MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND
RISK MANAGEMENT PLAN

CALENDAR YEAR 2015

(Revised July 28, 2015)

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PREFACE

The County of Middlesex and its related agencies joined together in 1995 to implement a program to address the issue of rising health care costs. These agencies created the Middlesex County Joint Health Insurance Fund ("FUND") effective July 1, 1995. The initial Fund Members were:

1. County of Middlesex
2. Middlesex County Board of Social Services
3. Middlesex County College
4. Middlesex County Improvement Authority
5. Roosevelt Care Center
6. Middlesex County Vocational and Technical School (withdrew 12/31/2003)
7. Middlesex County Utilities Authority
8. Middlesex County Mosquito Extermination Commission

The objective of the FUND is to assist its member agencies in containing medical costs through:

A. Implementation of an aggressive cost-containment management system.

B. Volume purchase of specific and aggregate reinsurance, as well as other administrative services.

C. Negotiated hospital and provider discounts.

D. Flexible benefit plan allowing member officials to negotiate changes with their employee bargaining units.

E. Risk Management Information Systems to provide member officials with the data they need to make effective long-range decisions.

F. Independent demographic rating based on exposure and experience.

I. COVERAGES

The coverages to be provided by the Fund are:

Physician services and Hospitalization Insurance

The following coverages may be provided by the Fund or subscribed to by a Local Unit separately:

Dental

Prescription

Vision

A. **CURRENT PLAN OF BENEFITS:** Section XI describes the benefits, and existing Plan Coverage for each Local Unit as of January 1, 2015.

B. **PLAN OF BENEFIT CHANGES:** Each member Local Unit is able to negotiate changes in its plan of benefits with its employee bargaining groups, provided that the change is consistent with the Fund's cost containment objectives and is approved by the Fund and its reinsurer(s). Through the Program Manager, the Fund provides member Local Units with information concerning the impact on its assessment rates so that the Local Unit can project the cost impact of a plan change.

C. **PLAN DOCUMENT:** The Fund prepares a detailed Plan Document for each member Local Unit (or each employee bargaining group within a member Local Unit as the case may be) and an employee handbook providing a summary of the coverage provided by the plan. Each booklet (or Certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

1) General Information

a) Enrollment procedures and eligibility

b) Dependent eligibility

c) When coverage begins

d) When coverage can be changed

e) When coverage ends

f) COBRA provisions

g) Conversion privilege

h) Enrollment form and instructions

2) Benefits

a) Definitions

b) Description of each benefit

i) Eligible services and supplies

ii) Deductibles and co-payments

iii) Examples as needed

iv) Plan Benefit Limits

c) Exclusions

d) Retiree coverage, before age 65 or after

3) Claim Procedures

a) Submission of claim

b) Proof of loss

c) Appeal procedures

d) HIPAA Privacy Notice

D. **RETIREES:** The Fund provides coverage for eligible Plan Participants including retirees insured by a state administered pension plan. Where the Local Unit has made arrangements for the Fund to directly bill its retirees, the Fund shall use the rates established by its Actuary. The Fund's coverage of a retiree shall terminate effective the date the member Local Unit withdraws from the Fund or otherwise ceases to be a member of the Fund.

Each Local Unit/Employer shall pay all of the premiums for employees who have retired on a disability pension, or have retired under the appropriate subsections of NJSA40A:10-23 applicable to the participants specific Local Unit. Service with the employer shall be construed for this purpose as any combination of public employment for which retirement service credit has been accrued by the employee in a state or locally administered retirement system, notwithstanding the fact that such service credit was accrued by the employment with one or more

state, county, or municipal governments or agencies, or purchased by the employee for service accrued through employment by another state or federal agency pursuant to N.J.S.A. 43:15A-73.1.

Coverage for a retiree's dependents may be paid by the employer for the lifetime of the retiree who retires in accordance with NJSA40A:10-23. Upon the death of the retiree, the spouse or eligible dependent may continue coverage but must pay the full or a portion of the premium for the selected coverage, depending on the employer's plan provisions.

E. **CONVERSION OPTIONS:** Retirees and their Dependents may purchase individual coverage, under an individual direct payment basis if the retiree is receiving a pension under NJSA40A:10-23 and is not eligible for employer paid health coverage. Employees and their Dependents are eligible to purchase the continuation of health coverage under the COBRA provisions.

F. **RUN OUT:** The Fund covers all claims incurred during the Fund year including claims incurred during the year that are paid after year end, and establishes an actuarially sound Incurred But Not Reported ("IBNR") reserve to pay the run out liability. In the event a member Local Unit withdraws from the Fund, or otherwise ceases to be a member of the Fund, prior to the end of the Fund's fiscal year, the Fund covers the run out of claims incurred by the member's active employees, its retirees, and its individuals covered under COBRA and conversion options prior to the date the member Local Unit withdraws from the Fund. For purposes of this section, incurred Claims shall be defined in accordance with the definition of this term in the Fund's excess policy.

G. **HEALTH MAINTENANCE ORGANIZATION (HMO's):** The Fund will negotiate for HMO programs on a group basis for its member Local Units. See Section XI for the summaries of HMO plans available.

H. **POINT OF SERVICE (POS)**: The Fund will offer a POS option to covered employees in accordance with the Health Care Choice Plan Document.

I. **OPEN ENROLLMENT:** Open enrollment shall occur in November and December of each year.

J. **CHARGES:** Local Units can establish the portion of costs paid by employees and retirees.

II. APPEALING A CLAIM

A. The Fund shall comply with the requirements of N.J.S.A. §17B:30-13.1 and 13.2.

B. If under a self-insured plan (Horizon Traditional, Horizon Health Care Choice, AETNA, CIGNA and MEDCO/Express Scripts), the Plan Participant is dissatisfied with the determination of the claim processor, the Plan Participant may appeal the processors determination to the Third Party Administrator (TPA) Management Review Team who shall notify the Plan Participant in writing of their determination. Subject to the provisions of the Patient Protection and Affordable Care Act (PPACA), the respective TPA's will allow two levels (Level 1 and Level 2) of appeal to the Plan Participant after the initial notification of an adverse determination.

C. If the Plan Participant is not satisfied with the determination made by the TPA Management Review Team subsequent to the Level 1 and Level 2 internal appeals as referenced above, the Plan Participant may appeal the processor's determination to the External Appeal Process of the Third Party Administrator.

Effective July 1, 2012 as required by PPACA, the external review process was implemented for adverse benefit determinations concerning medical necessity, appropriateness, health care setting, level of care, rescission of coverage or effectiveness of a covered benefit.

Therefore, for services obtained on or after July 1, 2012, if a Plan Participant is dissatisfied with the results of the carrier appeal process, he/she may pursue an External Appeal with the TPA's Independent Review Organization. To do so, the Plan Participant must send a written request to the Carrier/TPA within four (4) months from receipt of the carrier's final adverse benefit determination.

D. The Plan Participant may appeal an adverse determination (not relating to medical judgment as defined in italics in Section II C above) by the TPA concerning a claim to the Fund Commissioners by forwarding a copy of the determination letter issued by the TPA to the Executive Director. The Executive Director shall schedule a meeting of the Fund Claim Appeals Committee. Prior to distribution of any writing concerning the appeal, all reference to the Plan Participant or the Local Unit Employer shall be stricken. The Plan Participant may attend the closed session and/or may be represented at the meeting, provided that the Plan Participant has executed a Waiver of Confidentiality Form provided by the Fund in advance of the meeting designating the representative who shall also execute a Confidentiality Agreement. The Committee shall render its decision (or deferral pending receipt of additional information) upon conclusion of the deliberations, and confirm the determination in writing with the reasons therefore within five (5) days thereafter. An appeal involving a claim of Two Thousand Dollars ($2,000) or less may be determined by the Fund Administrator without the necessity of calling a meeting of the Fund Appeals Committee. Any such appeal decisions will be documented and approved by the Commissioners.

E. If the Plan Participant is dissatisfied with the determination of the Appeals Hearing Committee or Fund Administrator, as applicable, the Plan Participant may exercise any remedies provided by law. In the event that such remedies include an independent external review (other than an Independent Review Organization appeal as mandated by the terms of the Patient Protection and Affordable Care Act), the Plan Participant and the Fund shall each be responsible for any and all of their own costs and legal fees incurred in connection with such review.

F. A participant in a fully insured plan will be subject to the Claim Appeal procedures under the fully insured Plan.

III. CONFIDENTIALITY

A. The Plan Participant's claim information is privileged and confidential and shall not be included as a part of any open public record.

B. Fund Commissioners and Local Unit officials shall not have access to any employee claim information which reveals the identity of any individual Plan Participant.

C. All claims and inquiries are to be handled directly by the Third Party Administrator. All employees of the Third Party Administrator handling the Fund's claims shall execute a nondisclosure statement to protect the identity of the Plan Participants.

D. Only Fund Commissioners/Executive Committee members and necessary Fund professionals shall participate in any closed session discussion of claims. These claims discussions, whether general or specific to a coverage dispute, shall at all times be confidential and anonymous so that the identity of the Local Unit and/or claimant cannot be ascertained. When necessary, as in a specific claim dispute, the anonymity of the claimant shall be accomplished by assigning a blind claim number and deleting all reference to the individuals name or place of employment. The claimant may demand the matter be handled with disclosure of his identity by so demanding in writing to the Fund Commissioners/Executive Committee.

E. Documents identifying the employee, or from which the employees identity might be deduced shall not be accessible to any persons other than the Third Party Administrator, Administrator/Executive Director, Fund Attorney, when strictly necessary, or duly appointed claim auditors when such records are needed to verify the accuracy of claim data as part of an audit.

F. Any person having access to claim information must sign a written non-disclosure agreement.

G. The Fund will provide Participants with a notice of the uses and disclosures of protected health information.

H. The Fund will maintain procedures and policies intended to comply with the Standards for Privacy or Individually Identified Information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

IV. ENROLLMENT

A. All plan documents will have the following language: You may remove family members from the policy at any time but you may only add members within sixty (60) days of the change in family status, (marriage, birth of a child, etc.). It is the employee's responsibility to notify their employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until the employee has formally requested that change. Newborn or adopted children shall be automatically covered from birth for thirty one (31) days even if not enrolled within the required sixty (60) days.

B. Participating employees shall have an open enrollment period in November and December of each year, during which they may switch between the available options. The changes shall be effective at the beginning of the next Fund year.

V. REINSURANCE AND SELF-INSURED RETENTIONS

For coverages provided on a self-insured basis, the Fund shall secure excess insurance and/or reinsurance from an insurance company in a form and an amount acceptable to the Commissioner of Banking and Insurance. The policy form may include provisions for aggregate reinsurance in addition to specific (individual) reinsurance.

A. Fund's Retained (i.e. self-insured) Limit of Liability

1) The following specific limit applies per enrolled participant per plan for claims incurred on or after January 1, 2015: Traditional ($500,000), PPO ($500,000) Health Care Choice ($500,000), CIGNA HMO ($500,000), and Aetna HMO ($500,000).

2) No aggregate limit is in effect for 2015 under the self-insured plans.

B. Insurer's Limit of Liability is unlimited.

C. Reinsurance Policy Form agreements cover claims incurred from January 1, 2015 through December 31, 2015 and paid between January 1, 2015 through December 31, 2016.

Reinsurance coverage shall include applicable prescription drug card expenses and is subject to the terms and conditions in the Policy forms.

VI. CONTRACTED SERVICES

A. **EXECUTIVE DIRECTOR/FUND ADMINISTRATOR:** The Fund shall contract with an Executive Director/Fund Administrator. The Executive Director/Fund Administrator will have the following responsibilities:

1) Carry out the policies established by the Fund Commissioners or Executive Committee, and otherwise administer and provide for the day-to-day management of the Fund.

2) Prepare for approval of the Executive Committee/Commissioners, and implement the Fund's operations manual and the policy and procedures manual.

3) Prepare the Fund's budget, compile and bill the monthly assessments to each Local Unit.

4) Maintain the Fund's underwriting files, including census data, prepare new member submissions for review by the Executive Committee/ Commissioners, and supply underwriting data to other Fund professionals as needed.

5) Oversee the Treasurer's maintenance of the Fund's general ledger, accounts payable, and accounts receivable functions.

6) Prepare minutes of each Fund meeting.

7) Prepare and submit all filings required by State regulations including monthly and quarterly financial reports.

8) Attend all meetings of the Executive Committee/Commissioners and Professionals.

9) Prepare agendas for monthly meetings of the Executive Committee/ Commissioners and an agenda package which is to be submitted in advance to Commissioners and Fund Professionals.

10) Manage and administer all participant complaints and direct them to appropriate professionals.

11) Manage and administer all claim appeals.

12) Manage and be responsible for communications with the Department of Personnel and Benefit Coordinators of each Local Unit, Commissioners and the employees of the Local Units.

13) Perform such other duties specified by the Executive Committee/ Commissioners.

14) Coordinate the activities of the various Fund Professionals and develop appropriate procedures with regard to the flow of information between and among Professionals and Commissioners.

15) Negotiate all vendor contracts.

16) Serve as Custodian of Fund records and maintain same.

17) Develop checklist of required regulatory filings.

18) Prepare monthly financial reports for the New Jersey Department of Banking and Insurance.

19) Manage and oversee the MCJHIF Eligibility System.

20) Coordinate the financial reports of the Treasurer.

21) Assume overall executive responsibility for the operations of the Fund except that the EXECUTIVE DIRECTOR/FUND ADMINISTRATOR shall not be responsible for the errors and omissions of any other servicing organization except as to generally monitor the compliance of said organization with the directives of the Executive Committee/ Commissioners, their Service Provider Contract, or the applicable statutes and regulations as to the form and timeliness of said undertakings. For example, the Administrator shall be responsible to verify the issuance of excess or reinsurance policies, and the timely receipt of said policies by the Fund, however, the Administrator shall not be responsible for the content of the policies or the adequacy of the coverage.

B. **PROGRAM RISK MANAGER**: The Fund shall contract with a program manager who will perform the following functions:

1) Meet with and advise various subcommittees established by the Fund for purposes of plan design and cost containment.

2) When required, prepare required written specifications for review by the Fund Commissioners/Executive Committee for HMOs, POS, TPAs, managed care and cost containment providers, reinsurance, claim auditors, technical writers and, at the request of the Fund Commissioners/Executive Committee, secure these services and/or reinsurance in compliance with the Local Public Contracts Law.

3) Prepare required written reports to the Fund Commissioners/Executive Committee and the Executive Director concerning the compliance of the various service providers listed in paragraph 2, above with respect to the written specifications, provided, however, that this evaluation is not intended to be in the scope of an audit and shall not include financial related reviews, or evaluate the accuracy of claim payments.

4) Provide field services to the member Local Units including:

   a) Resolve coverage, claims and service questions for employees and bargaining units.

   b) Advise member Local Units concerning plan design changes, present such changes to the Fund Commissioners/Executive Committee for approval in accordance with the Funds' procedures and coordinate all appropriate revisions to documents necessitated by such changes.

5) Identify Local Units which may qualify for membership, be available to discuss the Fund with potential members, assist in the preparation of applications, review the new member submissions prepared by the Executive Director and coordinate the field level implementation of the program in the event the Local Unit is accepted for membership by the Fund Commissioners/Executive Committee.

6) Attend all meetings of the Fund Commissioners/Executive Committee.

7) Perform such duties as may be reasonably requested by the Fund Commissioners/Executive Committee.

C. **THIRD PARTY CLAIMS ADMINISTRATOR ("TPA"):** The Fund shall contract with a TPA to adjudicate major medical and hospitalization claims and generate claim reports and other related information. The TPA performs the following functions:

1) Process all medical claims and prepare an Explanation of Benefits form, as well as the benefits checks, for all participants in accordance with the written provisions of the plan. TPA shall have authority to settle all claims up to $25,000. Any claim in excess of $25,000 must be brought

before the Commissioners for approval. The TPA may pay claims in excess of $25,000 in order to secure provider discounts with the understanding that if the Commissioners do not approve such payments due to a finding of processing error on the part of the TPA, the TPA will recover such payments and/or reimburse the Fund for the amount of the incorrect payment.

2) Furnish monthly statements of all claims paid. The monthly statements shall not reveal the name or identity of the employee or claimant.

3) Provide any statistical information or claims information as may be required for annual statements under ERISA and TEFRA.

4) Maintain and file the appropriate Internal Revenue Service Forms as may be required under Revenue Ruling 70- 06B.

5) Pay any New York Pool Surcharges required by the Fund.

6) Coordinate COBRA administration with selected COBRA administrator.

7) Provide all other services necessary for the proper administration of the plan.

D. **BUSINESS ASSOCIATE AGREEMENT:** All Professionals and firms providing contractual services to the Fund shall executive a Business Associate Agreement pursuant to the HIPAA Privacy regulations.

VII. COST CONTAINMENT SERVICES

Cost Containment procedures for each Local Unit will depend on the Local Unit's benefit plan design. Services are provided by contract with the Fund's network providers.

A. PRE HOSPITAL REVIEW

The Pre-Admission Certification Program works with the physician to determine the most effective and efficient course of treatment and confirms to the covered participant that the care is medically necessary and appropriate. For medical, surgical, obstetrical, mental health, or substance abuse admission requests, this program works with attending physicians to determine whether:

Hospitalization is medically necessary
Length of stay is appropriate
Another form of treatment is available and appropriate
A diversion to an alternate care facility is possible

B. SECOND SURGICAL OPINION

The Second Surgical Opinion benefit is designed to provide the eligible participant with an additional medical opinion when an elective, non-emergency surgical procedure is recommended. This provision helps to prevent unnecessary surgery, protecting the participant from the inconvenience and trauma of an operation that could be avoided.

Surgeries requiring second surgical opinion shall be defined in the Plan documents.

C. LARGE CASE MANAGEMENT

The large case management program involves a professional coordination of health services through assessment, service plan development and monitoring to identify potential candidates for large case management intervention through the use of established criteria; Determine treatment alternatives and assist in designing medically appropriate treatment options; and Manage the patient's health care benefits, preventing unnecessary exhaustion of resources by applying cost adaptations when necessary, to produce the most cost effective use of health care dollars.

Prime cases for large case management are those showing high claims costs, extended lengths of confinements, discharge planning complications and diagnostic categories which typically require extensive medical intervention.

D. CONTINUED STAY REVIEW

During hospitalization, the patient's progress is continuously tracked and monitored through discussions with the attending physician to ensure that the treatment plan is being followed.

VIII. ASSESSMENTS

A. BASE MONTHLY ASSESSMENT

By November 30th of each Fund year, the Actuary shall compute the probable net cost for the next Fund year, and the Executive Director shall prepare a draft budget for the review of the Fund Commissioners/Executive Committee. Each member's base monthly assessment shall be one twelfth of its pro rata share of the adopted budget based on its actuarial rates computed by the Actuary [standard premium computed by the Actuary]. The Fund Commissioners/Executive Committee may also adopt a capping formula which distributes the increases in base monthly assessments so that no member's per employee rates increase by more than the average fund-wide increase plus a percentage specified by the Fund

Commissioners/Executive Committee. Each member's base monthly assessment shall be certified by majority vote of the Fund Commissioners or Fund Commissioners/Executive Committee as applicable to the governing body of each participating Local Unit at least one (1) month prior to the beginning of the next fiscal quarter.

B. RATING PERIODS FOR INITIAL MEMBERS AND FOR MEMBERS JOINING THE FUND

During the Fund's Fiscal Year, there are factors considered in the development of adjusted rates for new members. The rating period for initial members is the number of months until the end of the initial Fund Year. Rates for additional members joining during the Fund Year are established independently by the Actuary and take into consideration cost trends from the beginning of the Fund's fiscal year until the date the new member joins the Fund. For example, if the projected medical trend is 18%, the actuarial rates for a Local Unit joining the Fund six (6) months into the Fund year would be 9% higher than if the Local Unit joined effective at the beginning of the Fund Year.

C. ADJUSTED MONTHLY ASSESSMENT

Forty five (45) days prior to the beginning of the second, third and fourth quarters, the base monthly assessment for each Local Unit shall be adjusted if necessary as follows:

1) With the approval of the Fund Commissioners/Executive Committee the Administrator/Executive Director shall modify the base monthly assessment for each member unit to reflect changes in the plan of benefits and employee census. The Executive Director/Fund Administrator shall use a rating structure approved by the Actuary.

2) The Actuary shall project:

   a) The amount of claim payments the Fund is expected to pay during the next quarter.

   b) The value of claims to be incurred but unpaid as of the end of the next quarter.

3) The Treasurer shall deposit each member's assessment into the applicable accounts including the Administrative Account, Contingency Account and the Claim or Loss Retention Trust Fund Account by Fund year.

D. CLAIM RESERVING PRACTICES AND SUPPLEMENTAL ASSESSMENTS

The Fund complies with statutory accounting standards and establishes reserves based on the probable total claim cost at conclusion. Section X explains the assumptions and methodology used by the Actuary to calculate policy and claim reserves. The Fund Commissioners/Executive Committee shall by majority vote levy on the participating Local Units additional assessments whenever needed or so ordered by the Commissioner of Insurance to supplement the Fund's Claim Loss Retention or Administrative Accounts to assure the payment of the Fund's obligations. No retiree or individual directly billed for coverage under COBRA or conversion options shall be subject to supplemental assessment and any such deficits shall be assessed to the appropriate member Local Units.

1) All supplemental assessments shall be charged to the participating member Local Units by applicable Fund year, and shall be apportioned by that year's assessments for that line of coverage.

2) All Local Units shall be given thirty (30) days advance written notice of the Fund's intention to charge an additional assessment, and the Fund shall conduct a hearing before adopting the supplemental assessment.

3) The Fund shall submit to the Commissioners of Banking and Insurance and the Department of Community Affairs a report of the causes of the insufficiency, the assessments necessary to replenish it and the steps taken to prevent a recurrence.

4) Where the Fund agrees to process the run-in liability of a member Local Unit which was previously self-insured, and then charge the Local Unit an amount equal to run-in liability, the following procedure will be followed. The initial assessment for the run-in shall be at least adequate to cover the projected cash flow during the initial Fund Year, payable in two installments, and shall be subject to an agreement by the member Local Unit that in the event the initial assessment proves inadequate to cover the total cost of the run-in including expenses and claims, the Fund shall charge the member Local Unit an additional assessment which shall be due the following Fund Year. Run-in claims are not paid through reinsurance. Individual run-in liability is incurred and paid for by the Local Unit.

E. FAILURE OR REFUSAL TO PROVIDE REQUIRED ASSESSMENTS

Should any member fail or refuse to pay its assessments or supplemental assessments, or should the Fund fail to assess the funds required to meet its obligations, the Chairperson, or in the event by his or her failure to do so, the custodian of the Fund's assets shall notify the Commissioner of Banking and

Insurance and the Commissioner of Community Affairs. Past due assessments shall bear interest from the due date at the rate of interest established annually by the Fund Commissioners or Fund Commissioners/Executive Committee on any assessment not paid within thirty (30) days of the date due.

F. INSOLVENCY OR BANKRUPTCY

Insolvency and/or Bankruptcy of a member does not release the Fund, or any other member, of joint and several liability for the payment of any claim incurred by the member during the period of its membership, including, but not limited to, being subject to and liable for supplemental assessments.

IX. ACTUARIAL METHODOLOGY

A. CLAIMS RESERVES METHODOLOGY AND ASSUMPTIONS

A full claim study lag is used.

The claim lag study is similar to methods used by many health insurance carriers. In this method, the following steps are undertaken:

1) Claims are tabulated by month of incurral and lag (number of months between incurral and payment).

2) Exposures are obtained for the corresponding incurral months.

3) Paid pure premiums, defined as the ratios of claims to exposures for each of the incurred/paid cells of the claim lag table are computed.

4) Completion factors for each incurral period are developed.

5) The estimated ultimate pure premium for a given incurral period is equal to (3)/(4). The estimated ultimate pure premiums for recent months tend to produce unreliable results because of their relatively low level of completion. To correct for this effect, the average of pure premiums for another period after adjustment for trend may be substituted for these recent premiums.

6) The ultimate incurred claims for a given incurral period is then equal to the ultimate pure premium (5) times the exposure for the incurral period.

7) The actuarial liability is then equal to (6) less claims incurred and paid to the valuation date.

For some purposes, actuarial liabilities have implicit or explicit margins. Actuarial liabilities for claim reserves are best estimates, i.e. the estimate provides for no implicit or explicit margin.

When certain Local Units enter the Fund, claims incurred prior to their initial entry date into the Fund, or the date of their first assessment, may be paid by the Fund. This is referred to as run-in liability. This run-in liability is projected separately at the time the Local Unit joins the Fund.

The actuarial reserve estimates make no provision for terminal liability. This refers to liability incurred by the plan as a result of the termination of a Local Unit. The Local Units have executed agreements which hold each other jointly and severally liable for all claims and expenses incurred by the Fund. Assuming that this is the case, there is no need to establish any additional liability for this item.

No provision in the Actuary's projections is made for the liability for loss adjustment expenses. Further, the Actuary's figures are before any consideration of reinsurance.

B. INITIAL AND RENEWAL EXPECTED LOSS ASSESSMENT METHODOLOGIES

The following describes methodology and assumptions for the development of expected losses. It is important to note that:

1) The Actuary's expected loss rates are estimated to provide for incurred claims during the renewal period to which they apply. No portion of these rates are available to funding existing or future funding deficiencies and no portion of these rates is a distribution of prior funding surplus. Fund deficiencies are covered by additional assessments as detailed in the Bylaws and Plan of Risk Management.

2) The Actuary's expected loss rates make no provision for administrative costs.

3) The Actuary's expected loss rates are intended to reflect claims cost before consideration of claims expected to be paid by aggregate stop-loss reinsurance, and net of claims expected to be paid by specific stop-loss reinsurance.

4) The Actuary's expected loss rates make no provision for premiums for reinsurance.

5) The Actuary's expected loss rates make no provision for run-in liability.

6) The Actuary's expected loss rates are only estimates of plan costs based on best estimate actuarial assumptions. Actual plan costs may vary from these estimates.

7) Billing rates used are the responsibility of the Fund's management. However, the total loss Fund budget is at least equal to the actuarial rates and the Fund reconciles the billing rates to the budget on a periodic basis.

Renewal Methodology

Actuarial assumptions employed in the development of renewal rates are those commonly employed in underwriting group health insurance.

Specific values of these assumptions will vary from year to year. The following approach will be employed in developing future renewal rates.

1) Incurred claims for a recent period (the experience period) will be reviewed.

2) An Experience Period Central Rate ("EPCR") will be developed for the experience period. This is the product of incurred claims, a seasonally adjusted factor and an adjustment for specific stop-loss reinsurance divided by the exposure.

3) These experience period central rates and the current central rates (i.e. those currently applied to develop assessments for expected losses for the current Fund year) are then trended from the mid-point of their respective experience/renewal period to the mid-point of the next renewal period.

C. RATES FOR RETIRED MEMBERS

Retired lives insured by the Fund fall into two basic categories: (1) those not eligible for Medicare, and (2) those eligible for Medicare.

Members in category (1) are combined with the active employee population of the group.
For members in category (2), Medicare is the primary payer. Rates for these groups are based on an adjustment factor applied to active employee rates. This adjustment accounts for the demographics of this population as well as the reduction in claims costs due to the fact that Medicare pays a portion of plan costs.

X. CLOSURE OF FUND YEAR

Each individual Fund year will be closed after the expiration of the corresponding fund years' reinsurance contract and all liabilities, as certified by the actuary and auditor, have been satisfied. Typically ninety eight percent (98%) of all claims are known within twelve (12) months after the end of the fund year and unless reinsurance recovery or any claim litigation is involved that would require the Fund to request an extension from the Commissioner of Insurance the Fund will adhere to the following schedule. The following is the normal closure and return of surplus schedule:

15 months after the end of the Fund's Fiscal year: Receipt of the actuarial report.

16 months after the end of the Fund's fiscal year: Receipt of the Auditor's financial statement.

17 months after the end of the Fund's fiscal year: Presentation of Actuary's report and Auditor's financial statement to Fund Commissioners/Executive Committee for review.

18 months after the end of the Fund's fiscal year: Fund Commissioners/Executive Committee declare surplus or deficit as certified by the Fund Actuary and Auditor and the Fund Year closed.

Any deficits shall be carried over to the current year and funded through a special assessment in accordance with Article VIII(4) before the end of the year

Surplus refunds are to be made in accordance with N.J.A.C. 11:15-3.20 and Article VIII of the Fund's Bylaws.

XI. MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND HEALTH INSURANCE PLANS AVAILABLE FOR 2015

Middlesex County

Horizon Traditional Plan – (closed to new entrants)
Horizon Health Care Choice Plan
Cigna
Aetna
Oxford Freedom Access
Express Scripts, Inc. Prescription Plan
Delta Dental
Aetna Dental

Middlesex County College

Horizon Traditional Plan **(includes prescription drug coverage)**
Horizon Health Care Choice Plan **(includes prescription drug coverage)**
Cigna **(includes prescription drug coverage)**
Aetna

Middlesex County Improvement Authority

Horizon Traditional Plan – (closed to new entrants)
Horizon Health Care Choice Plan
Cigna
Aetna
Oxford Freedom Access

Middlesex County Mosquito Extermination Commission

Horizon Traditional Plan – (closed to new entrants) (includes prescription drug coverage)
Horizon Health Care Choice Plan (includes prescription drug coverage)
Cigna **(includes prescription drug coverage)**
Aetna
Oxford Freedom Access

Roosevelt Care Center

Horizon Traditional Plan - (closed to new entrants)
Horizon Health Care Choice Plan
Cigna
Aetna
Oxford Freedom Access

Middlesex County Board of Social Services

Horizon Traditional Plan - (closed to new entrants)
Horizon Health Care Choice Plan
Cigna
Aetna
Oxford Freedom Access
Express Scripts, Inc. Prescription Plan
Delta Dental
Aetna Dental

Middlesex County Utilities Authority

Horizon Traditional Plan
Horizon Health Care Choice Plan
Cigna
Aetna
Oxford Freedom Access
Express Scripts, Inc. Prescription Plan

** Please note:

Effective December 31, 2010, the Oxford HMO plan has been terminated and transitioned to the Oxford Freedom Access plan effective January 1, 2011.

Effective December 31, 2010, the Health Net HMO plan has been terminated and transitioned to the Oxford Freedom Access plan effective January 1, 2011.

Effective January 1, 2012, prescription drug benefits will be offered to the Middlesex County Administration, Middlesex County Board of Social Services, and the Middlesex County Utilities Authority through Medco Health Solutions, Inc. known as Express Scripts, Inc.

Effective February 2014, dental benefits will be offered to the Middlesex County Administration and the Middlesex County Board of Social Services through two dental providers.