURER – (Verrill & Verrill)
March 2021 Voucher List (Resolution 6-21) **.....Page 30**
Monthly Report January 2020 **.....Page 33**
Resolution 6-21: Bills List and Treasurers Report **.....Page 36**

ATTORNEY – (J. Kenneth Harris.)
Monthly Report

NETWORK & THIRD PARTY ADMINISTRATOR – (Aetna)
Monthly Report**.....Page 37**

NETWORK & THIRD PARTY ADMINISTRATOR – (AmeriHealth)
Monthly Report**.....Page 41**

NETWORK & THIRD PARTY ADMINISTRATOR – (Horizon)
Monthly Report

PRESCRIPTION ADMINISTRATOR – (Express Scripts)
Monthly Report **.....Page 51**

DENTAL ADMINISTRATOR – (Delta Dental)

OLD BUSINESS

NEW BUSINESS

PUBLIC COMMENT

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

MEETING ADJOURNED

SCHOOLS HEALTH INSURANCE FUND
EXECUTIVE DIRECTOR'S REPORT
MARCH 24, 2021

FINANCE & CONTRACTS COMMITTEE

PRO FORMA REPORTS

- **Fast Track Financial Reports –** SHIF – as of January 31, 2021 (page 6)

2021/2022 BUDGET ADOPTION (page 10)

The 2021-2022 budget was introduced at the previous meeting and draft rates were distributed to the member brokers/consultants. Included is the budget and assessments to be adopted in public session. The budget has changed slightly since introduction:

1. Census and assessments for 2 new members, Mendham Township BOE and Oxford BOE, is now included. These changes did not result in changes for the assessments of other members.

2. The Amerihealth contract has been finalized resulting in a slight increase in fees for the next fiscal year.

Motion: *Motion to open the Public Hearing on the 2021-2022 Budget*

Discussion of Budget and Assessments

Motion: *Motion to close the Public Hearing*

Motion: *Motion to adopt resolution 4-21 adopting the 2021-2022 Schools Health Insurance Fund Budget as Amended.*

If no changes were made during the public hearing, the draft rates that were previously distributed will not change and will be included in the open enrollment packets. Resolution #4-21 adopting the 2021-2022 budget is included on page 20.

AMERIHEALTH (AHA) CONTRACT

The AHA contract with the SHIF has been updated with the most current public sector language requirements and to reflect more terms that are standard for AHA. There are also minor changes in compensation resulting in a return of fees for prior periods ($27,102) and slightly higher fees for our next fiscal year ($18,576). This new contract covers the period from 1/1/2019 to 12/31/2021. The contract is included in Appendix III. **Going forward, our firm intention is to finalize the AHA contract at least 2 months prior to expiration for reasons of both efficiency and regulatory compliance.** We will also explore making this contract, and the Aetna contract, coterminous with our fiscal year.

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

RFP UPDATE

RFP's for Actuary, Auditor, Attorney, Treasurer, Executive Director and Program Manager were released on March 3rd, with responses due April 1st. The contracts committee will review the responses and provide a recommendation at the May meeting.

WEST DEPTFORD BOE

In 2016, West Deptford BOE entered the Fund with a 2 month assessment deferral that was approved by the Executive Committee. The BOE is requesting to use some of its closed year balance to clear one month of the deferred bills. The district's closed year balance is approximately $1.9 million and the one month payment would be approximately $620,000. The remaining one month balance will be revisited within a year.

> **MOTION:** *Motion to authorize the West Deptford Board of Education to utilize closed year balance funds in the amount of approximately $620,000 to clear a one month payable to the Fund.*

OPERATIONS & NOMINATIONS COMMITTEE

NEW MEMBERSHIP APPROVAL

The Fund received two new member submissions – Shamong BOE (5/1/2021) and Ramapo Indian Hills BOE (5/1/2021). The Operations Committee reviewed and have recommended membership. The growth capacity is also listed below with the inclusion of these two groups, which shows the Fund is still within the approved 35% growth cap. Resolution #5–21 ratifies these members and is included on page 21. Minutes from this meeting are included in Appendix II.

Underwriting Factor	Ramapo Indian Hills BOE	Fund Average or Standard	Relativity
Current Carrier or Arrangement	Horizon	Aetna	
Age Sex Factor	1.196	1.160	103.06%
Enrollment	259	14,236	1.82%
Claims Pick (Per Employee Per Month)			
Medical	$ 1,769.00	$ 1,583.00	111.75%
Rx			
Combined			
Trend + Margin Applied	10.00%	10.00%	100.00%
Risk Manager Fee Applied	$ 60,000.00		
Rate Effective Date			
From	5/1/2021		
To	6/30/2022		
Prior Fund Member?	No		
Lines of Coverage to Fund			
Medical	Yes		
Dental	No		
Rx	No		
Anticipated Commissioner Involvement	TBD		
Explanatory Notes or Contingencies			

Underwriting Factor	Shamong BOE	Fund Average or Standard	Relativity
Current Carrier or Arrangement	Horizon	Aetna	
Age Sex Factor	1.155	1.160	99.59%
Enrollment	83	14,236	0.58%
Claims Pick (Per Employee Per Month)			
Medical	$ 1,694.00	$ 1,583.00	107.01%
Rx			
Combined			
Trend + Margin Applied	14.00%	10.00%	140.00%
Risk Manager Fee Applied	3.00%		
Rate Effective Date			
From	5/1/2021		
To	6/3/2022		
Prior Fund Member?	Yes		
Lines of Coverage to Fund			
Medical	Yes		
Dental	No		
Rx	No		
Anticipated Commissioner Involvement	TBD		
Explanatory Notes or Contingencies	Previous SHIF member >3 years ago.		

New Member Underwriting Status - FY 2020-2021

Group	Employees	Proposal Released	BOE Approval	Union Approval	Signed I&T	Effective Date
Lenape BOE	850	Y	Y	Y	Y	7/1/2020
Gloucester County Tech Ed	151	Y	Y	Y	Y	7/1/2020
Gloucester County SSSD	430	Y	Y	Y	Y	7/1/2020
Foundation Academy	112	Y	Y	Y	Y	7/1/2020
Maple Shade BOE	262	Y	Y	Y	Y	7/1/2020
North Hunterdon Voorhees BOE	302	Y	Y	Y	Y	10/1/2020
Gloucester City BOE	260	Y	Y	Y	Y	10/1/2020
Colts Neck BOE	183	Y	Y	Y	Y	1/1/2021
Newton BOE	179	Y	Y	Y	Y	1/1/2021
West Morris BOE	270	Y	Y	Y	Y	1/1/2021
Robbinsville BOE	291	Y	Y	Y	Y	1/1/2021
Hunterdon Central	396	Y	Y	Y	Y	1/1/2021
Medham Township BOE	97	Y	Y	Y	Y	2/1/2021
Oxford BOE	28	Y	Y	Y	Y	3/1/2021
Eastern Camden County BOE	224	Y	Y	Y	N	4/1/2021
Shamong BOE	83	Y	Y	Y	Y	5/1/2021
Ramapo Indian Hills BOE	259	Y	Y	Y	Y	5/1/2021
Total Employees	**4,377**					
% Growth	**34.65%**					

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 IV. 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 Schools Health Insurance Trustee, 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.

INDEMNITY AND TRUST AGREEMENTS

In order to be in compliance with the Fund bylaws all members should have a current indemnity & trust agreement with the Fund that also needs to be filed with the State. Included on page 23 is a list of members who have renewing agreements due by June 20, 2021 or earlier. An email was sent out to all Brokers and Consultants on March 16, 2021 with the Indemnity & Trust Agreement and resolution to renew membership to be distributed to their members. Please reach out to kkamprath@permainc.com for a blank form and resolution to renew membership to be executed if one was not received.

WELLNESS COMMITTEE

2021-2022 GRANT APPLICATIONS

The Wellness Committee will meet in April to review the grant application process for next budget year. Applications will be sent to brokers by the end of April with a June submission date.

SCHOOLS HEALTH INSURANCE FUND
FINANCIAL FAST TRACK REPORT
AS OF January 31, 2021

			THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
1.	**UNDERWRITING INCOME**		**29,917,822**	**194,581,221**	**920,023,827**	**1,114,605,049**
2.	**CLAIM EXPENSES**					
	Paid Claims		23,465,182	160,903,515	715,408,543	**876,312,058**
	IBNR		1,846,555	9,779,162	17,568,000	**27,347,162**
	Less Specific Excess		-	(603,005)	(9,166,694)	**(9,769,699)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS		**25,311,737**	**170,079,673**	**723,809,848**	**893,889,521**
3.	**EXPENSES**					
	MA & HMO Premiums		9,809	66,576	373,956	**440,532**
	Excess Premiums		749,453	4,859,467	28,788,460	**33,647,927**
	Administrative		2,130,775	13,901,594	71,115,583	**85,017,177**
	TOTAL EXPENSES		**2,890,038**	**18,827,638**	**100,277,999**	**119,105,637**
4.	**UNDERWRITING PROFIT (1-2-3)**		1,716,047	5,673,911	95,935,980	**101,609,891**
5.	**INVESTMENT INCOME**		96,700	717,167	5,347,562	**6,064,729**
6.	**DIVIDEND INCOME**		0	0	5,555,319	**5,555,319**
7.	**STATUTORY PROFIT (4+5+6)**		**1,812,747**	**6,391,078**	**106,838,861**	**113,229,939**
8.	**DIVIDEND**		0	8,847,129	29,015,714	**37,862,843**
9.	**TRANSFERRED SURPLUS**				28,079,045	**28,079,045**
10	**STATUTORY SURPLUS (7-8)**		**1,812,747**	**(2,456,051)**	**105,902,193**	**103,446,142**
	SURPLUS (DEFICITS) BY FUND YEAR					
	Closed	**Surplus**	26,246	(2,456,727)	74,571,508	**72,114,781**
		Cash	(334,516)	(4,183,292)	89,930,595	**85,747,303**
	2019/2020	**Surplus**	(172,991)	(2,990,946)	31,330,684	**28,339,738**
		Cash	(172,991)	(7,242,642)	41,300,539	**34,057,897**
	2020/2021	**Surplus**	1,959,492	2,991,622		**2,991,622**
		Cash	(13,489,729)	6,561,372		**6,561,372**
	TOTAL SURPLUS (DEFICITS)		**1,812,747**	**(2,456,051)**	**105,902,192**	**103,446,141**
	TOTAL CASH		**(13,997,236)**	**(4,864,562)**	**131,231,133**	**126,366,571**
	CLAIM ANALYSIS BY FUND YEAR					
	TOTAL CLOSED YEAR CLAIMS		**33,737**	**699,559**	**502,985,244**	**503,684,802**
	FUND YEAR 2019/2020					
	Paid Claims		195,954	14,775,117	204,983,246	**219,758,364**
	IBNR		0	(17,568,000)	17,568,000	**0**
	Less Specific Excess		0	(610,669)	(1,726,642)	**(2,337,311)**
	Less Aggregate Excess		0	0	0	**0**
	TOTAL		**195,954**	**(3,403,552)**	**220,824,605**	**217,421,053**
	FUND YEAR 2020/2021					
	Paid Claims		23,235,491	145,544,979		**145,544,979**
	IBNR		1,846,555	27,347,162		**27,347,162**
	Less Specific Excess		0	(108,475)		**(108,475)**
	Less Aggregate Excess		0	0		**0**
	TOTAL		**25,082,046**	**172,783,666**	**0**	**172,783,666**
	COMBINED TOTAL CLAIMS		**25,311,737**	**170,079,673**	**723,809,848**	**893,889,521**

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.

Schools Health Insurance Fund
CONSOLIDATED BALANCE SHEET
AS OF JANUARY 31, 2021

BY FUND YEAR

	SHIF 2020/2021	SHIF 2019/2020	CLOSED YEAR	FUND BALANCE
ASSETS				
Cash & Cash Equivalents	6,561,372	34,057,897	85,747,303	126,366,571
Assesstments Receivable (Prepaid)	24,372,438	750,442	339,009	25,461,889
Interest Receivable	-	48	(48)	0
Specific Excess Receivable	108,475	972,129	-	1,080,604
Aggregate Excess Receivable	-	-	-	-
Dividend Receivable	-	-	1,935,535	1,935,535
Prepaid Admin Fees	4,853	-	-	4,853
Other Assets	2,357,511	120,564	-	2,478,075
Total Assets	33,404,649	35,901,079	88,021,799	157,327,528
LIABILITIES				
Accounts Payable	-	-	-	-
IBNR Reserve	27,347,162	0	-	27,347,162
A4 Retiree Surcharge	2,799,982	1,712,884	-	4,512,866
Dividends Payable	-	5,769,055	15,907,018	21,676,073
Accrued/Other Liabilities	265,883	79,403	-	345,286
Total Liabilities	30,413,027	7,561,342	15,907,018	53,881,387
EQUITY				
Surplus / (Deficit)	2,991,622	28,339,738	72,114,782	103,446,142
Total Equity	2,991,622	28,339,738	72,114,782	103,446,142
Total Liabilities & Equity	33,404,649	35,901,079	88,021,799	157,327,528
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.

SCHOOLS HEALTH INSURANCE FUND

RATIOS

	FY2019	2020-2021						
INDICES	**YEAR END**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**
Cash Position	$ 131,231,133	$ 128,376,474	$ 130,096,742	$ 133,171,102	$ 135,513,823	$ 140,298,665	$ 140,363,807	$ 126,366,571
IBNR	$ 17,568,000	$ 19,758,746	$ 20,688,660	$ 22,234,285	$ 23,488,418	$ 24,639,481	$ 25,500,607	$ 27,347,162
Assets	$ 144,357,224	$ 144,634,440	$ 145,606,889	$ 146,910,480	$ 152,501,183	$ 153,561,454	$ 153,442,662	$ 157,327,528
Liabilities	$ 38,455,031	$ 39,319,706	$ 39,319,479	$ 40,599,941	$ 51,024,388	$ 52,150,354	$ 51,809,268	$ 53,881,387
Surplus	$ 105,902,193	$ 105,314,734	$ 106,287,410	$ 106,310,539	$ 101,476,795	$ 101,411,100	$ 101,633,394	$ 103,446,142
Claims Paid -- Month	$ 14,349,346	$ 23,183,550	$ 22,593,496	$ 23,485,018	$ 20,009,280	$ 24,075,430	$ 24,091,558	$ 23,465,182
Claims Budget -- Month	$ 20,917,732	$ 24,604,605	$ 24,531,995	$ 24,749,094	$ 24,986,810	$ 24,951,340	$ 24,910,240	$ 27,025,512
Claims Paid -- YTD	$ 220,191,936	$ 23,183,550	$ 45,777,046	$ 69,262,065	$ 89,271,345	$ 113,346,775	$ 137,438,333	$ 160,903,515
Claims Budget -- YTD	$ 249,348,523	$ 24,604,605	$ 49,136,600	$ 73,885,694	$ 98,872,504	$ 123,823,844	$ 148,734,084	$ 175,759,596
RATIOS								
Cash Position to Claims Paid	9.15	5.54	5.76	5.67	6.77	5.83	5.83	5.39
Claims Paid to Claims Budget -- Month	0.69	0.94	0.92	0.95	0.8	0.96	0.97	0.87
Claims Paid to Claims Budget -- YTD	0.88	0.94	0.93	0.94	0.9	0.92	0.92	0.92
Cash Position to IBNR	7.47	6.5	6.29	5.99	5.77	5.69	5.5	4.62
Assets to Liabilities	3.75	3.68	3.70	3.62	2.99	2.94	2.96	2.92
Surplus as Months of Claims	5.06	4.28	4.33	4.3	4.06	4.06	4.08	3.83
IBNR to Claims Budget -- Month	0.84	0.8	0.84	0.9	0.94	0.99	1.02	1.01

Schools Health Insurance Fund
2020/2021 Budget Status Report
as of January 31, 2021

Expected Losses	YTD Budgeted	YTD Expensed	$ Variance	% Varaiance
Medical Claims	155,531,941	152,647,669	2,884,272	2%
Prescription Claims	18,000,423	18,036,314	(35,891)	0%
Dental Claims	2,227,232	2,099,683	127,549	6%
Subtotal Claims	175,759,596	172,783,666	2,975,930	2%
Rate Stabilization Reserve	0	0	0	0%
HMO Premiums	50,871	60,454	(9,583)	-19%
Reinsurance				
Specific	4,858,564	4,859,467	(903)	0%
Total Loss Fund	180,669,031	177,703,587	2,965,444	2%
Expenses				
Legal	21,504	21,504	-	0%
Treasurer	11,958	11,997	(39)	0%
Administrator	899,624	899,813	(189)	0%
Program Manager	2,415,325	2,415,789	(465)	0%
Local Entity Risk Management	2,524,772	2,524,961	(189)	0%
TPA - Med Aetna	3,395,960	3,422,500	(20,786)	-1%
Program Manager - Guardian Nurses	472,500	458,669	13,831	3%
TPA - Med AmeriHealth Admin	838,261	832,665	5,596	1%
TPA - Med Horizon	20,813	20,868	(55)	0%
TPA - Vision	5,754	Included above in Med Aetna		
TPA - Dental	100,754	101,272	(518)	-1%
Actuary	17,004	16,709	295	2%
Auditor	11,550	11,550	0	0%
Subtotal Expenses	10,735,779	10,738,297	(2,518)	0%
Misc/Contingenct Expenses	32,141	15,912	16,228	50%
Data Analysis System	37,917	51,762	(13,845)	-37%
Wellness Program	260,336	260,336	1	0%
Affordable Care Act Taxes	61,106	61,158	(52)	0%
A4 Retiree Surcharge	2,799,575	2,799,982	(407)	0%
Plan Documents	17,500	26,410	(8,910)	-51%
Enrollment Audits	0	0	-	0%
Total Expenses	13,944,354	13,953,857	(9,503)	0%
Total Budget	194,613,385	191,657,444	2,955,941	2%

SCHOOLS HEALTH INSURANCE FUND
2021/2022 BUDGET FOR ADOPTION

Based upon this draft budget, assessments will rise on July 1, 2021 by an average by 3.07%.

CLAIM FUNDS

Using the analysis provided John Vataha of Actuarial Solutions, the following changes in the claims budget are projected:

- Medical +5.07%
- Rx -6.37%
- Dental -.50%

In total, these changes, along with reinsurance and expense adjustments, result in the average assessment increase of 3.07%.

The medical increase is within industry trend ranges (~5% to ~9%). The projection involved discounting claims data for periods when the Covid-19 pandemic resulted in suppressed utilization of medical services (most obviously in the March to June, 2020 period).

The Rx change is significantly below industry trend (~10%) and is due to improvements in Express Scripts contract terms and growing formulary rebates. The budgeted amount assumes that formulary rebates will equal 24% of claims spend. This compares to an offset of 15% in the 2020/2021 budget.

Industry trend of dental is approximately 4%. Our claim rates are dropping by .5% due to positive results on new members.

RATE STABILIZATION RESERVE AND DIVIDEND CONSIDERATIONS

Up to 2.5% of assessments can be budgeted for rate stabilization. The SHIF considers this line item in tandem with the review of surplus retention and dividend policy. Given the SHIF's strong surplus, a rate stabilization reserve has not been included in this draft budget.

The Finance Committee and Trustees balance the needs of the membership and the Fund in determining how and when to distribute surplus. The Committee will review dividend capacity again after the June 30, 2021 audit is available. Following is a re-cap of recent dividend history and current capacity.

Schools Health Insurance Fund		
Surplus Objective		
Annual Claims Budget	$	336,142,670
Trended for Growth @ 20%	$	403,371,204
Surplus Target @ 2.5 Months of Claims	$	84,035,667
Surplus as of 11/30/2020 + 5% UW Income	$	121,579,660
Available for Dividend	$	37,543,993
Available as % of Claims		9%
1 Month of Assessments	$	27,410,898
Dividend Illstrated at 1/3rd of Available	$	12,514,664

History of Surplus and Dividends Since Formation	Surplus	Dividend	Dividend as % of Surplus
2016 -2017	$ 35,699,535	$ 661,580	1.85%
2017 - 2018	$ 44,952,292	$ 4,934,411	10.98%
2018 - 2019	$ 75,246,310	$ 6,222,844	8.27%
2019 - 2020	$ 105,902,193	$ 17,196,879	16.24%
2020 - 2021	$ 101,411,100	$ 8,847,129	8.72%

REINSURANCE

The Fund obtains reinsurance through the Reinsurance Health Insurance Fund. The SHIF currently takes responsibility for specific claims below $450,000, the Reinsurance HIF assumes claims from $450,001 to $875,000, and claims above $875,000 cede to the reinsurance market.

The budget is prepared with an increase in retention on specific claims by SHIF to $475,000 and a reduction in cost of 19.12%. Most of the decrease (18%) is due to positive overall results for SHIF and the Reinsurance HIF. The balance of the decrease is due to the $25,000 increase in retention.

SHIF has the capacity to assume more of its overall claims load, but the modest $25,000 increase in retention is due to unknowable, but potentially higher risks resulting from Covid-19 related utilization deferrals.

EXPENSES

- **Operating Expenses:** The category includes the cost of operating the Fund, items such as the administrator, attorney, treasurer, program manager, auditor, advertising and meeting costs, etc. Operating expenses represents 1.76% of the budget. Simultaneous to budget introduction, we will seek authorization to issue RFPs for professional and administrative services associated with this category.
    - **a.** Please note that the higher than normal increase for the treasurer position is due to the dramatic increase in membership and associated accounts receivable duties.
    - **b.** The higher than normal increase for data analysis is also due to growth in membership. This was discussed with Finance Committee who will be reviewing work product and value.

- **Claims Adjustment Expense:** This represents 2.19% of the overall budget. These contracts are negotiated between the claims agents and affiliated HIFs. Negotiations for the upcoming year are pending.

- **Local Brokerage or Risk Manager Fees:** The Fund implements broker fees that are determined by local units. A 2% increase is budgeted for purposes of budget development but other increases are implemented at the request of specific risk managers. If an entity determines that the fee should be higher or lower, PERMA will adjust rates accordingly.

- **Taxes:** The "Affordable Care Act" tax on the HIF is the Patient-Centered Outcomes Research Fee (the "Comparative Effectiveness Fee"). The New Jersey A4 Retiree Surcharge is budgeted at 1.8% of medical claims using the latest factor published by the Division of Taxation.

- **Wellness:** The wellness line item is included to fund grants to BOEs. The funding level is unchanged on a per-employee, per-month basis.

- **Guardian Nurses:** The Guardian Nurses line is now budgeted on a per-employee-per-month rate to allow flexibility to add an additional nurse as the Fund population grows. Additional nurse requests will be fully reviewed by the Operations Committee and Executive Committee.

ASSESSMENTS

Rate changes are applied by-member by line-of-coverage, with loss ratio adjustments of up to +- 2.5% per year for members with more than 2 years of claims experience. Assessments also vary depending upon participation in lines of coverage. Rate increases by line of coverage are:

- Medical (including vision) +5.56%
- Rx -5.5%
- Dental self-insured program flat, DMO programs +2.5%

One new member has a higher than normal increase due to deferral of assessments from the current fund year as part of their membership approval. Also, one member is applying dividends in order to reduce their prospective rates.

Respectfully Submitted, **PERMA**

Budget As Introduced

SCHOOLS HEALTH INSURANCE FUND
2021-2022 Proposed Budget

Census:	Monthly Census	Annual Census
Medical - Aetna	12,686	152,232
Medical - AmeriHealth Admin	3,098	37,176
Medical - Horizon	35	420
Rx	7,886	94,632
Dental	4,595	55,140
Vision	1,018	12,216
Rx No Medical (Incl in Rx above)	11	132
Dental Only (Incl in Dental above)	354	4,248
DMO Only	3	36

	LINE ITEMS	2020-2021 Annualized Budget	2021-2022 Proposed Budget	$ Change	% Change
1	**Claims**				
2	Medical Claims	$ 286,180,526	$ 300,696,260	$ 14,515,734	5.07%
3	Prescription Claims	$ 33,834,912	$ 31,678,271	$ (2,156,641)	-6.37%
4	Dental Claims	$ 3,787,074	$ 3,768,139	$ (18,935)	-0.50%
5	**Subtotal**	**$ 323,802,512**	**$ 336,142,670**	**$ 12,340,158**	**3.81%**
6					
7	**Rate Stabilization Reserve**	**$ -**	**$ -**	**$ -**	**0.00%**
8					
9	**DMO Premiums**	**$ 84,604**	**$ 86,541**	**$ 1,938**	**2.29%**
10					
11	**Reinsurance**				
12	**Specific**	**$ 9,022,525**	**$ 7,296,988**	**$ (1,725,537)**	**-19.12%**
13					
14	**Total Loss Fund**	**$ 332,909,641**	**$ 343,526,200**	**$ 10,616,559**	**3.19%**
15					
16	**Professional and Administrative Expenses**				
17	Legal	$ 36,864	$ 37,601	$ 737	2.00%
18	Treasurer	$ 20,500	$ 25,910	$ 5,410	26.39%
19	Administrator	$ 1,667,645	$ 1,684,321	$ 16,676	1.00%
20	Program Manager	$ 4,474,841	$ 4,519,589	$ 44,748	1.00%
21	Local Entity Risk Management	$ 4,618,776	$ 4,744,134	$ 125,358	2.71%
22	Program Manager - Guardian Nurses	$ 810,000	$ 810,000	$ (0)	0.00%
23	TPA - Med Aetna	$ 6,492,695	$ 6,492,695	$ -	0.00%
24	TPA - Med AmeriHealth Admin	$ 1,421,982	$ 1,421,982	$ -	0.00%
25	TPA - Med Horizon	$ 23,100	$ 23,100	$ -	0.00%
26	TPA - Dental	$ 172,037	$ 172,037	$ -	0.00%
27	TPA - Vision	$ 11,117	$ 11,117	$ -	0.00%
28	Actuary	$ 29,150	$ 29,733	$ 583	2.00%
29	Auditor	$ 19,800	$ 20,196	$ 396	2.00%
30	**Subtotal**	**$ 19,798,507**	**$ 19,992,415**	**$ 193,909**	**0.98%**
31					
32	**Misc/Contingenct Expenses**	$ 55,098	$ 46,157	$ (8,941)	-16.23%
33	Data Analysis System	$ 65,000	$ 119,829	$ 54,829	84.35%
34	Wellness Program	$ 483,454	$ 483,454	$ -	0.00%
35	Affordable Care Act Taxes	$ 113,645	$ 119,327	$ 5,682	5.00%
36	A4 Retiree Surcharge	$ 5,151,249	$ 5,412,533	$ 261,283	5.07%
37	Plan Documents	$ 30,000	$ 30,000	$ -	0.00%
38					
39	**Subtotal**	**$ 5,898,446**	**$ 6,211,299**	**$ 312,853**	**5.30%**
40					
41	**Total Expenses**	**$ 25,696,953**	**$ 26,203,714**	**$ 506,761**	**1.97%**
42					
43	**Total Budget**	**$ 358,606,594**	**$ 369,729,914**	**$ 11,123,320**	**3.10%**
44	**Dividend Applied to rates**		**$ 271,514**		
45	**Total Billing**	**$ 358,440,168**	**$ 369,458,400**	**$ 11,018,232**	**3.07%**

Budget for Adoption

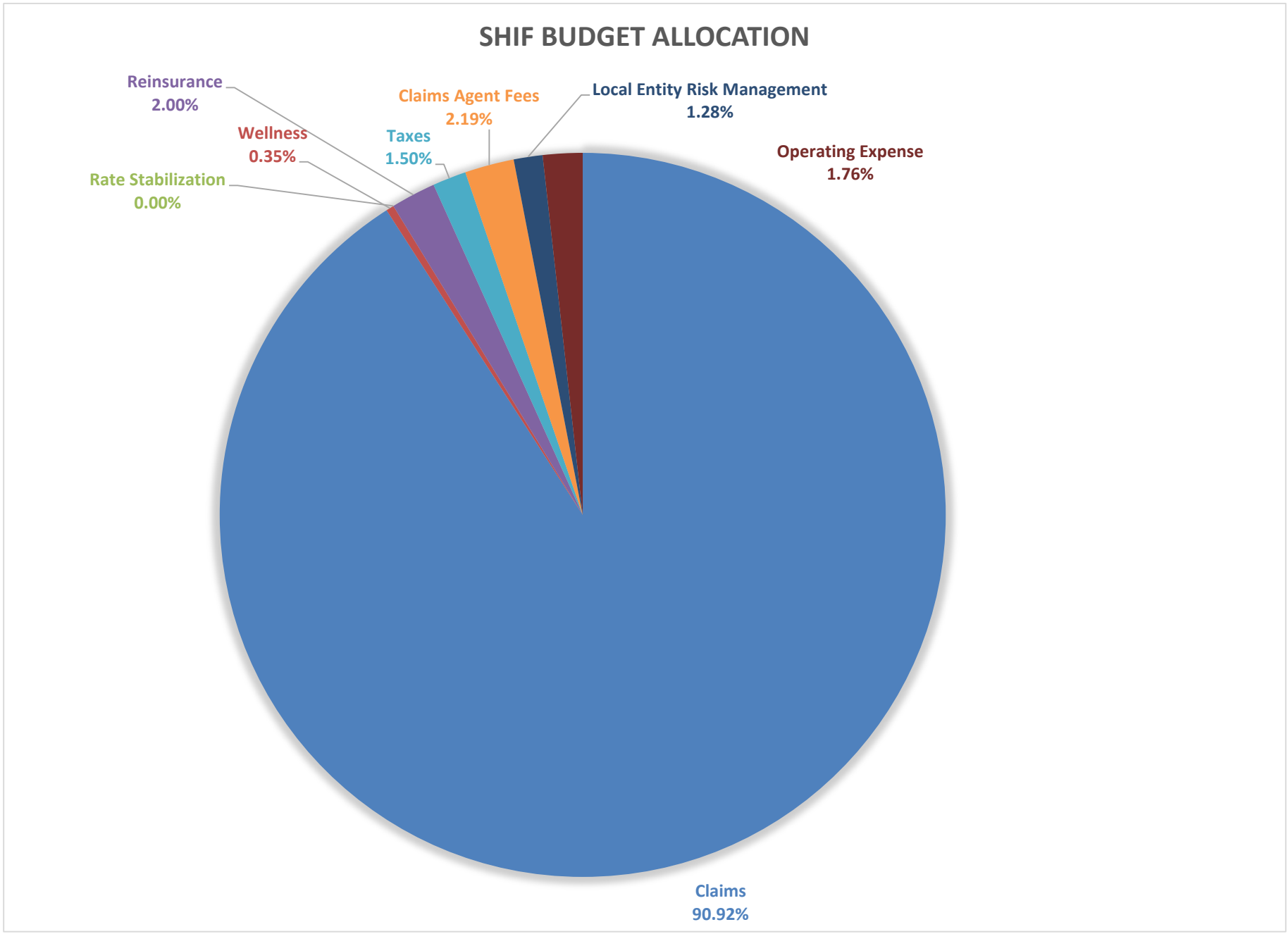
SCHOOLS HEALTH INSURANCE FUND
2021-2022 Proposed Budget

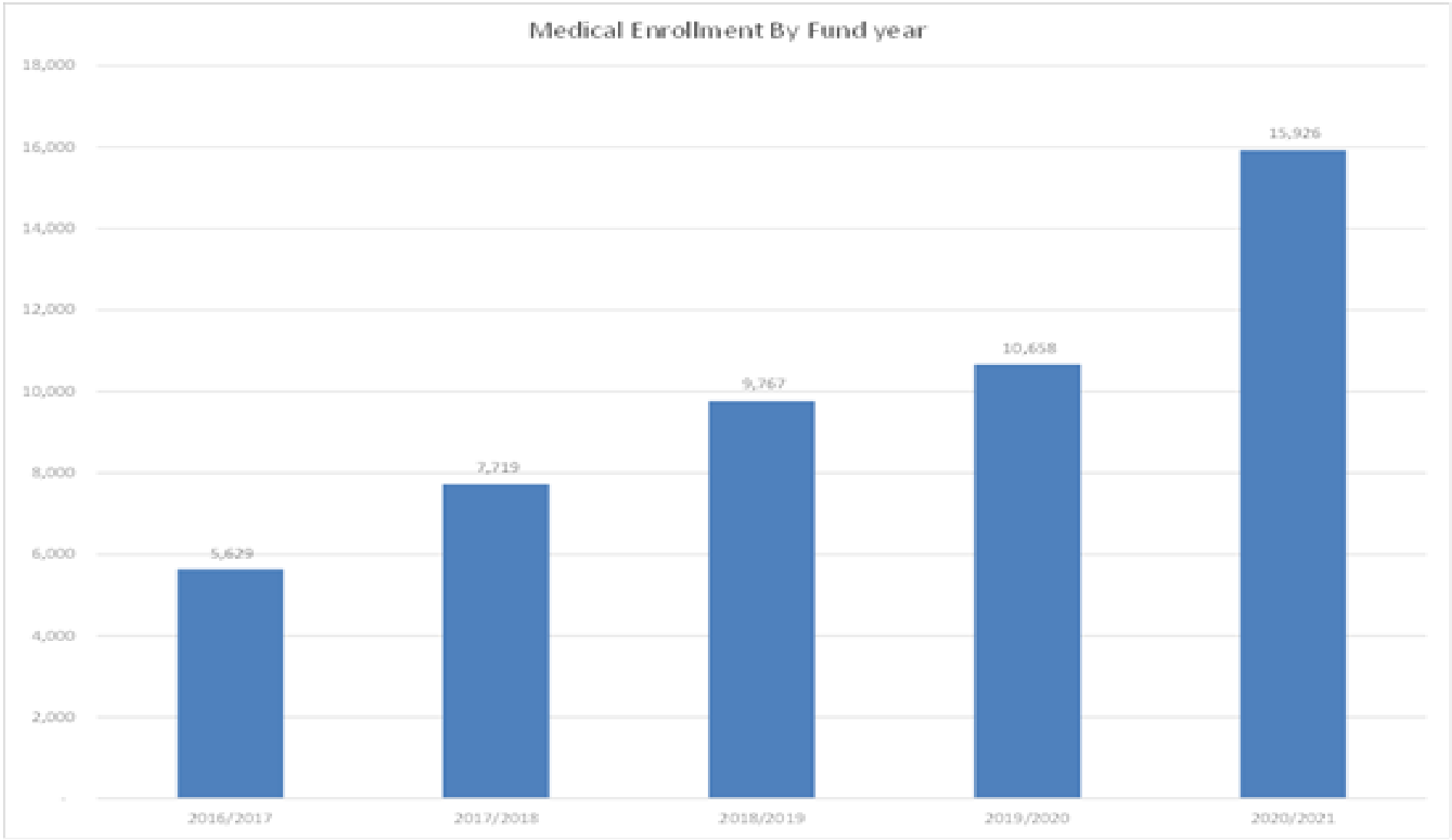
Census:	Monthly Census	Annual Census
Medical - Aetna	12,796	153,552
Medical - AmeriHealth Admin	3,096	37,152
Medical - Horizon	34	408
Rx	7,996	95,952
Dental	4,579	54,948
Vision	988	11,856
Rx No Medical (Incl in Rx above)	9	108
Dental Only (Incl in Dental above)	350	4,200
DMO Only	3	36

	LINE ITEMS	2020-2021 Annualized Budget	2021-2022 Proposed Budget	$ Change	% Change
1	**Claims**				
2	Medical Claims	$ 288,216,025	$ 302,890,600	$ 14,674,575	5.09%
3	Prescription Claims	$ 34,455,216	$ 32,237,754	$ (2,217,462)	-6.44%
4	Dental Claims	$ 3,769,880	$ 3,751,031	$ (18,849)	-0.50%
5	**Subtotal**	**$ 326,441,121**	**$ 338,879,385**	**$ 12,438,264**	**3.81%**
6					
7	**Rate Stabilization Reserve**	$ -	$ -	$ -	**0.00%**
8					
9	**DMO Premiums**	**$ 84,669**	**$ 86,618**	**$ 1,950**	**2.30%**
10					
11	**Reinsurance**				
12	**Specific**	**$ 9,083,553**	**$ 7,346,345**	**$ (1,737,208)**	**-19.12%**
13					
14	**Total Loss Fund**	**$ 335,609,343**	**$ 346,312,348**	**$ 10,703,006**	**3.19%**
15					
16	**Professional and Administrative Expenses**				
17	Legal	$ 36,864	$ 37,601	$ 737	2.00%
18	Treasurer	$ 20,500	$ 25,910	$ 5,410	26.39%
19	Administrator	$ 1,678,052	$ 1,694,833	$ 16,781	1.00%
20	Program Manager	$ 4,507,634	$ 4,552,710	$ 45,076	1.00%
21	Local Entity Risk Management	$ 4,616,903	$ 4,742,157	$ 125,254	2.71%
22	Program Manager - Guardian Nurses	$ 810,000	$ 814,137	$ 4,137	0.51%
23	TPA - Med Aetna	$ 6,548,993	$ 6,548,993	$ -	0.00%
24	TPA - Med AmeriHealth Admin	$ 1,421,064	$ 1,439,640	$ 18,576	1.31%
25	TPA - Med Horizon	$ 22,440	$ 22,440	$ -	0.00%
26	TPA - Dental	$ 171,438	$ 171,438	$ -	0.00%
27	TPA - Vision	$ 10,789	$ 10,789	$ -	0.00%
28	Actuary	$ 29,150	$ 29,733	$ 583	2.00%
29	Auditor	$ 19,800	$ 20,196	$ 396	2.00%
30	**Subtotal**	**$ 19,893,627**	**$ 20,110,577**	**$ 216,950**	**1.09%**
31					
32	**Misc/Contingenct Expenses**	$ 55,098	$ 45,881	$ (9,217)	-16.73%
33	Data Analysis System	$ 65,000	$ 120,369	$ 55,369	85.18%
34	Wellness Program	$ 486,724	$ 486,724	$ -	0.00%
35	Affordable Care Act Taxes	$ 114,422	$ 120,144	$ 5,721	5.00%
36	A4 Retiree Surcharge	$ 5,187,888	$ 5,452,031	$ 264,142	5.09%
37	Plan Documents	$ 30,000	$ 30,000	$ -	0.00%
38					
39	**Subtotal**	**$ 5,939,133**	**$ 6,255,149**	**$ 316,016**	**5.32%**
40					
41	**Total Expenses**	**$ 25,832,760**	**$ 26,365,726**	**$ 532,966**	**2.06%**
42					
43	**Total Budget**	**$ 361,442,102**	**$ 372,678,074**	**$ 11,235,972**	**3.11%**
44	**Dividend Applied to rates**		**$ 271,514**		
45	**Total Billing**	**$ 361,313,796**	**$ 372,406,560**	**$ 11,092,764**	**3.07%**

NOTE ON BASIS OF BUDGET YEAR OVER YEAR COMPARISON

The budget uses the January 2021 census to illustrate both the current and prospective year budget. This allows for a normalized comparison of rates for both expenses and assessments. The proposed budget is based upon 15,819 medical contracts. By contrast, the 2020/2021 budget was based on 12,709 medical contracts.


SHIF BUDGET ALLOCATION
Reinsurance
2.00%
Wellness
0.35%
Rate Stabilization
0.00%
Taxes
1.50%
Claims Agent Fees
2.19%
Local Entity Risk Management
1.28%
Operating Expense
1.76%
Claims
90.92%


Medical Enrollment By Fund year
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
-
5,629
7,719
9,767
10,658
15,926
2016/2017
2017/2018
2018/2019
2019/2020
2020/2021

Group Name	2020/2021 Assessments Total	2021/2022 Assessments Net of Dividend Total	Change $ Total	Change % Total
Alexandria Township BOE	$ 1,618,692	$ 1,644,648	$ 25,956	1.60%
Bellmawr Public School District	$ 2,810,100	$ 2,974,440	$ 164,340	5.85%
Berlin Borough BOE	$ 1,822,860	$ 1,783,044	$ (39,816)	-2.18%
Bethlehem Township School District	$ 1,580,124	$ 1,598,892	$ 18,768	1.19%
Black Horse Pike Regional BOE	$ 9,879,372	$ 9,998,616	$ 119,244	1.21%
Blairstown BOE	$ 970,008	$ 973,932	$ 3,924	0.40%
Burlington City BOE	$ 4,342,140	$ 4,644,168	$ 302,028	6.96%
Burlington Township BOE	$ 6,803,940	$ 6,994,200	$ 190,260	2.80%
Byram Township BOE	$ 2,005,608	$ 2,033,832	$ 28,224	1.41%
Califon BOE	$ 459,312	$ 464,760	$ 5,448	1.19%
Chathams School District	$ 10,816,956	$ 10,950,734	$ 133,778	1.24%
Chesterfield BOE	$ 1,927,800	$ 1,984,176	$ 56,376	2.92%
Cinnaminson Township BOE	$ 6,586,992	$ 6,637,680	$ 50,688	0.77%
Clayton BOE	$ 2,735,520	$ 2,815,596	$ 80,076	2.93%
Collingswood BOE	$ 5,193,732	$ 5,345,052	$ 151,320	2.91%
Colts Neck Township BOE	$ 4,208,640	$ 4,208,640	$ -	0.00%
Delran Township Public Schools	$ 6,217,728	$ 6,399,456	$ 181,728	2.92%
Delsea Regional BOE	$ 5,527,080	$ 5,594,208	$ 67,128	1.21%
Deptford Township BOE	$ 11,141,088	$ 11,293,116	$ 152,028	1.36%
East Greenwich BOE	$ 2,482,644	$ 2,678,760	$ 196,116	7.90%
Eatontown BOE	$ 3,225,108	$ 3,411,324	$ 186,216	5.77%
Evesham Twp BOE	$ 11,878,980	$ 12,456,084	$ 577,104	4.86%
Ewing Township BOE	$ 9,127,176	$ 9,875,316	$ 748,140	8.20%
Florence Township BOE	$ 2,754,828	$ 2,835,216	$ 80,388	2.92%
Foundation Academy Charter School	$ 1,982,268	$ 2,053,344	$ 71,076	3.59%
Frankford Township BOE	$ 1,415,808	$ 1,435,740	$ 19,932	1.41%
Franklin Township Public Schools (GC)	$ 5,130,288	$ 5,188,632	$ 58,344	1.14%
Franklin Township School District	$ 781,116	$ 831,252	$ 50,136	6.42%
Fredon Township BOE	$ 551,520	$ 567,648	$ 16,128	2.92%
Frelinghuysen Township BOE	$ 296,772	$ 299,196	$ 2,424	0.82%
Gateway Regional BOE	$ 2,658,852	$ 2,855,280	$ 196,428	7.39%
Glassboro BOE	$ 6,873,936	$ 7,151,004	$ 277,068	4.03%
Glen Ridge Public Schools	$ 5,097,684	$ 5,315,556	$ 217,872	4.27%
Gloucester City BOE	$ 6,760,872	$ 7,071,924	$ 311,052	4.60%
Gloucester County Special Services School District	$ 10,748,808	$ 11,096,940	$ 348,132	3.24%
Gloucester County Vocational School District	$ 3,825,240	$ 3,921,528	$ 96,288	2.52%
Greenwich Township BOE	$ 1,668,744	$ 1,717,632	$ 48,888	2.93%
Hardyston Township BOE	$ 1,686,756	$ 1,711,092	$ 24,336	1.44%
Harrison Township BOE	$ 2,187,384	$ 2,271,324	$ 83,940	3.84%
High Point Regional BOE	$ 2,377,968	$ 2,447,256	$ 69,288	2.91%
Hope Township School District	$ 433,020	$ 444,360	$ 11,340	2.62%
Hunterdon Central Regional HS BOE	$ 11,922,108	$ 12,296,124	$ 374,016	3.14%
Jamesburg BOE	$ 1,621,212	$ 1,613,880	$ (7,332)	-0.45%
Kingsway Regional School District	$ 5,645,796	$ 5,685,240	$ 39,444	0.70%
Leap Academy University Charter School	$ 2,540,916	$ 2,565,084	$ 24,168	0.95%
Lebanon Township BOE	$ 2,183,268	$ 2,245,548	$ 62,280	2.85%
Lenape Regional High School	$ 16,879,248	$ 18,091,224	$ 1,211,976	7.18%
Lenape Valley Regional BOE	$ 2,412,384	$ 2,428,488	$ 16,104	0.67%
Logan Township BOE	$ 2,105,400	$ 2,129,472	$ 24,072	1.14%
Lower Alloways Creek BOE	$ 390,972	$ 395,112	$ 4,140	1.06%
Lumberton Township BOE	$ 2,658,408	$ 2,805,888	$ 147,480	5.55%
Mansfield Township BOE	$ 1,459,356	$ 1,540,320	$ 80,964	5.55%
Mantua Township BOE	$ 3,399,036	$ 3,498,456	$ 99,420	2.92%
Maple Shade Township BOE	$ 5,107,836	$ 5,391,600	$ 283,764	5.56%
Medford Lakes BOE	$ 1,205,364	$ 1,220,244	$ 14,880	1.23%
Medford Township BOE	$ 5,866,368	$ 6,038,280	$ 171,912	2.93%
Mendham Borough School District	$ 1,593,540	$ 1,611,960	$ 18,420	1.16%
Mendham Township School District	$ 2,675,328	$ 2,752,260	$ 76,932	2.88%
Moorestown Twp Public Schools	$ 14,463,480	$ 14,715,924	$ 252,444	1.75%
Mount Laurel Township Schools	$ 11,313,048	$ 11,381,412	$ 68,364	0.60%
MT. Holly Township BOE	$ 2,456,028	$ 2,527,800	$ 71,772	2.92%

Group Name	2020/2021 Assessments Total	2021/2022 Assessments Net of Dividend Total	Change $ Total	Change % Total
Newton BOE	$ 4,134,276	$ 4,364,760	$ 230,484	5.57%
North Hunterdon-Voorhees BOE	$ 6,094,632	$ 6,433,272	$ 338,640	5.56%
Northern Burlington County Regional School District	$ 5,642,700	$ 5,941,140	$ 298,440	5.29%
Ogdensburg Borough School District	$ 842,172	$ 846,600	$ 4,428	0.53%
Oxford Central Sch	$ 852,828	$ 852,828	$ -	0.00%
Paulsboro Public Schools	$ 3,032,388	$ 3,201,228	$ 168,840	5.57%
Pinelands Regional School District	$ 5,694,960	$ 5,785,392	$ 90,432	1.59%
Pohatcong Township BOE	$ 810,744	$ 834,396	$ 23,652	2.92%
Rancocas Valley Regional BOE	$ 3,504,852	$ 3,695,496	$ 190,644	5.44%
Riverside Township BOE	$ 3,157,836	$ 3,250,476	$ 92,640	2.93%
Robbinsville BOE	$ 4,981,080	$ 4,981,080	$ -	0.00%
Sandyston-Walpack Consolidated School District	$ 416,820	$ 421,260	$ 4,440	1.07%
South Harrison BOE	$ 697,308	$ 702,528	$ 5,220	0.75%
Southampton Township BOE	$ 1,854,732	$ 1,881,096	$ 26,364	1.42%
Sparta BOE	$ 7,803,588	$ 8,237,292	$ 433,704	5.56%
Springfield Township BOE	$ 577,224	$ 594,108	$ 16,884	2.93%
Stillwater Township BOE	$ 1,194,312	$ 1,207,980	$ 13,668	1.14%
Swedesboro-Woolwich BOE	$ 3,613,440	$ 3,719,112	$ 105,672	2.92%
Tabernacle BOE	$ 1,768,884	$ 1,914,084	$ 145,200	8.21%
Upper Pittsgrove BOE	$ 580,680	$ 597,396	$ 16,716	2.88%
Voorhees Township BOE	$ 8,040,024	$ 8,228,244	$ 188,220	2.34%
Washington Borough BOE	$ 1,240,188	$ 1,276,356	$ 36,168	2.92%
Watchung Hills Regional High School	$ 5,465,808	$ 5,519,172	$ 53,364	0.98%
West Deptford BOE	$ 7,425,804	$ 7,518,216	$ 92,412	1.24%
West Morris Regional High School	$ 5,628,156	$ 5,703,132	$ 74,976	1.33%
White Township BOE	$ 892,104	$ 918,108	$ 26,004	2.91%
Woodbury City BOE	$ 3,174,720	$ 3,351,960	$ 177,240	5.58%
Woodbury Heights BOE	$ 543,864	$ 550,560	$ 6,696	1.23%
Woodland Township BOE	$ 424,104	$ 429,924	$ 5,820	1.37%
Woodstown-Pilesgrove BOE	$ 2,731,008	$ 2,810,964	$ 79,956	2.93%
Totals	**$ 361,313,796**	**$ 372,678,074**	**$ 11,364,278**	**3.15%**

RESOLUTION 4-21

SCHOOLS HEALTH INSURANCE FUND
ADOPTION OF THE 2021-2022 BUDGET

WHEREAS, The Schools Health Insurance Fund is required under State regulation to adopt an annual budget in accordance with the bylaws of the Fund; and

WHEREAS, the Board of Trustees met on February 24, 2021 in Public Session to introduce the proposed budget for 2021-2022 Fund Year; and

WHEREAS, the Board of Trustees met on March 24, 2021 in Public Session to adopt the proposed budget for 2021-2022 Fund Year; and

WHEREAS, a public hearing to adopt the 2021-2022 budget was held on March 24, 2021 at 12:00 pm.

NOW THEREFORE BE IT RESOLVED that the Board of Trustees of the Schools Health Insurance Fund hereby adopt the 2021-2022 budget in the amount of $372,678,074

BE IT FURTHER RESOLVED that copies of this resolution shall be sent to each Trustee, Risk Manager, and Governing Body, the New Jersey Department of Banking and Insurance, and the New Jersey Department of Community Affairs.

ADOPTED: MARCH 24, 2021

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

RESOLUTION NO. 5-21

SCHOOLS HEALTH INSURANCE FUND
RESOLUTION TO OFFER MEMBERSHIP

WHEREAS, a number of local boards of education in the state of New Jersey have joined together to form a School Board Joint Insurance Fund, under the name of the Schools Health Insurance Fund (the "Fund"), as permitted by law; and

WHEREAS, the Fund held a Public Meeting on **March 24, 2021** for the purposes of conducting the official business of the Fund; and

WHEREAS, the Executive Director and Actuary of the Fund has reviewed the risk, underwriting detail, and actuarial projections for the entities listed below and recommend offers of membership; and

WHEREAS, the Risk Management Plan includes a cap of new membership at 20% of the prior year's membership in one Fund Year;

W**HEREAS,** the Operations Committee deemed it appropriate to extend the Fund Year 2020-2021 cap to 35% of the membership on September 8, 2020.

WHEREAS, the Operations Committee has reviewed the following new member submissions and has approved membership to the School Boards that submit a fully executed Indemnity and Trust agreement to join the Fund.

Shamong BOE	83	Y	Y	Y	Y	5/1/2021
Ramapo Indian Hills BOE	259	Y	Y	Y	Y	5/1/2021

BE IT RESOLVED, it has been determined that the admission to membership in the Fund of the above mentioned school boards would be in the best interests of the Fund and the inclusion of the entity in the Fund is consistent with the Fund's By-laws;

BE IT RESOLVED, that the Schools Health Insurance Fund hereby offers membership to the above mentioned entity's for medical, prescription, and/or dental coverage, contingent upon receipt of the Fund's authorizing resolution to join the Fund and its executed Indemnity and Trust agreement.

ADOPTED: MARCH 24, 2021

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

REGULATORY
SCHOOLS HEALTH INSURANCE FUND
YEAR: 2020/2021 AS OF MARCH 16, 2021

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	**List of Compliance included on Page**
New Members	**Filed**
Withdrawals	**N/A**
Risk Management Plan and By Laws	**Filed**
Cash Management Plan	**Filed**
Unaudited Financials	**Q2 filed**
Annual Audit	**June 30, 2020 - 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	**List of Compliance included below**
Benefit Changes	**N/A**

Professional	Contract Received	Insurance Received	Contract Term
Executive Director	Yes	Yes	1/1/2019 - 6/30/2021
Program Manager	Yes	Yes	1/1/2019 - 6/30/2021
Actuary	Yes	Yes	1/1/2019 - 6/30/2021
Attorney	Yes	Yes	1/1/2019 - 6/30/2021
Auditor	Yes	Yes	1/1/2019 - 6/30/2021
Treasurer	Yes	Yes	1/1/2019 - 6/30/2021
Aetna	Yes	in progress	*ONE YEAR RENEWALS NEGOTIATED
AmeriHealth	In Progress	in progress	*ONE YEAR RENEWALS NEGOTIATED
Horizon	Yes	in progress	*ONE YEAR RENEWALS NEGOTIATED
Delta Dental	Yes	Yes	*ONE YEAR RENEWALS NEGOTIATED

INDEMNITY AND TRUST AGREEMENT COMPLIANCE LISTING

MEMBER	I&T END DATE
Tabernacle BOE	6/30/2020
Delsea Regional BOE	12/31/2020
Blairstown BOE	12/31/2020
Clayton BOE	12/31/2020
Jamesburg BOE	12/31/2020
Pohatcong Township BOE	12/31/2020
Washington Borough BOE	12/31/2020
Bellmawr Public School District	6/20/2021
Franklin Township Public Schools (GC)	6/30/2021
Alexandria Township BOE	6/30/2021
Bethlehem Township School District	6/30/2021
Black Horse Pike Regional BOE	6/30/2021
Burlington Township BOE	6/30/2021
Byram Township BOE	6/30/2021
Cinnaminson Township BOE	6/30/2021
Collingswood BOE	6/30/2021
Florence Township BOE	6/30/2021
Frankford Township BOE	6/30/2021
Fredon Township BOE	6/30/2021
Frelinghuysen Township BOE	6/30/2021
Greenwich Township BOE	6/30/2021
Hardyston Township BOE	6/30/2021
Harrison Township BOE	6/30/2021
High Point Regional BOE	6/30/2021
Lebanon Township BOE	6/30/2021
Logan Township BOE	6/30/2021
Mantua Township BOE	6/30/2021
Medford Lakes BOE	6/30/2021
Moorestown Twp Public Schools	6/30/2021
MT. Holly Township BOE	6/30/2021
Ogdensburg School District	6/30/2021
Rancocas Valley Regional BOE	6/30/2021
Riverside Township BOE	6/30/2021
South Harrison BOE	6/30/2021
Southampton Township BOE	6/30/2021
Springfield Township BOE	6/30/2021
Swedesboro-Woolwich BOE	6/30/2021
West Deptford BOE	6/30/2021
White Township BOE	6/30/2021
Woodbury Heights BOE	6/30/2021
Pinelands Regional School District	9/30/2021
Sandyston-Walpack Consolidated School District	12/31/2021
West Morris BOE	12/31/2021

Kingsway Regional School District	6/30/2022
East Greenwich BOE	6/30/2022
Deptford Township BOE	6/30/2022
Hope Township School District	6/30/2022
Mansfield Township BOE	6/30/2022
Northern Burlington County Regional School District	6/30/2022
Paulsboro Public Schools	6/30/2022
Sparta BOE	6/30/2022
Colts Neck BOE	6/30/2022
Oxford BOE	6/30/2022
Eastern Camden County BOE	6/30/2022
Robbinsville BOE	7/1/2022
Lumberton BOE	12/31/2022
Ewing Township BOE	6/30/2023
Glassboro BOE	6/30/2023
Foundations Academy	6/30/2023
Burlington City BOE	6/30/2023
Glen Ridge Public Schools	6/30/2023
Berlin Borough BOE	6/30/2023
Leap Academy University Charter School	6/30/2023
Woodland Township BOE	6/30/2023
Chathams School District	6/30/2023
Woodbury City BOE	6/30/2023
Califon BOE	6/30/2023
Franklin Township School District	6/30/2023
Gateway Regional BOE	6/30/2023
Mount Laurel Township Schools	6/30/2023
Maple Shade BOE	6/30/2023
Lenape BOE	6/30/2023
Lenape Valley Regional BOE	6/30/2023
Lower Alloways Creek BOE	6/30/2023
Stillwater Township BOE	6/30/2023
Mendham Borough School District	6/30/2023
Upper Pittsgrove BOE	6/30/2023
Eatontown BOE	6/30/2023
Evesham Twp BOE	6/30/2023
Medford Township BOE	6/30/2023
Woodstown-Pilesgrove BOE	6/30/2023
Gloucester SSSD	6/30/2023
Gloucester County Vo Tech	6/30/2023
Newton BOE	6/30/2023
North Hunterdon -Voorhees BOE	9/30/2023
Gloucester City School District	9/30/2023
Voorhees Township BOE	12/31/2023
Watchung Hills Regional High School	12/31/2023
Hunterdon Central Regional High School	12/31/2023
Mendham Township School District	1/31/2024
Shamong Township BOE	4/30/2024
Ramapo Indian Hills BOE	joining 5/1

School's Health Insurance Fund
Program Manager's Report
March 2021
Program Manager: Conner Strong & Buckelew
Online Enrollment Training: shif_enrollments@permainc.com
Enrollments/Eligibility/Billing: shif_enrollments@permainc.com
Brokers: brokerservice@permainc.com

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 SHIF 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 period. 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 SHIF Client Servicing Team. The team can be reached by email at brokerservice@permainc.com.

CONNER STRONG COVID-19 RESOURCES
Conner Strong & Buckelew has compiled a database of COVID-19 resources available to our clients. To access the resource center please use the link below.

- Link-https://www.connerstrong.com/insights/covid-19-resource-center/

Online Enrollment System Training Schedule – 2021

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 to 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, 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

7/1 OPERATIONAL UPDATE

ANNUAL OPEN ENROLLMENT

The 7/1 annual Open Enrollment period is approaching. As in the past, this will be a passive Open Enrollment.

- only members who want to make a change need to complete an enrollment form
- unless a member elects a change, current elections will automatically rollover on July 1
- OE will **begin 4/26/21 and close on 5/14/21**
- deadline for entities to enter OE changes in Benefit Express is **5/21/21**
- All OE Communications will be distributed electronically to group enrollment contacts prior to the OE start date.

Please note that only members electing a change will receive new ID cards.

A sample copy of the Open Enrollment Guide will be distributed to all broker partners by end of week. If you do not wish your group to receive this communications, please let our office know.

JULY 1 PLAN CHANGES

Please note the cut off for plan additions and/or edits to existing plans is **Friday May 14**

GARDEN STATE EDUCATOR'S PLAN UPDATE

A status update will be provided during the SHIF meeting.

COVID-19 UPDATES

COVID 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 SHIF 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

The SHIF prepared a "COVID-19 Vaccine Flyer" which was distributed via email last week. A copy is also included in this agenda. Please distribute to your membership as you see fit.

AETNA UPDATES

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 April 30, 2021. The facility will be out-of-network for SHIF 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, 42 SHIF 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 Federal Government recently passed a sweeping COVID relief package, which includes a provision regarding subsides for COBRA premiums. 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.

Appeals:

Appeal Type	Decision
Medical	Benefit Application

Schools Health Insurance Fund
Board Meeting Summary
March 24, 2021

Total Referrals		1/1/21 through 3/2/21	1/1/20 through 3/2/20
Total Members Referred		516	455
Total Members Referred (ACUTE)		440	405
Total Members Referred (COMPLEX)		76	50
Hospitalizations			
Total Members Hospitalized - (141 members)		147	116
Members Requiring ICU Level Care		9	9
COVID-19 (Inpatients 2/9/2021- 3/2/2021)		7 (No ICU admits)	-----
Mobilizations---Acute		39	99
Inpatient Visits		13	63
Accompaniments		8	33
Home Visits		18	3
Mobilizations---Complex Program		24	13
Inpatient Visits		2	2
Accompaniments		19	9
Home Visits		3	2
Potential High Claimants for 2/9/2021- 3/2/2021		Diagnosis	Status
Patient #1 ICU Admission x 2 days		Cardiac	Declined home visit
Patient #2 ICU Admission x 7 days		Cardiac Arrest	Received home visit
Patient #3 ICU Admission x 4 days		Cardiac	Declined home visit
Patient #4 ICU Admission x 3 days		Allergic reaction	Well known to GN
High Claimant Report --Paid through 12/31/2020		Status	Insurer
High Claimant	Amount		
HC #1 NICU Baby	$515,306.36	Engaged: SHIF Care/Medicaid	AHA
HC #2 will fall off	$443,168.78	Engaged: July 2020 Transplant	Aetna
HC #3 will fall off	$383,849.59	Completed case	Aetna
HC #4 Oncology	$362,807.26	Engaged: continue treatment	AHA
HC #5 Oncology	$316,571.57	In Outreach	Aetna
HC #6 will fall off	$304,556.41	Engaged: remission	Aetna
HC #7 Oncology	$298,465.95	Engaged: 9/2020 started tx	Aetna
HC #8 NICU Baby	$296,804.62	In Outreach	Aetna
HC #9 Stable	$294,321.37	Declined Assistance	Aetna
HC #10 Transplant	$291,058.38	Engaged: needs transplant	AHA

Lighting Your Way Through the Healthcare Maze

GuardianNurses.com

SCHOOL HEALTH INSURANCE FUND
DIVIDEND BILLS LIST

Confirmation of Payment **MARCH 2021**

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

BE IT RESOLVED that the School Health Insurance 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 19-20

CheckNumber	Vendor Name	Comment	InvoiceAmount
002837			
002837	CINNAMINSON TOWNSHIP BOE	DIVIDEND 2020	254,487.00
			254,487.00
		Total Payments FY Closed	**254,487.00**
		TOTAL PAYMENTS ALL FUND YEARS	**$254,487.00**

_____
Chairperson

Attest:
_____ Dated: _____

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

_____
Treasurer

SCHOOL HEALTH INSURANCE FUND
BILLS LIST

Resolution No. 6-21 **MARCH 2021**

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

BE IT RESOLVED that the School Health Insurance 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 19-20

CheckNumber	Vendor Name	Comment	InvoiceAmount
002838			
002838	CINNAMINSON TOWNSHIP BOE	REIMBURSEMENT 19-20	4,059.24
			4,059.24
		Total Payments FY 2019-2020	**4,059.24**

FUND YEAR 20-21

CheckNumber	Vendor Name	Comment	InvoiceAmount
002839			
002839	DELTA DENTAL INSURANCE COMPANY	INV BE004325727 3/21	861.25
002839	DELTA DENTAL INSURANCE COMPANY	INV BE004325682 3/21	252.64
			1,113.89
002840			
002840	FLAGSHIP HEALTH SYSTEMS INC	DEPTFORD 3/21	1,977.22
002840	FLAGSHIP HEALTH SYSTEMS INC	LEAP 3/21	1,634.61
002840	FLAGSHIP HEALTH SYSTEMS INC	CINNAMINSON 3/21	-745.08
002840	FLAGSHIP HEALTH SYSTEMS INC	CINNAMINSON COMPLETE 3/21	-657.05
			2,209.70
002841			
002841	DELTA DENTAL OF NEW JERSEY INC	DENTAL TPA 3/21	14,270.88
			14,270.88
002842			
002842	HORIZON BCBSNJ	MEDICAL 3/21	1,877.50
			1,877.50
002843			
002843	AETNA LIFE INSURANCE COMPANY	VISION 3/21	983.71
002843	AETNA LIFE INSURANCE COMPANY	MEDICAL 3/21	487,690.30
			488,674.01
002844			
002844	AMERIHEALTH ADMINISTRATORS	WELLNESS/MARKETING 1/21	-3,846.25
002844	AMERIHEALTH ADMINISTRATORS	MEDICAL TPA 3/21	125,914.00
002844	AMERIHEALTH ADMINISTRATORS	ADJUSTMENT 1/19 - 6/19	-36,540.00
002844	AMERIHEALTH ADMINISTRATORS	ADJUSTMENT 7/19 - 6/20	9,437.75
002844	AMERIHEALTH ADMINISTRATORS	MEDICAL TPA 1/21	121,541.50
			216,507.00
002845			
002845	PERMA RISK MANAGEMENT SERVICES	POSTAGE 2/21	21.78
002845	PERMA RISK MANAGEMENT SERVICES	ADMIN FEES 3/21	139,734.61
			139,756.39
002846			
002846	J. KENNETH HARRIS, ATTY AT LAW	PLAN DOCUMENT FEE 3/21	4,680.00
002846	J. KENNETH HARRIS, ATTY AT LAW	ATTORNEY FEE 3/21	3,072.00
			7,752.00
002847			
002847	VERRILL & VERRILL, LLC	TREASURER 2/21	1,708.33
			1,708.33
002848			
002848	COURIER POST	ACCT:CHL-092208 - AD - 2.27.21	53.76
002848	COURIER POST	ACCT:CHL-092208 - AD - 2.27.21	56.72
002848	COURIER POST	ACCT:CHL-092208 - AD - 2.15.21	66.84
002848	COURIER POST	ACCT:CHL-092208 - AD - 2.16.21	50.56
002848	COURIER POST	ACCT:CHL-092208 - AD - 2.27.21	68.16
			296.04
002849			
002849	CONNER STRONG & BUCKELEW	TERM 3 - Q2 + 5% QUARTERLY PROC FEE	20,913.42
			20,913.42
002850			
002850	CONNER STRONG & BUCKELEW	BELLMAWR BOE 2/21	200.00
			200.00
002851			
002851	CONNER STRONG & BUCKELEW	COLLINGSWOOD GIF CARDS 2/21	100.00
			100.00
002852			
002852	CONNER STRONG & BUCKELEW	GUAR NURSES - COVID IMMOBIL FEE CRED	62,667.00
			62,667.00
002853			
002853	CONNER STRONG & BUCKELEW	MEDICAL 3/21	310,656.77
002853	CONNER STRONG & BUCKELEW	RX 3/21	47,275.12
002853	CONNER STRONG & BUCKELEW	BROKER FEES 3/21	391,363.06
002853	CONNER STRONG & BUCKELEW	HEALTH CARE REFORM 3/21	5,558.81
			754,853.76
002854			
002854	CONNER STRONG & BUCKELEW	DENTAL 3/21	12,106.54
			12,106.54
002855			
002855	ALLSTATE INFORMATION MANAGEMNT	ACT#962 - ARC & STOR - 2.28.21	7.79
			7.79

002856			
002856	MEDICAL EVALUATION SPECIALISTS	MES# 1345103 2/21	225.00
002856	MEDICAL EVALUATION SPECIALISTS	MES# 1338829 2/21	245.00
002856	MEDICAL EVALUATION SPECIALISTS	MES#1326113 2/21	367.50
002856	MEDICAL EVALUATION SPECIALISTS	MES# 1328534 2/21	225.00
			1,062.50
002857			
002857	ASSURED PARTNERS OF NEW JERSEY	REIMBURSEMENT 2/21	1,424.50
			1,424.50
002858			
002858	WELLNESS COACHES USA	SWEDESBORO 3/21	1,970.00
002858	WELLNESS COACHES USA	DELRAN 3/21	1,666.66
			3,636.66
002859			
002859	ALEXANDRIA TOWNSHIP BOE	EQUIPMENT 9/20	4,931.52
			4,931.52
002860			
002860	TIMBER CREEK H.S. CAFETERIA ACCT	WELLNESS BREAKFAST 2/21	210.00
			210.00
002861			
002861	DENNISE JONES	FITNESS FUSION 2/21	600.00
			600.00
002862			
002862	CINNAMINSON TOWNSHIP BOE	REIMBURSEMENT 20-21	21,524.46
			21,524.46
002863			
002863	AETNA BEHAVIORAL HEALTH LLC	LEAP 3/21	470.00
			470.00
002864			
002864	TRITON CAFETERIA	WELLNESS 1/21 2/21	282.00
			282.00
002865			
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 3.2.21	75.95
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 3.2.21	15.66
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 3.2.21	24.36
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 3.2.21	49.60
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 2.16.21	74.40
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 2.16.21	22.62
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 2.17.21	20.15
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 3.1.21	48.30
002865	NJ ADVANCE MEDIA	ACCT#1000890281 - AD - 2.17.21	6.38
			337.42
002866			
002866	JAMES FALLON	YOGA 2/21	480.00
002866	JAMES FALLON	YOGA CLASS 1/21	480.00
			960.00
002867			
002867	ADVANTA HEALTH SOLUTIONS INC	ACTIVEFIT MNGMNT FEE 1/21	3,800.00
002867	ADVANTA HEALTH SOLUTIONS INC	ACTIVEFIT MNGMNT FEE 3/21	1,780.00
002867	ADVANTA HEALTH SOLUTIONS INC	ACTIVEFIT MNGMNT FEE 1/21	580.00
002867	ADVANTA HEALTH SOLUTIONS INC	ACTIVEFIT MNGMNT FEE 3/21	444.00
			6,604.00
002868			
002868	HOPE TOWNSHIP BOARD OF EDUCATION	GRANT REIMBURSEMENT 2/21	270.00
002868	HOPE TOWNSHIP BOARD OF EDUCATION	GRANT REIMBURSEMENT 2/21	187.20
			457.20
002869			
002869	STRETCH ME CHERRY HILL, LLC	8 STRETCH SESSIONS 3/21	400.00
			400.00
002870			
002870	LYNN S. NOBLE	RYKA WOMEN'S HYDRO REIM 3/21	69.99
			69.99
002871			
002871	MILDRED DOW	SNEAKERS 3/21	98.00
			98.00
002872			
002872	DARCY LUCIA	WELLNESS DAY SUPPLIES 3/21	24.47
			24.47
002873			
002873	LINDA MOORE	WELLNESS SUPPLIES 3/21	33.82
			33.82
002874			
002874	MUNICIPAL REINSURANCE HIF	SPECIFIC REINSURANCE 3/21	756,915.25
			756,915.25
		Total Payments FY 2020-2021	**2,525,056.04**
		TOTAL PAYMENTS ALL FUND YEARS	**$2,529,115.28**

_____
Chairperson

Attest:
_____ Dated: _____

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

_____
Treasurer

SCHOOLS HEALTH INSURANCE FUND

SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED

Current Fund Year: 2021 **Month Ending: January**	**Medical**	**Dental**	**Rx**	**)ividend Payabl**	**Med.Adv**	**Reinsurance**	**abilization (BO**	**LFC**	**Admin**	**TOTAL**
OPEN BALANCE	104,132,953.78	1,410,517.95	18,842,236.27	(256,328.72)	0.00	(413,314.23)	1,906,084.67	0.00	14,741,657.62	140,363,807.34
RECEIPTS										
Assessments	9,540,718.41	127,650.64	1,125,960.12	0.00	0.00	300,224.03	0.00	0.00	851,292.80	11,945,846.00
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	70,521.91	953.32	12,734.75	1,878.60	0.00	5.35	1,288.25	0.00	9,963.33	97,345.51
Invest Adj	(0.58)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.58)
Subtotal Invest	70,521.33	953.32	12,734.75	1,878.60	0.00	5.35	1,288.25	0.00	9,963.33	97,344.93
Other *	94,727.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	94,727.00
TOTAL	9,705,966.74	128,603.96	1,138,694.87	1,878.60	0.00	300,229.38	1,288.25	0.00	861,256.13	12,137,917.93
EXPENSES										
Claims Transfers	20,235,522.41	249,484.93	3,015,806.46	0.00	0.00	0.00	0.00	0.00	0.00	23,500,813.80
Expenses	4,707.88	9,809.13	(40,339.25)	361,407.00	0.00	749,453.04	0.00	0.00	1,549,302.33	2,634,340.13
Other *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL	20,240,230.29	259,294.06	2,975,467.21	361,407.00	0.00	749,453.04	0.00	0.00	1,549,302.33	26,135,153.93
END BALANCE	**93,598,690.23**	**1,279,827.85**	**17,005,463.93**	**(615,857.12)**	**0.00**	**(862,537.89)**	**1,907,372.92**	**0.00**	**14,053,611.42**	**126,366,571.34**

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS												
SCHOOLS HEALTH INSURANCE FUND												
ALL FUND YEARS COMBINED												
CURRENT MONTH	**January**											
CURRENT FUND YEAR	**2017**											
	Description:	**Republic Bank - General Account**	**Republic Bank - Expense Account**	**Republic Bank Investment Account**	**Ocean First Bank**	**Wilmington Trust Investment Account**	**New Jersey Cash Management Investment Account**	**Parke Bank Investment Account #8626**	**Parke Bank - Certificate of Deposit #9000618634**	**William Penn Bank - Money Market Account**	**William Penn Bank-Money Market Acct #1893**
	ID Number:											
	Maturity (Yrs)								**3/13/2021**		
	Purchase Yield:	**0.75**	**0.75**	**0.75**	**0.25**	**0.01**	**0.05**	**0.80**	**1.98**	**1.00**	**1.00**
	TOTAL for All Accts & instruments											
Opening Cash & Investment Balance	**$ 140,363,806.87**	**$ 5,745,343.97**	**$ 107,428.16**	**$ 95,072,367.23**	**$ 1,087,426.15**	**$ 894.89**	**$ 88,457.88**	**$ 12,004,549.39**	**$5,000,000.00**	**$ 5,109,524.22**	**$ 16,147,814.98**
Opening Interest Accrual Balance	**$ 0.01**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 0.01**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
1 Interest Accrued and/or Interest Cost	$0.00	$0.00	$0.00	$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	$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	$0.00
4 Accretion	$0.00	$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	$97,345.51	$1,535.55	$856.87	$57,641.99	$213.04	$0.01	$3.85	$8,159.72	$8,130.77	$5,319.50	$15,484.21
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	$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	$0.00
8 Net Investment Income	$97,345.51	$1,535.55	$856.87	$57,641.99	$213.04	$0.01	$3.85	$8,159.72	$8,130.77	$5,319.50	$15,484.21
9 Deposits - Purchases	$25,683,043.90	$23,040,573.00	$2,634,340.13	$0.00	$0.00	$0.00	$0.00	$8,130.77	$0.00	$0.00	$0.00
10 (Withdrawals - Sales)	-$39,777,624.94	-$26,135,153.93	-$2,634,340.13	-$11,000,000.00	$0.00	-$0.11	$0.00	$0.00	-$8,130.77	$0.00	$0.00
		OK	OK	OK	OK	OK	OK	OK	OK	OK	OK
Ending Cash & Investment Balance	$126,366,571.34	$2,652,298.59	$108,285.03	$84,130,009.22	$1,087,639.19	$894.79	$88,461.73	$12,020,839.88	$5,000,000.00	$5,114,843.72	$16,163,299.19
Ending Interest Accrual Balance	$0.01	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00
Plus Outstanding Checks	$2,707,803.05	$0.00	$2,707,803.05	$0.00	$0.00	$0.00	$0.00	$0.00	$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	$0.00
Balance per Bank	$129,074,374.39	**$2,652,298.59**	$2,816,088.08	$84,130,009.22	$1,087,639.19	$894.79	$88,461.73	$12,020,839.88	$5,000,000.00	$5,114,843.72	$16,163,299.19

CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES

SCHOOLS HEALTH INSURANCE FUND

Month	**January**
Current Fund Year	**2021**

Policy Year	Coverage	1. Calc. Net Paid Thru Last Month	2. Monthly Net Paid January	3. Monthly Recoveries January	4. Calc. Net Paid Thru January	5. TPA Net Paid Thru January	6. Variance To Be Reconciled	7. Delinquent Unreconciled Variance From	8. Change This Month
2020	Medical	125,003,181.82	20,235,522.41	0.00	145,238,704.23	0.00	145,238,704.23	125,003,181.82	20,235,522.41
	Dental	1,722,801.11	249,484.93	0.00	1,972,286.04	0.00	1,972,286.04	1,722,801.11	249,484.93
	Rx	17,004,885.31	3,015,806.46	0.00	20,020,691.77	0.00	20,020,691.77	17,004,885.31	3,015,806.46
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	**143,730,868.24**	**23,500,813.80**	**0.00**	**167,231,682.04**	**0.00**	**167,231,682.04**	**143,730,868.24**	**23,500,813.80**

RESOLUTION NO. 6-21

SCHOOLS HEALTH INSURANCE FUND
APPROVAL OF THE MARCH 2021 BILLS LIST AND TREASURERS REPORT

WHEREAS, the **Schools Health Insurance Fund** (the "Fund") held a Public Meeting on **March 24, 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 of March 2021 for consideration and approval of the Board of Trustees; and

WHEREAS, The Treasurer for the Fund presented a Treasurers Report which detailed the claims payments and imprest transfers for the Fund for the Month of January for all Fund Years for consideration and approval of the Board of Trustees; and

WHEREAS, a quorum of the Board of Trustees was present thereby conforming with the By-laws of the Fund to conduct official business of the Fund,

NOW THEREFORE BE IT RESOLVED the Board of Trustees of the Fund hereby approves 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 School Board Joint Insurance Funds.

NOW, THEREFORE BE IT FURTHER RESOLVED, the Board of Trustees of the Fund hereby approves the Treasurer's 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 School Board Joint Insurance Funds.

ADOPTED: MARCH 24, 2021

BY:_____
CHAIRPERSON

ATTEST:_____
SECRETARY

SCHOOLS HEALTH INSURANCE FUND

Monthly Claim Activity Report

March 24, 2021

SCHOOLS HEALTH INSURANCE FUND

	MEDICAL CLAIMS PAID 2019-2020	# OF EES	PER EE	MEDICAL CLAIMS PAID 2020-2021	# OF EES	PER EE
JULY	$13,328,939	9,208	**$ 1,448**	$14,230,010	11,287	**$ 1,261**
AUGUST	$13,809,169	9,125	**$ 1,513**	$15,900,571	11,067	**$ 1,437**
SEPTEMBER	$12,760,915	9,314	**$ 1,370**	$18,681,552	11,211	**$ 1,666**
OCTOBER	$15,203,317	9,308	**$ 1,633**	$16,487,889	11,339	**$ 1,454**
NOVEMBER	$12,308,118	9,314	**$ 1,321**	$17,288,537	11,343	**$ 1,524**
DECEMBER	$13,518,336	9,334	**$ 1,448**	$16,700,894	11,329	**$ 1,474**
JANUARY	$13,470,288	9,469	**$ 1,423**	$17,448,884	12,718	**$ 1,372**
FEBRUARY	$12,973,048	9,520	**$ 1,363**			
MARCH	$14,932,728	9,515	**$ 1,569**			
APRIL	$10,118,416	9,513	**$ 1,064**			
MAY	$8,317,184	9,511	**$ 874**			
JUNE	$11,827,511	9,504	**$ 1,244**			
TOTALS	**$152,567,970**			**$116,738,338**		
				2020-2021 Avg.	**11,471**	**$ 1,455**
				2019-2020 Avg.	**9,386**	**$ 1,356**

Large Claimant Report (Drilldown) - Claims Over $50000

Plan Sponsor Unique ID :	All	**Paid Dates:**	01/01/2021 - 01/31/2021
Customer:	**SCHOOLS HEALTH INSURANCE FUND**	**Service Dates:**	01/01/2016 - 01/31/2021
Group / Control:	00141839,00169659,00737392,00737419	**Line of Business:**	All
Subgroup / Suffix:	All	**Funding Category:**	All

	Billed Amt	Paid Amt	Diagnosis/Treatment
	$514,308.50	$458,875.86	ERYTHEMA INTERTRIGO
	$1.989.713.67	$355.770.01	SEPSIS DUE TO ANAEROBES
	$219.788.66	$294.587.18	LIVER TRANSPLANT FAILURE
	$179.034.10	$170.873.14	AMYOTROPHIC LATERAL SCLEROSIS
	$705.605.60	$166.998.15	NONTRAUMATIC SUBARACHNOID
	$490,169.00	$159,810.55	ENCOUNTER FOR ANTINEOPLASTIC
	$212,949.66	$140,694.68	ENCOUNTER FOR ANTINEOPLASTIC
	$641,198.00	$136,836.06	MALIGNANT NEOPLASM OF PARIETAL LOBE
	$167,488.59	$132,086.64	SPINAL STENOSIS, LUMBAR REGION WITH NEUROGENIC
	$292,671.65	$124,921.19	ENCOUNTER FOR ANTINEOPLASTIC
	$186.892.07	$113.462.36	MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT
	$154.124.00	$101.517.49	TWIN LIVEBORN INFANT. DELIVERED VAGINALLY
	$184.127.38	$100.301.20	CHRONIC ISCHEMIC HEART DISEASE. UNSPECIFIED
	$162.132.00	$95.333.49	TWIN LIVEBORN INFANT. DELIVERED VAGINALLY
	$99,047.00	$94,489.00	DEFORMITY OF RECONSTRUCTED BREAST
	$85,263.74	$92,152.65	INTRASPINAL ABSCESS AND GRANULOMA
	$231,250.61	$90,810.49	HYPERTENSIVE EMERGENCY
	$293,200.77	$88,787.16	UNSPECIFIED ATRIAL FIBRILLATION
	$103.753.00	$86.910.01	TETRALOGY OF FALLOT
	$161.441.52	$81.255.61	MALIGNANT NEOPLASM OF OVERLAPPING SITES OF
	$586.826.00	$79.671.81	MALIGNANT NEOPLASM OF PROSTATE
	$199.170.50	$71.669.71	SPINAL STENOSIS. LUMBAR REGION WITHOUT
	$88.932.82	$71.533.29	SINGLE LIVEBORN INFANT. DELIVERED BY CESAREAN
	$78,743.77	$70,630.71	CEREBRAL INFARCTION DUE TO UNSPECIFIED
	$439,620.35	$70,000.15	MALIGNANT NEOPLASM OF CARDIA
	$82,301.73	$68,995.25	ANOREXIA NERVOSA, RESTRICTING TYPE
	$188,702.70	$68,121.40	SEPSIS, UNSPECIFIED ORGANISM
	$118.786.86	$65.332.80	EPILEPSY. UNSPECIFIED. INTRACTABLE. WITHOUT
	$153.910.00	$58.453.59	ENCOUNTER FOR ANTINEOPLASTIC
	$148.032.30	$57.505.84	NONTRAUMATIC INTRACEREBRAL
	$97.816.42	$56.787.28	OTHER PULMONARY EMBOLISM WITHOUT ACUTE
	$99,515.15	$56,235.79	ENCOUNTER FOR ANTINEOPLASTIC
	$57,995.20	$55,545.99	MALIGNANT NEOPLASM OF OVERLAPPING SITES OF
	$145,319.46	$55,334.14	SEPSIS, UNSPECIFIED ORGANISM
	$64,489.07	$54,199.66	NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION
	$93,299.92	$53,726.73	SUPERIOR GLENOID LABRUM LESION OF RIGHT
	$149.283.69	$51.466.84	DIVERTICULITIS OF LARGE INTESTINE WITH
	$118.762.45	$50.773.93	BILATERAL PRIMARY OSTEOARTHRITIS OF HIP
	$102.454.14	$50.616.00	PAROXYSMAL ATRIAL FIBRILLATION
	$67.601.32	$50.461.98	MALIGNANT NEOPLASM OF BONE AND ARTICULAR
	$79,805.60	$50,104.72	MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF
TOTAL:	**$10,235,528.97**	**$4,353,640.53**	

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Schools Health Insurance Fund

2/1/20 through 1/31/21 (Unless otherwise noted)

Medical Claims Paid Per Employee
July 20 – January 2021

Total Medical Paid per Employee: **$1,455**

Network Discounts

Inpatient:	**66.3%**
Ambulatory:	**68.1%**
Physician/Other:	**61.0%**
TOTAL:	**64.9%**

Provider Network

% Admissions In-Network:	**96.7%**
% Physician Office:	**96.2%**

Aetna Book of Business:
Admissions 97.8%; Physician 91.8%

Top Facilities Utilized (by total Medical Spend)

- Virtua-West Jersey
- University of Pennsylvania
- Cooper
- Kennedy Health
- Virtua Memorial- Burlington

Claimants Over $50,000
(January 2021 - January 2021)

Number of Claims Over $50,000: **41**
Claimants per 1000 members: **1.2**
Avg. Paid per Claimant: **$106,180**
Percent of Total Paid: **24.3%**

- **Aetna BOB- HCC account for an average of 40.9% of total Medical Cost**

Teladoc Activity:
Jan 20221– Jan 2021

Total Registrations: **97**
Total Online Visits: **133**
Total Net Claims Savings: **$18,070**
Total Visits w/ Rx: **77**

Utilization by Age

0-17: 5.3%
18-26: 12.0%
27-30: 11.3%
31-45: 42.9%
46-55: 16.5%
55-65: 9.8%
66+: 2.3%

Mental Health Visits: 13
Dermatology Visits: 6

New

Allentown Service Center Performance: Metrics thru FEB 2021

Customer Service Results

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

Claims Performance Results

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

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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

Proprietary


AmeriHealth®
ADMINISTRATORS

Schools Health Insurance Fund

	Medical Claim 2020-2021	# of EE's 2020-2021	PER EE		Medical Claim 2019-2020	# OF EE'S 2019-2020	PER EE 2019
JULY	$2,636,206.12	3104	$849.29	JULY	$2,243,876.00	3134	$715.96
AUGUST	$4,021,019.01	3093	$1,300.03	AUGUST	$5,606,458.00	3126	$1,793.49
SEPTEMBER	$3,662,263.71	3130	$1,170.05	SEPTEMBER	$3,462,796.00	3171	$1,092.00
OCTOBER	$5,400,921.75	3124	$1,728.84	OCTOBER	$4,764,536.00	3159	$1,508.00
NOVEMBER	$3,676,934.35	3113	$1,181.15	NOVEMBER	$3,460,031.00	3165	$1,093.22
DECEMBER	$5,111,087.09	3102	$1,647.67	DECEMBER	$3,045,874.00	3162	$963.27
JANUARY	$4,450,033.08	3108	$1,431.79	JANUARY	$5,952,694.48	3151	$1,889.14
FEBRUARY	$4,149,253.33	3108	$1,335.02	FEBRUARY	$4,906,818.27	3162	$1,549.35
MARCH				MARCH	$3,426,454.40	3154	$1,086.38
APRIL				APRIL	$4,036,179.58	3153	$1,280.10
MAY				MAY	$1,968,418.45	3152	$624.49
JUNE				JUNE	$6,531,932.47	3156	$2,069.68
TOTALS	$33,107,718.44			TOTAL	$49,406,068.65		
	AVERAGE	3110	$1,330.48		AVERAGE	3153.75	$1,305.42

PLAN SPONSOR INFORMATION SERVICES

Large Claimant Report- Claims Over $50,000.00

Group: Schools Health Insurance Fund **Service Dates:** -

Paid Dates: 2/01/2021 -2/31/2021 **Line of Business:** All

Network Service ALL **Product Line:** All

Claimant	Relationship	Paid Amount	Diagnosis
1	Spouse	$216,558	Spondylosis; Intervertebral Disc Disorders; Other Back Problems
2	Subscriber	$128,333	Anemia
3	Dependent	$124,399	Intracranial Injury
4	Spouse	$84,507	Other Gastrointestinal Cancer
5	Spouse	$80,958	Diseases Of The Heart
6	Spouse	$72,988	Diseases Of The Heart
7	Dependent	$61,496	Diseases Of The Heart
8	Subscriber	$53,833	Cancer Of Breast
9	Spouse	$52,922	Biliary Tract Disease
10	Dependent	$50,230	Schizophrenia And Other Psychotic Disorders
Total		$926,223.87	

Schools HIF

Paid Claims 7/1/20-6/30/21

Average payment per member PMPM 7/1/20- 6/30/21	$504.38
Number of claimants with paid claims over $50,000 for YTD	100
Total paid on those claimants:	$11,833,838.97

Top Facilities Utilized based on paid claims:
VIRTUA WEST JERSEY HEALTH SYSTEM INC, NJ
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, PA
CHILDRENS HOSPITAL OF PHILADELPHIA, PA
KENNEDY UNIVERSITY HOSPITAL GAC, NJ
COOPER UNIVERSITY HOSPITAL, NJ

MD LIVE UTILIZATION
Total Registrations 2021 YTD: 3
Total Online Visits 2020 : 94
Member Satisfaction YTD: 93%

Provider Network
% Inpatient In- Network: 99.3%
% Professional providers In-Network: 94.6%
% Outpatient providers In-Network- 96.1%

Metric	**AHA January MTD**	**AHA February MTD**
1st Call Resolution	83.70%	85.21%
ASA	124.60	27.06
Abandonment Rate	7.40%	1.99%

Totals	**2021 YTD**
Total Inpatient Admissions	249
Total Inpatient Days	1,109
Total ER visits	676

SCHOOLS HEALTH INSURANCE FUND (SHIF) - 0001396696

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	24	33	$6,970.46	$211.23	$5.44
1-5	157	232	$125,833.67	$542.39	$17.68
6-18	528	842	$105,107.40	$124.83	$4.48
19-25	380	817	$87,715.50	$107.36	$7.90
26-39	762	1479	$210,426.69	$142.28	$10.57
40-64	1606	3307	$978,778.49	$295.97	$23.71
65+	128	322	$294,179.04	$913.60	$92.22
Unknown	0	0	$0.00	$0.00	$0.00

REL TO INS	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Employee	1666	3266	$541,904.87	$165.92	$13.33
Spouse	826	1776	$618,934.92	$348.50	$25.92
Dependent	1070	1990	$648,171.46	$325.71	$15.13

GENDER	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
Female	2090	4167	$644,966.73	$154.78	$11.18
Male	1472	2865	$1,164,044.52	$406.30	$23.44
Undisclosed	0	0	$0.00	$0.00	$0.00

ST CD	CLAIMANT COUNT	CLAIM COUNT	NET PAY	COST PER CLAIM	COST PMPM
DE	12	16	$1,456.28	$91.02	$3.45
MA	1	1	$42.13	$42.13	$3.24
NJ	3479	6899	$1,798,167.46	$260.64	$17.20
NY	1	1	$27.22	$27.22	$2.09
PA	69	115	$9,318.16	$81.03	$4.09

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	128	168	$97,558.90	$580.71	$0.91
Emergency Room With Observation Bed	35	37	$10,426.89	$281.81	$0.10
Observation Bed	2	2	$91.70	$45.85	$0.00
Office Physician Visit	157	176	$19,949.73	$113.35	$0.19
Other Physician Visit	21	23	$4,389.42	$190.84	$0.04
Pathology (Laboratory)	3065	5298	$489,293.52	$92.35	$4.56
Telemedicine	146	176	$18,397.39	$104.53	$0.17
Urgent Care	225	264	$39,111.02	$148.15	$0.36

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	2	2	2	$50,296.35	1.2	$25,148.18	$2.53	4
40-64	10	10	10	$616,422.55	2.4	$61,642.26	$14.93	6.1
65+	4	4	4	$239,402.35	15.6	$59,850.59	$75.05	5.75
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
Virtua West Jersey Health System Inc	467	583	$621,703.57	$1,066.39	$5.79
KENNEDY UNIVERSITY HOSPITAL GAC	233	312	$254,135.41	$814.54	$2.37
Labcorp Raritan	1595	2053	$177,360.20	$86.39	$1.65
Childrens Hospital of Philadelphia	71	84	$119,802.88	$1,426.22	$1.12
Virtua Our Lady of Lourdes Hospital	5	6	$80,210.20	$13,368.37	$0.75
Inspira Medical Center Mullica Hill	171	209	$73,196.68	$350.22	$0.68
Quest Diagnostics Inc	554	657	$62,738.46	$95.49	$0.58
GENESIS LABORATORY MANAGEMENT	127	155	$45,672.78	$294.66	$0.43
St Christopher's Hospital for Children	2	7	$33,010.52	$4,715.79	$0.31
Cooper University Hospital	171	207	$31,907.01	$154.14	$0.30
Pace Orthopedic & Sports Medicine	25	72	$30,145.23	$418.68	$0.28
Hackensack University Medical Group PC	173	212	$25,326.61	$119.47	$0.24
EPA of South Jersey	19	23	$14,391.44	$625.71	$0.13
Medical Diagnostic Laboratories LLC	4	65	$14,331.00	$220.48	$0.13
PROHEALTH CARE ASSOC LLP	56	63	$12,240.00	$194.29	$0.11
Salem Medical Center	15	18	$9,377.08	$520.95	$0.09
Inspira Medical Center Vineland	41	45	$9,253.08	$205.62	$0.09
Accu Reference Medical Lab	40	47	$9,200.00	$195.74	$0.09
TEMPUS LABS INC.	78	85	$8,500.00	$100.00	$0.08
Minute Clinic Diagnostic of New Jersey LLC	323	383	$7,543.32	$19.70	$0.07
PM Pediatrics of Livingston	34	38	$6,195.00	$163.03	$0.06
Capital Health System	3	3	$6,144.23	$2,048.08	$0.06
Kennedy Health Alliance	7	32	$5,883.27	$183.85	$0.05
Patient First Maryland Physicians Group Pc	28	32	$5,682.00	$177.56	$0.05
ACUTIS DIAGNOSTICS INC	21	44	$5,081.63	$115.49	$0.05

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	7	3	$741.00	$74.10
19-25	16	5	$896.82	$42.71
26-39	157	37	$12,268.76	$63.24
40-64	328	102	$25,767.79	$59.93
65+	35	18	$3,378.00	$63.74
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	1	1	$165.00	$165,000.00
1-5	9	9	$1,425.00	$158,333.33
6-18	32	38	$4,670.79	$145,962.19
19-25	39	56	$8,300.51	$212,833.59
26-39	54	59	$8,529.64	$157,956.30
40-64	89	100	$15,829.08	$177,854.83
65+	1	1	$191.00	$191,000.00
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®

School Health Insurance Fund

Total Component/Date of Service (Month)	201907	201908	201909	2019Q3	201910	201911	201912	2019Q4	202001	202002	202003	2020Q1	202004	202005	202006	2020Q2	Jul19-Jun20
Membership	17,109	17,119	17,405	17,211	17,376	17,405	17,171	17,317	17,015	17,220	17,273	17,169	17,286	17,264	17,251	17,267	17,241
Total Days	566,227	567,524	539,822	1,673,573	598,375	548,130	602,622	1,749,127	608,101	576,147	672,499	1,856,747	574,162	553,861	593,028	1,721,051	7,000,498
Total Patients	6,340	6,329	6,235	9,907	6,614	6,482	6,798	10,373	6,996	6,842	6,832	10,667	5,783	5,738	6,119	9,151	12,166
Total Plan Cost	$2,302,563	$2,161,544	$2,212,705	$6,676,812	$2,356,577	$2,243,172	$2,466,480	$7,066,229	$2,397,904	$2,222,058	$2,707,223	$7,327,185	$2,421,657	$2,270,596	$2,493,162	$7,185,414	$28,255,640
Generic Fill Rate (GFR) - Total	81.9%	82.1%	82.2%	82.0%	81.5%	83.1%	83.5%	82.7%	84.4%	84.6%	83.1%	84.1%	82.8%	83.5%	83.7%	83.4%	83.1%
Plan Cost PMPM	$134.58	$126.27	$127.13	$129.31	$135.62	$128.88	$143.64	$136.01	$140.93	$129.04	$156.73	$142.25	$140.09	$131.52	$144.52	$138.71	$136.57
Total Specialty Plan Cost	$691,348	$649,996	$792,860	$2,134,204	$787,145	$716,065	$815,237	$2,318,447	$832,872	$733,276	$920,812	$2,486,961	$890,943	$828,749	$913,971	$2,633,663	$9,576,276
Specialty % of Total Specialty Plan Cost	30.0%	30.1%	35.8%	32.0%	33.4%	31.9%	33.1%	32.8%	34.7%	33.0%	34.1%	34.0%	36.8%	36.5%	36.7%	36.7%	33.9%

Total Component/Date of Service (Month)	202007	202008	202009	2020Q3	202010	202011	202012	2020Q4	202101	202102	202103	2021Q1	202104	202105	202106	2021Q2	Jul20-Jun21
Membership	18,915	18,770	18,990	18,892	19,733	19,723	19,686	19,714	20,984	21,174							
Total Days	647,662	643,683	616,496	1,907,841	673,374	649,746	710,040	2,033,160	685,309	658,671							
Total Patients	6,783	6,746	6,701	10,567	7,159	6,831	7,032	10,738	7,356	7,283							
Total Plan Cost	$3,038,795	$2,621,055	$2,535,206	$8,195,055	$2,911,109	$2,669,769	$2,879,196	$8,460,074	$2,989,234	$2,487,048							
Generic Fill Rate (GFR) - Total	83.8%	83.2%	82.2%	83.1%	81.3%	83.5%	83.8%	82.8%	84.7%	85.0%							
Plan Cost PMPM	$160.66	$139.64	$133.50	$144.60	$147.52	$135.36	$146.26	$143.05	$142.45	$117.46							
% Change Plan Cost PMPM	19.4%	10.6%	5.0%	11.9%	8.8%	5.0%	1.8%	5.2%	1.1%	-6.2%							
Total Specialty Plan Cost	$1,115,455	$849,637	$897,512	$2,862,604	$918,749	$901,580	$925,365	$2,745,695	$973,599	$735,840							
Specialty % of Total Specialty Plan Cost	36.7%	32.4%	35.4%	34.9%	31.6%	33.8%	32.1%	32.5%	32.6%	29.6%							

Fiscal Year	PMPM
Jul 2019 - Feb 2020	$132.74
Jul 2020 - Feb 2021	$140.09
Trend - Jul 2020 - Feb 2021	5.5%

APPENDIX I

SCHOOLS HEALTH INSURANCE FUND
OPEN MINUTES
FEBRUARY 24, 2021
ZOOM MEETING/CONFERENCE CALL
12:00 PM

Meeting of Board of Trustees called to order by Chair Collins
Open Public Meetings notice read into record.

ROLL CALL 2020-2021 BOARD OF TRUSTEES

Trustee	**BOE**		
Joseph Collins	Delsea Regional BOE	Chairman	Present
Beth Ann Coleman	Collingswood BOE	Secretary	Present
Lisa Giovanelli	Rancocas Valley BOE		Present
Michael Colling	Medford Lakes BOE		Present
Christopher Lessard	Frankford Township BOE		Present
Christopher Destratis	Swedesboro-Woolwich BOE		Present
Evon Digangi	Mount Holly BOE		Absent
Nicholas Bice	Burlington Township BOE		Present
Marie Goodwin	Medford Township BOE		Absent
Jason Schimpf	Kingsway Regional School District		Present
Helen Haley	Voorhees Township BOE		Present

PRESENT FUND PROFESSIONALS:

FUND ADMINISTRATOR:	**PERMA Risk Management** Emily Koval Paul Laracy Karen Kamprath
PROGRAM MANAGER:	**Conner Strong & Buckelew** Jozsef Pfeiffer Brandon Lodics
FUND ATTORNEY:	Ken Harris
FUND TREASURER:	Lorraine Verrill
FUND ACTUARY:	Absent
FUND AUDITOR:	Absent
MEDICAL TPA AMERIHEALTH:	Kristina Strain
MEDICAL TPA AETNA:	Jason Silverstein
MEDICAL TPA HORIZON:	Michelle Witherspoon
EXPRESS SCRIPTS:	Ken Rostkowski Kyle Colalillo
DELTA DENTAL	Brian Remlinger
GUARDIAN NURSES:	Robin Sambuco Jackie Kane

ALSO PRESENT
John Cobb, J Cobb Insurance
John Lajewski, Conner Strong & Buckelew
Brian Reilly, Centric Benefits Consulting
Ed O'Malley, AJG
Rob Wachter, Mt. Laurel BOE
Susan Morris, Conner Strong & Buckelew
Anthony Tonzini, Integrity Consulting
Beth Scheiderman, Watchung Hills BOE
Brooke Frapwell, Brown & Brown
Carrie Specht, Assured Partners
Chuck Grande , Integrity Consulting
Cande Kristoff, Delran BOE
Connie Stewart, Lenape BOE

Danielle Tarvin, Springfield BOE
Dina Murray, Allen Associates
Felicia Kicinski, Mendham BOE
Jim Finn, Brown & Brown
Joe Madera, Hardenbergh
Joel Sand, Kistler Tiffany
Kim Porter, Cherry Hill Benefits
Lynsey Eddy, AJG
Mary Muscarella, Brown & Brown
Mike Blake, Maple Shade BOE
Paul McGowan, Brown & Brown
Robert Weil, Conner Strong & Buckelew
Scott Davenport, Conner Strong & Buckelew
Steve Anuszewski, Steven Anuszewski Financial Services
Susan Jarnagin, AJG
Teri Weeks, Gloucester City BOE
Thomas Tafuri, Brown & Brown
Timothy Stys, Watchung Hills BOE
Todd Reitzel, Deptfod BOE
Tom Egan, Cinnaminson BOE
Tracey Judge, Assured Partners
Cassidy Dudley, Springfield Township BOE
John Recchinti, Evesham Township BOE

MOTION TO APPROVE OPEN MINUTES OF DECEMBER 2, 2020

Moved:	Trustee Coleman
Second:	Trustee Giovanelli
Vote:	All in Favor

PUBLIC COMMENT - None

EXECUTIVE DIRECTORS REPORT

FINANCIAL FAST TRACK – Executive Director said the financial fast track shows there was a claims suppression of about 20% in Q1. He said that resulted in savings and increased the Fund surplus. He said as of July 1 the Fund has basically been operating at break even consistently month to month.

AMERIHEALTH (AHA) CONTRACT STATUS – Executive Director said we continue to negotiate with AmeriHealth to complete the contractual terms for 2019 – 2021. He said we expect that the contracts will be finalized within the coming month and that they can be presented for final approval at the March meeting.

2021/2022 BUDGET INTRODUCTION – Executive Director said the major action item is the introduction of the 2021/2022 budget. He said the overall assessment increase is up about 3%. He said

medical claims are increasing by 5% and RX is down by slightly over 6%. He said we do have improved formulary rebates coming from ESI. He said dental is down .5%. He said there was a lot more work and estimation involved in this budget because of Covid. He said because of this the Fund has more potential for variability in the next year due to the disruption of normal claims patterns. Executive Director said the finance committee is to hold further action on any dividends until we receive the June 30th audit. He said the reinsurance line is down about 19% due to good experience at the reinsurance level. He said overall expenses are up about 2%. He said contracts are due for most professionals for July 1 so expenses are budgeted appropriately.

MOTION TO ADOPT RESOLUTION 1-21, INTRODUCING THE 2021-2022 BUDGET IN THE AMOUNT OF $369,729,914 AND ADVERTISE A PUBLIC HEARING FOR MARCH 24, 2021 AT 12:00 PM TO ADOPT THE BUDGET.

Moved:	Trustee Colling
Second:	Trustee Bice
Vote:	All in Favor

CLAIM FUNDS

Using the analysis provided John Vataha of Actuarial Solutions, the following changes in the claims budget are projected:

- Medical +5.07%
- Rx -6.37%
- Dental -.50%

In total, these changes, along with reinsurance and expense adjustments, result in the average assessment increase of 3.07%.

The medical increase is within industry trend ranges (~5% to ~9%). The projection involved discounting claims data for periods when the Covid-19 pandemic resulted in suppressed utilization of medical services (most obviously in the March to June, 2020 period).

The Rx change is significantly below industry trend (~10%) and is due to improvements in Express Scripts contract terms and growing formulary rebates. The budgeted amount assumes that formulary rebates will equal 24% of claim spend. This compares to an offset of 15% in the 2020/2021 budget.

The dental outcome is also below industry trend (~4%).

RATE STABILIZATION RESERVE AND DIVIDEND CONSIDERATIONS

Up to 2.5% of assessments can be budgeted for rate stabilization. The SHIF considers this line item in tandem with the review of surplus retention and dividend policy. Given the SHIF's strong surplus, a rate stabilization reserve has not been included in this draft budget.

The Finance Committee and Trustees balance the needs of the membership and the Fund in determining how and when to distribute surplus. The Committee will review dividend capacity again after the June 30, 2021 audit is available. Following is a re-cap of recent dividend history and current capacity.

Schools Health Insurance Fund	
Surplus Objective	
Annual Claims Budget	$ 336,142,670
Trended for Growth @ 20%	$ 403,371,204
Surplus Target @ 2.5 Months of Claims	$ 84,035,667
Surplus as of 11/30/2020 + 5% UW Income	$ 121,579,660
Available for Dividend	$ 37,543,993
Available as % of Claims	9%
1 Month of Assessments	$ 27,410,898
Dividend Illstrated at 1/3rd of Available	$ 12,514,664

History of Surplus and Dividends Since Formation	Surplus	Dividend	Dividend as % of Surplus
2016 -2017	$ 35,699,535	$ 661,580	1.85%
2017 - 2018	$ 44,952,292	$ 4,934,411	10.98%
2018 - 2019	$ 75,246,310	$ 6,222,844	8.27%
2019 - 2020	$ 105,902,193	$ 17,196,879	16.24%
2020 - 2021	$ 101,411,100	$ 8,847,129	8.72%

REINSURANCE

The Fund obtains reinsurance through the Reinsurance Health Insurance Fund. The SHIF currently takes responsibility for specific claims below $450,000, the Reinsurance HIF assumes claims from $450,001 to $875,000, and claims above $875,000 cede to the reinsurance market.

The budget is prepared with an increase in retention on specific claims by SHIF to $475,000 and a reduction in cost of 19.12%. Most of the decrease (18%) is due to positive overall results for SHIF and the Reinsurance HIF. The balance of the decrease is due to the $25,000 increase in retention.

SHIF has the capacity to assume more of its overall claims load, but the modest $25,000 increase in retention is due to unknowable, but potentially higher risks resulting from Covid-19 related utilization deferrals.

EXPENSES

- **Operating Expenses:** The category includes the cost of operating the Fund, items such as the administrator, attorney, treasurer, program manager, auditor, advertising and meeting costs, etc. Operating expenses represents 1.76% of the budget. Simultaneous to budget introduction, we will seek authorization to issue RFPs for professional and administrative services associated with this category.
    - **a.** Please note that the higher than normal increase for the treasurer position is due to the dramatic increase in membership and associated accounts receivable duties.
    - **b.** The higher than normal increase for data analysis is also due to growth in membership. This was discussed with Finance Committee who will be reviewing work product and value.

- **Claims Adjustment Expense:** This represents 2.19% of the overall budget. These contracts are negotiated between the claims agents and affiliated HIFs. Negotiations for the upcoming year are pending.

- **Local Brokerage or Risk Manager Fees:** The Fund implements broker fees that are determined by local units. A 2% increase is budgeted for purposes of budget development but other increases are implemented at the request of specific risk managers. If an entity determines that the fee should be higher or lower, PERMA will adjust rates accordingly.

- **Taxes:** The "Affordable Care Act" tax on the HIF is the Patient-Centered Outcomes Research Fee (the "Comparative Effectiveness Fee"). The New Jersey A4 Retiree Surcharge is budgeted at 1.8% of medical claims using the latest factor published by the Division of Taxation.

- **Wellness:** The wellness line item is included to fund grants to BOEs. The funding level is unchanged on a per-employee, per-month basis.

- **Guardian Nurses:** The Guardian Nurses line is now budgeted on a per-employee-per-month rate to allow flexibility to add an additional nurse as the Fund population grows. Additional nurse requests will be fully reviewed by the Operations Committee and Executive Committee.

ASSESSMENTS

Rate changes are applied by-member by line-of-coverage, with loss ratio adjustments of up to +- 2.5% per year for members with more than 2 years of claims experience. Assessments also vary depending upon participation in lines of coverage. Rate increases by line of coverage are:

- Medical (including vision) +5.56%
- Rx -5.5%
- Dental self-insured program flat, DMO programs +2.5%

One new member has a higher than normal increase due to deferral of assessments from the current fund year as part of their membership approval. Also, one member is applying dividends in order to reduce their prospective rates.

NOTE ON BASIS OF BUDGET YEAR OVER YEAR COMPARISON

The budget uses the January 2021 census to illustrate both the current and prospective year budget. This allows for a normalized comparison of rates for both expenses and assessments. The proposed budget is based upon 15,819 medical contracts. By contrast, the 2020/2021 budget was based on 12,709 medical contracts.

Ms. Koval said this is Trustee Destratis's last meeting as he is moving to a district outside of the Fund. She said Trustee Sekelsky is returning to the Fund and will be sworn in to the Board of trustees as the March Meeting.

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND – Ms. Koval said the MRHIF met on February 10 to reorganize and took action on the following items.

1. Awarded a contract to ELMCRX Solutions 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 is completed and we will provide the report to each of the Funds in the next month.

NEW MEMBERSHIP APPROVAL – Ms. Koval said the Fund received two new member submissions - Oxford BOE (3/1) and Eastern Camden County BOE (4/1). The Operations Committee reviewed and are recommending membership. The growth capacity is also listed below with the inclusion of these two groups, which shows the Fund is still within the approved 35% growth cap. Resolution #2–21 ratifies these members.

MOTION TO APPROVE RESOLUTION 2-21.

Moved:	Trustee Coleman
Second:	Trustee Haley
Vote:	All in Favor

REQUESTS FOR PROPOSALS – Ms. Koval said under the Local Public Contracts law, the following positions need to go out for RFP for a two year term starting July 1, 2021: Actuary, Auditor, Attorney and Treasurer. The following positions will be for a three year term starting July 1, 2021: Executive Director and Program Manager. We expect to have results of these RFPs to the Contracts Committee by the end of March.

MOTION TO ISSUE AND ADVERTISE REQUESTS FOR PROPOSALS FOR PROFESSIONAL SERVICES CONTRACTS ON BEHALF OF THE FUND FOR ACTUARY, AUDITOR, ATTORNEY, TREASURER, EXECUTIVE DIRECTOR AND PROGRAM MANAGER.

Moved:	Trustee Giovanelli
Second:	Trustee Coleman
Vote:	All in Favor

PROGRAM MANAGER'S REPORT

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 SHIF 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 SHIF Client Servicing Team. The team can be reached by email at brokerservice@permainc.com.

CONNER STRONG COVID-19 RESOURCES

Conner Strong & Buckelew has compiled a database of COVID-19 resources available to our clients. To access the resource center please use the link below.

- Link-https://www.connerstrong.com/insights/covid-19-resource-center/

ONLINE ENROLLMENT SYSTEM TRAINING SCHEDULE – 2021

Program Manager said 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 to 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, 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

AETNA UPDATE
TELADOC MAILING
Program Manager said Aetna announced they sent 2021 Teladoc Welcome Letters in Late January to members via mail. Teladoc is Aetna's telemedicine program available to SHIF membership at no cost for most services. Member who use telemedicine services provided by their providers will continue incur applicable cost share. He said this service is available at no cost to our members.

NEGOTIATIONS WITH SALEM MEDICAL CENTER – CONTRACT EXTENSION – Program Manager said that Aetna is currently in negotiations with Salem Medical Center located in Salem, NJ. Salem Medical Center granted an extension from March 29, 2021 to June 1, 2021. Due to extension, the contract is now set to terminate on June 1, 2021. Negotiations are ongoing and both parties are continuing discussions in hopes of reaching an acceptable agreement. Letters **are not** being released at this time, but we will advise if that changes.

Impacted Hospital Location:
Salem Medical Center
310 Salem Woodstown Road
Salem, NJ 08079

ALTERNATE HOSPITALS

Salem County
Inspira Medical Center- Elmer
501 Front Street
Elmer, NJ 08318
Cumberland County
Inspira Medical Center- Vineland
1505 W Sherman Avenue
Vineland, NJ 08360
Gloucester County
Inspira Medical Center- Mullica Hill
700 Mullica Hill Road
Mullica Hill, NJ 08062
Jefferson Washington Township Turnersville
435 Hurffville-Cross Keys Road
Turnersville, NJ
Camden County
Cooper University Hospital

1 Cooper Plaza
Camden, NJ 08103
Jefferson Chery Hill Hospital
201 Chapel Ave W
Cherry Hill, NJ 08002
Jefferson Strafford Hospital
18 E Laurel Road
Stratford, NJ 08084
Virtua Our Lady of Lourdes Hospital
1600 Haddon Avenue
Camden, NJ 08103
Virtua Voorhees Hospital
100 Bowman Drive
Voorhees Township, NJ 08043

ESI UPDATES

Express Scripts (ESI) National Preferred Formulary (NPF) Update

Program Manager said ESI periodically evaluates the formulary guide in response to marketplace changes. He said we were recently advised that they have successfully negotiated additional discounts with drug companies, resulting in an update to the NPF. Effective 4/1/2021 an additional 32 drugs will be excluded from the formulary list. There are 192 SHIF members identified who may be impacted by this update. Impacted members are receiving letters from ESI encouraging them to consult their physician to discuss the available, covered clinical alternatives. As always, physicians may request a clinical formulary exception directly through Express Scripts for patients who are medically unable to tolerate/use clinical alternatives.

GUARDIAN NURSES

Program Manager said in order to better service our membership; Guardian Nurses would like to begin reaching out to school district enrollment contacts directly in the event a member phone number is not available. The program manager's office will begin distributing contact sheets to brokers and risk managers to confirm we have the most up to date information. Response is at the will of the BOE, but we strongly encourage participation. Should a BOE not want to distribute contact information to Guardian Nurses will note and exclude them from outreach. Process will begin in Early March.

GUARDIAN NURSES CONTRACT AMENDMENT

Program Manager said Guardian Nurses has requested authorization to amend their contract to include HSX, a sub-contractor that will provide live ER and inpatient data which will allow the Nurses to reach out to these patients more quickly. Guardian Nurses is absorbing the cost, but since there is a transfer of

employee information and an amendment to their contract, we are requesting authorization. A fully executed Business Associate Agreement has been signed between both parties.

LEGISLATIVE UPDATES - COVID-19 VACCINE UPDATES

VACCINE COVERAGE

Program Manager said In December 2020 the U.S. Food and Drug Administration (FDA) issued Emergency Use Authorizations (EUAs) for the use of the Pfizer-BioNTech and Moderna COVID-19 Vaccines for the prevention of coronavirus disease. Vaccines recommended by the CDC Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) will be covered under the plan. The federal government will pay the cost of the vaccine itself. The plan will fully cover the cost of administering the vaccine at participating and non-participating providers/facilities.

HOW TO REGISTER FOR THE VACCINE

The NJ Vaccination Scheduling System (NJVSS) provides individuals with the opportunity to pre-register for the vaccine, to be notified when they are eligible, and receive information that an appointment is available to them. Eligible individuals may also visit https://covid19.nj.gov/pages/vaccine to identify a vaccination location if appointments are not immediately available on NJVSS.

UPDATED INDEXED DOLLAR LIMITS

Program Manager said the Internal Revenue Service (IRS) recently announced the below 2021 limits regarding High Deductible Health Plans (HDHP) and Health Savings Accounts (HSA).

	2020	2021
HDHP Minimum Required Deductible- Self Only	$1,400	$1,400
HDHP Minimum Required Deductible- Family	$2,800	$2,800
HSA Contribution Limit- Self only HDHP	$3,550	$3,600
HSA Contribution Limit- Family HDHP	$7,100	$7,200
HSA/HDHP OOP Maximum- Self Only	$6,900	$7,000
HSA/HDHP OOP Maximum- Family	$13,800	$14,000

COVID-19 FSA RELIEF

The last passed COVID-19 relief bill permits employers to allow members with Flexible Spending Accounts (FSAs) to roll over unused funds.

Key provisions of the new ruling include:

- option to amend cafeteria plans and FSAs to allow employees to:
  - carryover unused amounts from plan year ending in 2020 to the 2021 plan year
  - carryover unused amounts from plan year ending in 2021 to the 2022 plan year
  - provide a 12-month grace period at the end of the 2020 and/or 2021 plan years
- option to amend FSAs allowing employees to make prospective election changes for plan years ending in 2021 (with no change in status)

- allowing employees who cease participation in an FSA during calendar years 2020 or 2021 to receive post-termination reimbursements from unused benefits through the end of the plan year when participation ceases (including grace period if applicable)

ADMINISTRATIVE AUTHORIZATIONS
Program Manager said the fund received seven medical appeals, which were sent to external review since our last meeting.

Appeal Type	External Review Decision
Medical	Denial Upheld
Medical	Denial Upheld
Medical	Overturn
Medical	Overturn
Medical	Overturn
Medical	Overturn
Medical	Overturn

ARTEMIS DATA WAREHOUSE
Mr. Lodics said while preparing for the new Fund year it was realized some logistic administrative updates need to be made to our existing contract with Artemis. He said this is currently not listed as a scope of service in the Program Managers Contract as it should be. He said he is asking for an amendment through the June 30th contract to include Artemis Data warehouse as well as ratify recent payments to Artemis in the amount of $95,560.

MOTION TO APPROVE THE CONTRACT AMENDEMENT AS DISCUSSED.

Moved: Trustee Lessard
Second: Trustee Giovanelli
Vote: All in Favor

GUARDIAN NURSES – Ms. Sambuco reviewed the report included in the Agenda. She said the total number of referrals was 294, which also includes precerts and lab results. She said there were 249 acute referrals and 45 complex referrals. She said the 4 potential high claimants for 2021 are Covid related and required the ICU.

TREASURER – Fund Treasurer reviewed the bills lists for December 2020, January 2021 and February 2021 as well as the treasurer's report. She noted there were a few accounts with William Penn Bank however they recently dropped their rates significantly so the funds were transferred to other institutions.

CONFIRMATION OF PAYMENT – DECEMBER 2020

FUND YEAR	AMOUNT
FUND YEAR 2019/2020	**$123,559.00**
FUND YEAR 2020/2021	**$2,306,659.09**
TOTAL ALL FUND YEARS	**$2,430,218.09**

CONFIRMATION OF PAYMENT – DECEMBER 2020 SUPPLEMENTAL

FUND YEAR	AMOUNT
FUND YEAR 2019/2020	$20,000.00
FUND YEAR 2020/2021	$46,344.73
TOTAL ALL FUND YEARS	$66,344.73

CONFIRMATION OF PAYMENT – DECEMBER 2020 DIVIDENDS

FUND YEAR	AMOUNT
FUND YEAR CLOSED	$910,597.00
FUND YEAR 2019/2020	$74,819.00
TOTAL ALL FUND YEARS	$985,416.00

CONFIRMATION OF PAYMENT – JANUARY 2021 DIVIDENDS

FUND YEAR	AMOUNT
FUND YEAR CLOSED	$361,407.00
TOTAL ALL FUND YEARS	$361,407.00

CONFIRMATION OF PAYMENT – JANUARY 2021

FUND YEAR	AMOUNT
FUND YEAR 2020/2021	$2,272,933.13
TOTAL ALL FUND YEARS	$2,272,933.13

RESOLUTION 3-21 – FEBRUARY 2021

FUND YEAR	AMOUNT
FUND YEAR CLOSED	$12,813.00
FUND YEAR 2019/2020	$21,265.95
FUND YEAR 2020/2021	$2,464,837.29
TOTAL ALL FUND YEARS	$2,498,916.24

MOTION TO APPROVE THE BILLS LIST AND TREASURERS REPORT AS PRESENTED:

MOTION: Trustee Coleman
SECOND: Trustee Bice
VOTE: **All in Favor**

FUND ATTORNEY – Fund Attorney said Governor Murphy signed executive order 222 to extend the public health emergency, as well as executive order 225 which increased 50% capacity at religious services. He said he also signed 3 bills that essentially legalizes the use of Marijuana for non medical purposes.

AETNA – Mr. Silverstein reviewed the claims for December 2020. He said the average pepm was $1,474. He said there were 10 claims over $50,000 for December. He reviewed the dashboard and noted that all metrics perform well however the average speed of answer and financial accuracy were missed and they are taking the necessary steps to correct that. He reviewed the Covid reporting distributed with Agenda.

AMERIHEALTH – Ms. Strain reviewed the claims for January 2021. She said the average pepm was $1,431.79. There were 9 claims over $50,000 for this reporting period. She also reviewed the Covid reporting included with the Agenda.

HORIZON- None

EXPRESS SCRIPTS – Mr. Colalillo said the trend is at 7.1% with a plan cost for January at $133.48. He said the Fund did pick up 17 new high cost specialty patients. He reviewed the covid 19 treatment and vaccine document.

DELTA – None

OLD BUSINESS – None

NEW BUSINESS – Mr. Laracy he will be moving towards retirement in the next year. He said he is very confident that the service of the Fund and Growth of the Fund will continue.

PUBLIC COMMENT: None

MOTION TO ADJOURN:

MOTION:	Trustee Coleman
SECOND:	Trustee Bice
VOTE:	Unanimous

MEETING ADJOURNED: 1:00 pm

NEXT MEETING: March 24, 2021
Zoom Meeting
12:00pm

Karen Kamprath, Assisting Secretary
Date Prepared: March 16, 2021

APPENDIX II

FINANCE COMMITTEE MINUTES
March 10, 2021
10:00 am

Attendees:
Bethann Coleman, Committee Member
Joe Collins, Committee Member
Evon Digangi, Committee Member *joined at 10:10 am
Paul Laracy, PERMA
Emily Koval, PERMA
Karen Kamprath, PERMA
Brandon Lodics, Conner Strong
Jozsef Pfeiffer, Conner Strong

The Committee met to discuss 2 possible new member submissions from Shamong BOE and Ramapo Indian Hills BOE. She said Shamong was previously a member and are very interested in coming back into the Fund. She said there age / sex factor is basically the same as the Fund. She said they are looking to join on 5/1 and would receive their renewal on 6/30/2022. In response to Chair Collins, Ms. Koval said she believes their reason for previously leaving was due to cost. Ms. Koval said the claims pick for Ramapo Indian Hills is almost 12% higher than the average but that would be expected with being located in Bergen County. She said they are also a 5/1 member and would receive their renewal on 6/30/2022. She said the growth capacity with adding these two groups would be just under 35%. In response to Chair Collins, Ms. Koval said there is a lot of interest for the next Fund year. Chair Collins said as always his concern is being able to service the Fund with the additional growth. Ms. Koval said the good thing this year was the growth was spread out well throughout the year so hopefully next year would be similar. The Committee agreed to recommend both groups for approval.

Underwriting Factor	**Shamong BOE**	**Fund Average or Standard**	**Relativity**
Current Carrier or Arrangement	Horizon	Aetna	
Age Sex Factor	1.155	1.160	99.59%
Enrollment	83	14,236	0.58%
Claims Pick (Per Employee Per Month)			
Medical	$ 1,694.00	$ 1,583.00	107.01%
Rx			
Combined			
Trend + Margin Applied	14.00%	10.00%	140.00%
Risk Manager Fee Applied	3.00%		
Rate Effective Date			
From	5/1/2021		
To	6/3/2022		
Prior Fund Member?	Yes		
Lines of Coverage to Fund			
Medical	Yes		
Dental	No		
Rx	No		
Anticipated Commissioner Involvement	TBD		
Explanatory Notes or Contingencies	Previous SHIF member >3 years ago.		

Underwriting Factor	Ramapo Indian Hills BOE	Fund Average or Standard	Relativity
Current Carrier or Arrangement	Horizon	Aetna	
Age Sex Factor	1.196	1.160	103.06%
Enrollment	259	14,236	1.82%
Claims Pick (Per Employee Per Month)			
Medical	$ 1,769.00	$ 1,583.00	111.75%
Rx			
Combined			
Trend + Margin Applied	10.00%	10.00%	100.00%
Risk Manager Fee Applied	$ 60,000.00		
Rate Effective Date			
From	5/1/2021		
To	6/30/2022		
Prior Fund Member?	No		
Lines of Coverage to Fund			
Medical	Yes		
Dental	No		
Rx	No		
Anticipated Commissioner Involvement	TBD		
Explanatory Notes or Contingencies			

New Member Underwriting Status - FY 2020-2021

Group	Employees	Proposal Released	BOE Approval	Union Approval	Signed I&T	Effective Date
Lenape BOE	850	Y	Y	Y	Y	7/1/2020
Gloucester County Tech Ed	151	Y	Y	Y	Y	7/1/2020
Gloucester County SSSD	430	Y	Y	Y	Y	7/1/2020
Foundation Academy	112	Y	Y	Y	Y	7/1/2020
Maple Shade BOE	262	Y	Y	Y	Y	7/1/2020
North Hunterdon Voorhees BOE	302	Y	Y	Y	Y	10/1/2020
Gloucester City BOE	260	Y	Y	Y	Y	10/1/2020
Colts Neck BOE	183	Y	Y	Y	Y	1/1/2021
Newton BOE	179	Y	Y	Y	Y	1/1/2021
West Morris BOE	270	Y	Y	Y	Y	1/1/2021
Robbinsville BOE	291	Y	Y	Y	Y	1/1/2021
Hunterdon Central	396	Y	Y	Y	Y	1/1/2021
Medham Township BOE	97	Y	Y	Y	Y	2/1/2021
Oxford BOE	28	Y	Y	Y	Y	3/1/2021
Eastern Camden County BOE	224	Y	Y	Y	N	4/1/2021
Shamong BOE	83	Y	Y	Y	Y	5/1/2021
Ramapo Indian Hills BOE	259	Y	Y	Y	Y	5/1/2021
Total Employees	**4,377**					
% Growth	**34.65%**					

APPENDIX III

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 **Schools 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 FUND's

Executive Director/Administrator at least 10 days prior to the next regularly scheduled meeting of the FUND's Board of Trustees. 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 consent, 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

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

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.

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 than is 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 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. 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.

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 January 1, 2019. . Upon completion of the above term, AmeriHealth Administrators may, upon mutual consent, amend the fee schedule 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:

Schools 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 with the intent of accepting the contract, 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 G.

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 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 Schools 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.

SCHOOLS HEALTH INSURANCE FUND	**AMERIHEALTHADMINISTRATORS, 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. <u>Claim Services</u>. 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 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. <u>Materials</u>. 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: 2579[6]

Administrative Fees

Effective Date 1/1/19 **36-month Term 1/1/19-12/31/21**

Medical/UM	$40.00 PEPM
Disease Management	$0.00[7]
Wellness Program Credit	($1.25)
Case Management Credit	($0.25)0[8]
Stop Loss Coordination Fee	$0.00
Total Base Medical Fee	$38.50

PPO Access Fee	Amount AHA pays PPO access
Network Directories	Pass through cost from network, plus reasonable internal costs, if any
Recovery Service Fee	30% of dollar amount collected, received, or recovered
Advance Medical Deposit	$300,552.00[9]
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

Third-Party PBM Vendor Integration

[6] This Contract is based on 2579 lives. A re-quote will be required if the actual number of lives varies by more than ten percent.

[7] Administered through Guardian Nurses.

[8] Administered through Guardian Nurses

[9] The total cumulative amount for all four Health Insurance Funds is $420,522.00

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

• Bi-directional feed to third-party PBM vendor.	$15,000.00 (minimum)
Set-up (one-time fee) actual cost, hourly charge.	$ .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 Schools 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 Schools 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 interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent 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

Schools Health Insurance Fund has elected to use a third party case management service.

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

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 IV

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

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