New Jersey Schools Insurance Group
6000 Midlantic Drive Suite 300 North
Mount Laurel, New Jersey 08054
(609) 386-6060 • FAX (609) 386-8877
www.njsig.org

1-888-NJ Pool 1

Board of Trustees Meeting of October 25, 2016
Action Item
2016/2017 Plan of Risk Management Amendment

The attached 2016/2017 Plan of Risk Management has been amended to provide the agents and brokers defined guidelines.

The approved plan will be filed with the Department of Banking and Insurance (DOBI).

Recommended Resolution: Approve the attached amended 2016/2017 Plan of Risk Management as presented.

William Mayo

William Mayo, CPCU, ARM
Executive Director

PROPOSED

New Jersey Schools Insurance Group

RISK MANAGEMENT PLAN

2016/2017

Rev.: 10/10/16

TABLE OF CONTENTS

TABLE OF CONTENTS Continued

NEW JERSEY SCHOOLS INSURANCE GROUP

RISK MANAGEMENT PLAN

The mission of the New Jersey Schools Insurance Group, a nonprofit school insurance pool, is to provide the availability of insurance to the New Jersey school districts by offering the best coverage at the lowest possible cost and by providing insurance education and risk management services.

I. INTRODUCTION

The New Jersey Schools Insurance Group (NJSIG) is a School District Self Insurance Fund formed under the provisions of N.J.S.A. *18A: 18B-1 et. seq*. As indicated by the Fund's name, the NJSIG's membership is comprised of Boards of Education.

The NJSIG commenced operations in October 1983.

The Fund's objectives include the following:

1. Providing qualified school districts with a long-term alternative to the conventional insurance market as a means of stabilizing the otherwise cyclical nature of insurance expenditures;

2. Maintaining a pro-active posture of safety and loss prevention programs specific to issues inherent in modern school district operations;

3. Aggressively evaluating, defending and/or settling claims made against member districts which fall within the coverage's afforded through the Fund.

4. Maintaining a conservative funding posture in an effort to ensure long-term financial security for the Fund and, by extension, the membership thereof.

II. COVERAGE PROVIDED, LIMITS OF LIABILITY, SELF INSURED RETENTION AND DEDUCTIBLES

A. GENERAL

The NJSIG offers coverage to its member districts either directly or through the commercial insurance market through one or more of the following vehicles:

- Pooled Self Insurance
- Excess Insurance
- Reinsurance
- Individual Contracts

The NJSIG offers its member districts the following coverage's:

1. Workers' Compensation and Employers' Liability

2. Automobile and Equipment Liability, General Liability and Property Damage;

3. School Board Legal Liability

4. Boiler and Machinery

5. Crime and Position Bonds

6. Electronic Data Processing

7. Excess Liability

8. Supplemental Indemnity

9. Cyber Liability

10. Crisis Management

11. Environmental

The specific limits of liability of the various coverages afforded by the Fund incorporates individual district deductibles, funded self-insured retention, and various jointly purchased conventional and excess/reinsurance policies. Unless specifically stated to the contrary, limits shown in the following sections, shall be considered to be inclusive of applicable pooled self-insured retention.

The specific structure of the Fund includes elements of risk retention and risk transfer, which reflects what is believed to be optimal limits of risk retention and transfer. The structure capitalizes on the collective financial and purchasing strength of the districts comprising the Fund's membership. The Fund also provides for aggregate excess insurance where applicable.

B. PROPERTY

1.	Limit of Liability	$ 450,000,000 Per Occurrence
2.	NJSIG Self Insured Retention (SIR)	$1,000,000 Per Occurrence
3.	Member District Deductible	optional $1,000 to $50,000
4.	Perils Included	see policies "Appendix A"

C. BOILER AND MACHINERY

1.	Limit of Liability	$100,000,000 per loss
2.	NJSIG Self Insured Retention	$0
3.	Member District Deductible	12 hours/$1,000 - $5,000
4.	Policy Sub-Limits/Extensions/Conditions	see policy

D. COMPREHENSIVE GENERAL AND AUTOMOBILE LIABILITY including Employee Benefits Liability

1.	Limit of Liability	up to $31,000,000 Per Occurrence
2.	NJSIG Self Insured Retention (SIR):	$500,000 Per Occurrence
3.	Member District Deductible	Liability - Options $0-$50,000 Except $1,000 Employee Benefits
4.	Insuring Agreement	Provides coverage for bodily injury, property damage and personal injury liability to which this insurance applies arising out of the business activities of any member district. See policy for further details.

E. WORKERS' COMPENSATION

1.	Limits of Liability:	
	- Workers' Compensation	Statutory benefits as required by the State of New Jersey
	- Employers Liability/Occupational Disease	$2,000,000 Per Occurrence
2.	NJSIG Specific Self Insured Retention	
	-Workers' Compensation	$1,000,000
	- Employers Liability/O.D.	$1,000,000
3.	Member District Deductible	None

As respects any one loss and/or accident or diseases and/or claim(s) and/or occurrence(s), including suit(s) brought in connection therewith, the NJSIG Loss Fund shall not be charged with any amount in excess of $1,000,000 as respect any one loss and/or accident or disease and/or claim(s) and/or occurrence(s), including suit(s) brought in connection therewith.

F. SCHOOL BOARD LEGAL LIABILITY

1.		Limits of Liability Up to $31,000,000 Per Occurrence/Aggregate, per member, claims made from prior acts available Limit chosen by district subject to retro-active dates in some cases.
2.	Member Deductible:	Minimum $5,000 to $200,000 Coverage A
3.	Member District Deductible	Minimum $5,000 to $50,000 Coverage B
4.	Insuring Agreement A: - Wrongful acts	see policy for details
5.	Insuring Agreement B:	see policy for details -non monetary damages defense costs.
6.	NJSIG Self Insured Retention	$0
7.	$1,000,000 to $31, 000,000 written as separate coverage with separate terms and conditions – see policy.	

G. REINSURANCE

A. The NJSIG may purchase reinsurance or excess insurance subject to the terms and conditions of the excess or reinsurer. The NJSIG has purchased reinsurance for the following:

1. Property: The NJSIG cedes 100% net loss per occurrence excess of $1,000,000 to a maximum of $450,000,000.

2. Comprehensive General Liability and Automobile Liability: The NJSIG retains $500,000 and cedes 100% each and every occurrence on an indemnity only.

3. Workers' Compensation: The NJSIG places excess statutory limits of liability and employers' liability in excess of $1,000,000 per occurrence.

B. The cost of reinsurance is variable depending on values or exposure insured. The final number will be determined by audit at year-end. Based upon known exposure at May 20, 2015 the cost will be as follows:

1.	Workers' Compensation	$ 1,497,416
2.	General Liability	$ 1,084,324
3.	Auto Liability	$ 1,175,998
4.	Property	$10,116,908
5.	Boiler & Machinery	$ 869,144
6.	Excess Liability	$ 3,915,322
7.	Errors & Omissions	$13,528,119
8.	Electronic Data Processing	$ 135,408
9.	Crime/Bond	$ 162,356
10.	Supplemental Indemnity	$ 1,010,931
		$33,495,926

III. OPERATIONAL PHILOSOPHY

A. GENERAL

As is the case with any organization, an established operating philosophy, formalized in documentation such as this, is a necessary precursor to success. This section of the Risk Management Plan is developed to provide general instruction for employees and providers of service to the Fund. Also included here are sections, which restate (and amplify) the roles and responsibilities of important parties and stress the importance of activities upon which the long-term success of the Fund will hinge in whole or in part.

B. SUB FUNDS

NJSIG has divided the state into 7 geographical groups known as sub funds. An eighth group of members (non-geographical) encompasses the entire State. Therefore, there are 8 sub-groups of members called sub funds.

These sub funds have no decision making authority relative to the operation of NJSIG. Sub fund governing documents do not supersede NJSIG bylaws and Plan of Risk Management (PoRM).

Each sub fund is individually rated for workers' compensation (WC) based on that particular sub fund's loss profile. This rating is performed yearly by an independent actuary. The implemented rates are evaluated by the NJSIG actuary to ensure the appropriate assessment is collected.

A sub fund administrator is assigned to each of the 7 geographical sub funds. That administrator is an insurance broker which has demonstrated school board risk management expertise. The administrator/NJSIG relationship is defined by a contract. That contract is reviewed and approved by the NJSIG Trustees.

NJSIG members are assigned to a sub fund by the NJSIG Underwriting Department in conjunction with the sub fund administrator. Continued membership in the sub fund is predicated on that member meeting the minimum standards of participation and maintaining the required loss profile as defined by the eligibility requirements listed in the Safety and Loss Prevention section of this PoRM.

Members may be removed from a sub fund (see Article III, Section 21, Subsection a, Eligibility Requirements) if they do not meet the eligibility requirements as defined in the Safety and Loss Prevention section of this PoRM upon recommendation of the NJSIG Loss Control Manager.

C. PREMIUM CONTRIBUTION

1. By May 15th of each year, the Actuary shall compute the probable net cost for the upcoming Fund year by line of coverage.

2. The annual assessment of each member school district shall be its pro-rated share of the probable net cost for the upcoming year for each line of coverage as computed, giving consideration for experience modifiers.

3. The Trustees may approve the division of the Group into one or more sub funds for rating or other purposes. A district's right to continue membership in a particular sub fund for the full term of its membership with the Group is contingent upon meeting the eligibility requirements defined in this Plan of Risk Management.

   * See note to "D" General Auto Coverage and Workers' Compensation

4. The calculation of contribution for each school district shall be based on the overall Fund year budget. Contributions may be modified to reflect the Loss History or other pertinent data of the individual districts.

5. The total amount of each member's annual assessment shall be certified by majority vote of the Trustees to the governing body of each member school district at least one (1) month prior to the beginning of the next fiscal year, provided the district has sent in required renewal information, and where necessary insurance or reinsurance is in place to support the quote.

6. The annual assessment shall be paid in twelve (12) installments in the case of workers' compensation and one installment for all other coverage's.

7. In the event the final budget passed in June necessitates changes in the annual assessment, a second installment shall be made to reflect this difference. (This is being said because regulations require us to say it. In the Group's history, this has never happened.)

D. AGENTS AND BROKERS

Member districts are required to retain the services of their own agent or broker. Services expected of agents and brokers are as follows:

a. The Agent or broker designated by the member district shall be retained in conformance with applicable State Law or regulation.

b. Agents or Brokers shall be paid by the Group a fee as defined in the risk management fee policy updated May 20, 2015. This fee is added to the premium contribution of that member district.

c. The Agent or Broker's specific responsibilities shall include but not be limited to:

   (1) The evaluation of the district's exposures.

(2) The explanation of the various coverages available from the Group.

(3) The preparation of reports, applications, statements of values, etc., required by the Group.

(4) The review of the school district's premium contribution and assisting in the preparation of the district's insurance budget.

(5) The review of the losses and engineering reports and providing assistance to the school district's safety committee.

(6) Assisting in the claims settlement process.

(7) Attendance at the meetings of the Trustees is encouraged and the performance of such other services as required by the school district or the Group.

(8) Attendance at sub fund meetings by the named broker of record relative to their member districts.

d. The Agent or Broker shall be a New Jersey licensed Property/Casualty Insurance Producer who has demonstrated and provided proof of prior experience in the management of public entity insurance risks. The Agent or Broker shall have at least a $5,000,000 **per claim** errors & omissions **insurance** limit **and provide evidence of coverage to NJSIG. Brokers earning less than $30,000 of annual NJSIG commission may request an annual exemption for the $5,000,000 insurance limit requirement. Such requests must be submitted to the Underwriting Manager in writing.**

E. CLAIMS RESPONSE AND RESERVING

1. CLAIM DEPARTMENT STATEMENT

a. Customer Service

The goal is to provide extraordinary claim service to all member districts, as our membership ultimately determines the degree of success of our department. Of significance is the strong need to have all our members feel a partnership in developing case conclusions.

b. Quality Services

Departmental procedures in the claim handbook have been developed to meet the present and future needs of our members. Such procedures are constantly reinforced with pride in "doing things right the first time", thereby building membership loyalty. Getting consistent results is the clearest measure of quality service.

c. Productivity through People

The department's services are truly "people intensive" as people are considered the highest value. All business begins with people as clients. Likewise, the support staff of the department will provide extraordinary member service as partners with the membership.

d. Integrity

There are no degrees of integrity. "Doing what we say and when we say it will be delivered" is the cornerstone of integrity as is honesty, fairness, ethics and legality. There is never room for compromise around integrity.

e. Reporting

In addition to the following reporting and other requirements, any member district shall have access to their files in our computer system.

STANDARDS OF PERFORMANCE

2. GENERAL LIABILITY/AUTO/E&O

a. Coverages

Claims will be promptly reviewed for coverage with the expected result being a prompt, accurate coverage determination. If there is a question on coverage, the issues will be documented and the matter reviewed. If issues of coverage remain, the matter will be referred to general legal counsel or coverage counsel with a request for a timely determination. Excess and/or reinsurance carriers will be informed as needed. Upon determination of coverage, any remaining questions or issues will be documented and communicated to the covered party with a reservation of rights document.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. All bodily injury/emotional distress cases are filed with ISO Claim Search.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the broker.

d. Insured/Claimant Contact

1. All insureds must be contacted within one business day of assignment to the claim handler.

2. Unrepresented claimants should be verbally contacted within two business days of assignment.

3. Claimant attorneys should be contacted verbally within three business days of assignment, followed up by a confirmation letter.

e. Investigation

1. All claims involving serious exposure, and/or questionable liability, whenever possible a statement that is either written or recorded will be obtained from an unrepresented claimant(s).

2. All cases where there is an expectation that a claim will be made, it will require a full detailed investigation relative to exposure, liability and subrogation/mitigation.

3. In cases involving serious exposure and/or discrepancies of fact(s), if a witness exists, a statement should be taken, as soon as their identity is known or within (30) thirty days of assignment.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered in a reasonable timely fashion depending on the request.

2. All reserves over $75,000 should be reviewed and approved by the supervisor and/or management.

3. All reserves over $125,000 should be reviewed with and approved by the Assistant or Claim Manager.

4. Claims that are 50% of retention, catastrophic losses or that meet the criteria under any of our reinsurance or excess reporting guidelines shall be reported to the reinsurer/excess carrier immediately.

5. All files must be on supervisor's diary. All files must be on the claim handler's diary. Updates must be provided to the insured or their broker upon request.

g. Direction

Initial and subsequent supervisory direction should be noted in file. Reserves should be updated when appropriate. Effective diary control shall be maintained. Supervisor approval is required for any independent experts needed and not on our approved vendor listing and the claim handler must obtain the qualification and rate structure.

h. Recovery/Subrogation/Contribution

1. Subrogation recovery and /or contribution potential for all claims shall be properly recognized and investigated and documented in the claim file.

2. Any subrogation, compromise or closure without recovery must be approved by management. Recovery/contribution shall be properly followed up on and concluded conducive toward maximizing the Insured's/Group's objectives and interests.

j Disposition

All claims should be finalized at the earliest possible time or after special damages are verified, and liability is known. Evaluation/authority should reflect liability, damages and mitigation. Negotiations should commence as soon as the above occurs.

j. General

1. Proper initial loss codes shall be utilized. Loss Control is to be notified as to any condition which should be corrected to prevent future occurrences. Loss Control will do a follow up to make sure the condition is brought to the attention of the appropriate district representative.
2. For all physical damage automobile losses where damages exceed $1,999 the vehicle must be inspected by an independent auto

appraiser within five business days of assignment and concluded within ten business days. Two estimates must be obtained where damages are less than $2,000 and reviewed for reasonableness by the claim handler before payment is made.

3. CMS reporting under Section III will be complied with in all qualifying cases.

3. WORKERS' COMPENSATION

a. Coverages

Coverage issues are promptly recognized, reviewed with management and resolved properly.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. All lost time cases are filed with ISO Claim Search.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the claimant. A medical authorization request letter and medical only acknowledgement letter are sent within two business days of request.

d. Insured/Claimant Contact

All insureds must be contacted on lost time cases within two business days of assignment.

e. Investigation

1. All claims involving questionable medical casualty, serious exposure, or subrogation, the claimant should be interviewed or statement obtained.

2. All cases involving questionable medical casualty, serious exposure, or subrogation, detailed insured investigation should be accomplished.

3. In cases involving discrepancies of fact(s), if a witness exists a statement should be taken as soon as their identity is known or within (30) thirty days of assignment.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered as dictated by the claim file or on diary, whichever is first.

2. All reserves combined over $75,000 should be reviewed and approved by the supervisor and/or management.

3. All reserves combined over $150,000 should be reviewed with Claim Manager.

4. Claims that are at 50% retention, catastrophic losses or that meet criteria under any of our reinsurance or excess reporting guidelines shall be reported to the reinsurer/excess carrier immediately.

5. Insured should be periodically updated as to status of all loss time cases. Light duty must be explored in all cases.

g. Direction

Initial and subsequent supervisory direction should be noted in file. Reserves should be updated when appropriate. Effective diary control shall be maintained. Expense control should be maintained through proper utilization of outside services. Outside services must provide a pricing list for their services indicating charges as well as proof of insurance, if not on the approved vendor list.

h. Recovery/Subrogation/Contribution

1. Subrogation potential for all claims shall be properly recognized and investigated and documented in the claim file.

2. Subrogation/contribution shall be properly followed up on and concluded conducive toward maximizing the Insured's/Group's objectives and interests.

i. General

1. Proper initial loss codes shall be utilized. Loss Control is to be notified as to any condition which should be corrected to prevent future occurrences. Loss Control will do a follow up to make sure the condition is brought to the attention of the appropriate district representative.
2. Compensability analysis shall be proper and in accordance with State Law.

3. Initial indemnity payment on all loss time cases shall occur within

twenty one business days of receipt of loss.

4. Medical bills should be process/paid within ten business days of receipt.

5. Lost wages/permanency are to be properly calculated based on current law and disability chart. Disability chart is updated by the State annually.

6. Physician contact and control is completed based on the treatment plan through our managed care company along with our in-house team.

7. CMS reporting under Section III will be complied with in all qualifying cases. FROI and SROI must be complied with in accordance with state law.

4. PROPERTY

a. Coverages

Claims will be promptly reviewed for coverage with the expected result being a prompt, accurate coverage determination. If there is a question on coverage, the issues will be documented and the matter reviewed. If issues of coverage remain, the matter will be referred to general legal counsel or coverage counsel with a request for a timely determination. Excess and/or reinsurance carriers will be informed as needed. Upon determination of coverage, any remaining questions or issues will be documented and communicated to the covered party with a reservation of rights document.

b. Initial Technical Processing

New losses are assigned promptly and entered into the claim system within one business day of receipt. Appropriate initial reserving is completed. Any loss involving asbestos, mold or any environmental hazard must be reported to the environmental impairment liability carrier.

c. Clerical Processing

An insured acknowledgement letter is sent out upon file set up with a copy to the broker.

d. Insured Contact

An insured acknowledgement letter is sent out upon file set up with a copy to the insured. Verbal contact with the insured business administrator within one

business day of assignment and scope of damages must be documented in the claim file.

e. Investigation

An independent property appraiser from our approved vendor list should be assigned to verify damages, cause of loss and provide appraisal estimate for repair or replacement. This physical inspection must be completed within three business days of assignment. If no inspection is warranted receipts, purchase orders or other substantiated documentation must be obtained to verify and pay the loss. A police report must be obtained where there may be subrogation. All losses that may exceed $35,000 must be assigned to subrogation counsel.

f. Reporting and Communication

1. The claim file should be posted with all significant file developments. General correspondence should be answered in a reasonable timely fashion.

2. All reserves over $75,000 should be reviewed and approved by the supervisor.

3. All reserves over $150,000 should be reviewed and approved by the Assistant or Claim Manager.

4. Status/updates must be provided to the business administrator at no longer than (30) thirty day intervals.

5. Claims that are reserved at 50% or more of retention or where there is a major loss must be reported to our excess/reinsurance carriers as soon as possible.

g. Direction

Initial and subsequent supervisory direction should be noted in the claim file. Reserves should be updated when appropriate. Effective diary control shall be maintained. Expense control should be accomplished through proper utilization of outside services/experts. Supervisor approval is required for any independent experts needed and not on our approved vendor listing.

h. Recovery/Subrogation

Subrogation potential for all claims shall be properly recognized, investigated and documented in the claim file.

Subrogation shall be properly followed up on and concluded toward maximizing the Insured's/Group's objectives and interests. Any subrogation compromise or closure without recovery must be approved by the Claim Manager.

i. Disposition

1. Loss and damage information shall be properly verified.

2. Statement of loss prepared where necessary and authorization requests in the file shall be timely and of good quality.

3. Depreciation shall be considered and applied, where appropriate.

4. Proper deductible shall be applied.

j. General

Proper initial loss codes shall be utilized. Loss Control shall be notified as to any losses/occurrences which could constitute a future risk, that is another loss/occurrence which may happen if there is no intervention or correction of the risk. Loss Control will notify the insured of the correction needed and follow up to make sure it is addressed.

5. PRODUCTIVITY/PENDING STANDARDS

a. Pending Guidelines

Claim Representative	to 150
Field Claim Representative	to 75
Sr. Claim Representative	to 175
Claim Examiner	to 200
Medical Claim Assistant	to 125

Claim Supervisor shall have up to six adjusters under their direct supervision, with all adjuster files on an "override" diary.

b. Productivity Guidelines

1. The goal is for all technical personnel to maintain a "one for one" on average for files opened/closed, conducive with maintaining a stable pending within the pending guidelines.

2. All technical personnel, on average, can receive two new files assignments per day. Claim Assistant, can receive three to six new assignments per day.

6. LEGAL CLAIM HANDLING

a. Counsel Billing

1. Counsel billings must be on a per case basis. The itemized bill must contain a description of each charged activity, the date of service and the time allocated for each activity. The bill must indicate the total time spent, the hourly approved rate, and the total charges. The file handler is expected to audit each bill and communicate with counsel on overcharges in terms of rates or activities conducted.

b. Legal Handling

1. On a general note, legal handling of counsel should be confined to the work, which only a lawyer is qualified to do. Investigative activities, etc. should generally be conducted by the file handler. As to negotiations, once suit is filed, generally defense counsel will handle. However, if a particular claim and the circumstances are such that it would be more advantageous to have the claim handler negotiate, then the claim handler should negotiate the claim. All negotiations should be documented in the file and formal notification will go out to the defense attorney to advise him/her of same.

7. CLAIM PAYMENT PROCEDURES

a. All indemnity payments, other than medical on all lines, are to be requested via completion of the input payment screen in the risk management information system (RMIS). Use of the repetitive payment option is recommended on long term compensation claims.

b. On bill payments, once a medical, legal, or service bill is determined to be proper, the claim handler highlights the amount to be paid, initials and dates it, indicates the payment and coverage kind and sends it to the bill processor for payment. A check of prior payments must be made to eliminate duplicate payments. Bills are to be paid within 10 calendar days of receipt, unless further clarification is necessary. IRS numbers found in the RMIS rolodex are

to be used with all payments.

8. INCOMING/OUTGOING CORRESPONDENCE

a. All incoming mail is date stamped on same day received and placed in ImageRight as a task for the respective claim handler. Before the end of the business day, the claim handler will process the task, and determine if it needs to be worked on as a priority or work it on diary.

b. Any correspondence not identified within two business days will be brought to the attention of the claim handler's supervisor for further action.

c. If after two business days of receipt such correspondence still cannot be matched, supervisor will confer with the Claim Manager to decide upon a duplicate file set up.

d. All outgoing correspondence when typed will be "proofread" by the claim handler, signed and placed in the out bin or copied to the file. The claim handler or file clerk will then make sure a copy of such outgoing correspondence is placed into the ImageRight file, and place into the mail the original correspondence. This entire procedure should take no longer than one business day.

9. SURVEILLANCE & ACTIVITY CHECKS

a. This activity is conducted on cases of extended disability cases where the medical information does not coincide with the claimant's reported activity and cases on which fraud is suspected. Discuss planned checks with the insured prior to initiation.

b. Activity checks on benefit recipients in fatal and permanent total compensation cases must be conducted every six to twelve months.

c. All cases where surveillance is indicated, supervisory authorization must be approved and indicated in the claim file.

10. OUTSIDE INDEPENDENT ADJUSTERS ASSIGNMENTS

a. First level of priority for files needing "Field Work" shall be our internal staff.

b. If internal staff is unable to handle due to "volume" or lack of specialty in a particular claim area, approval for outside assignment must be given by file handler's supervisor. If supervisor agrees with outside recommendation, such approval shall be indicated in the claim file and shall further be recorded in the independent assignment log.

c. Only Independents on the Group's "approved" list shall be utilized.

d. The claim handler maintains direction and control of the independent. The claim handler based on the independent's submission will make a liability assessment, reserve adjustments and determine the need for further work. Updates by independents are required at 30 day intervals.

11. REPORTING GUIDELINES

Claim handling reporting should be entered into the attachment screen of the claim file. These reports should be brief and to the point. Long dissertations, except in unusual circumstances, are both unnecessary and unwarranted.

Time limitations are as follows:

For workers' compensation/lost time cases, the report should be on the attachment screen within ten business days from receipt of the claim by the claim handler.

For general liability it will be fifteen business days; and for property it will be fifteen business days.

12. REPORTING GUIDELINES WORKERS' COMPENSATION

Workers' Compensation (Lost Time Cases) within ten business days from receipt by the claim handler.

1. Occurrence/Accident Description
2. Compensability Accepted/Denied – if denied explanation
3. Accepted/Injury
4. Subrogation
5. Follow up action plan (treatment, disability petition)
6. Reserve

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the point with an explanation in each category.

13. REPORTING GUIDELINES GENERAL LIABILITY/AUTO /E&O

General Liability/Auto /E&O within fifteen business days from receipt by the claim handler.

1. Description of Loss/Occurrence
2. Liability
3. Damages
4. Follow-up action plan
5. Reserves

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the point with an explanation in each category.

14. REPORTING GUIDELINES – PROPERTY WITHIN FIVE BUSINESS DAYS FROM RECEIPT BY THE CLAIM HANDLER.

Property

1. Description of Loss/Occurrence
2. Coverages
3. Damages/Scope
4. Follow-up action plan
5. Reserve

The above information should be entered into the attachment screen with the category noted in the claim file. This information should be brief and to the point with an explanation in each category.

15. REHABILITATION GUIDELINES - ADMINISTRATIVE CONTROLS

a. Criteria to be used in determining when a file should be referred for medical rehabilitation.

1. The following cases should mean immediate referrals:

- Spinal Cord Injuries
- Serious Head Injuries
- Amputations
- Severe Burn Cases
- Crush Injuries
- Heart Problems
- Stress -Related Disorders
- Serious Eye Injuries
- Complex Regional Pain Syndrome (RSD)

2. Other possible referrals within the first 8-10 weeks post-injury could include:

- Herniated Disc
- Multiple Fractures
- Exacerbation of Pre-existing Condition
- Exacerbation of Congenital Condition
- Extensive Over-treatment for an Obvious Soft Tissue Injury

A focus of rehabilitation is to assist the claimant in positive re-direction of his/her abilities, as well as to coordinate the medical aspects of the disability. Early identification and resolution of the barriers preventing a return to the labor market.

All referrals are to be made to our staff rehabilitation nurse. If our staff is unable to handle due to "volume" outside assignment shall be discussed with the supervisor, who will provide approval on the assignment, and enter in the rehabilitation nurse assignment log.

16. COMPLAINT HANDLING AND PROCEDURES

Complaint Handling

A consumer complaint may come from members, claimants, insurance departments, media, various organizations and businesses.

There are reasons that create a complaint. Review of the following may assist in reducing the number of complaints:

a. First -Time Communication

1. Improper conduct by employee or the independent adjuster-appraiser.

2. Questionable claim handling.

3. Unreasonable delays.

4. Questionable business practices.

b. Second - Time Communication

1. Ineffective explanation as to how the claim was adjusted, to policy owner, claimant, etc., etc.

2. Inadequate file documentation

3. Mistakes on the file

4. Failure to follow-up with member, claimant, and other interested parties when requested.

A complaint is an opportunity to re-sell our position and to demonstrate the organization's commitment to service. This does not necessarily require a change in our position, but it most certainly requires a very prompt response.

Resolution should occur within a few hours; surely within one business day. If the matter cannot be resolved in this length of time, the person complaining must be contacted with an explanation of the time they will receive a response.

If possible, the person charged with the responsibility of the file should resolve the complaint.

Mail or phone inquiries from the Insurance Department office and those complaints that can be handled on initial contact, need not be logged, all other complaints must be responded to within one business day. The following should be documented in case there is a re-opening of the inquiry.

Those verbal complaint-inquires that cannot be initially resolved and those received in writing should be handled in accordance with the following complaint procedure.

Responses to complaints must be factual with no subjective comments. Supervisor must avoid becoming "Super Adjusters". However, they are responsible for prompt and just resolution of the complaint.

Complaints are always reduced when the file is handled well the first time.

17. COMPLAINT PROCEDURE

a. Origin of the Complaint

b. Date Complaint is received in our Claim Department.

c. Our Completion and Routing

It is very important for the initial completion to be timely, accurate and with prompt follow up routing. Please handle as follows.

1. When the complaint is received, the person receiving the complaint will complete all applicable sections except the final disposition action. Please provide a clear, concise description of the complaint. All documents that accompany the complaint will be attached to the original, with a copy made for the Claims Manager.

2. Compliant Form Distribution - Original and one copy, with attachments, to claim handler's Supervisors for review and comments to claim handler on how the complaint can be used as a training tool.

3. Other Distribution - Claim Manager
Complaint Log

c. Update and Diary

1. Supervisor should diary for a complaint resolution within two business days.

2. Claim Manager should diary after five business days to determine that all complaints are properly handled.

d. Resolution

1. When the complaint is resolved, fill-out the steps taken/final resolution section, including the following:

a. Brief description of resolution; be specific and relate the facts of complaint only.

b. Attach copies of any letters or file notes that will become part of the permanent complaint file.

REMEMBER:

The complaint files are permanent records and subject to review by authorized individuals, such as State Insurance Department, attorneys, etc.

c. Claim Manager should diary review all correspondence before it is sent out.

2. If complainant is not satisfied with our response they can go up the chain of command for resolution or clarification. The Claim Manager is responsible for making sure all are aware of the issues. This should be done via telephone or/and email to the NJSIG Board President or designee as soon as possible.

18. GENERAL COMMENTS

1. Complaints from the media, consumer groups, outside vendors, or other external customers must be immediately referred to the Executive Director. Any reply must be reviewed and authorized by the Claim Manager.

2. Response to Insurance Department complaints should be immediate, with a written response no later than two business days after receipt.

3. Other complaints also need immediate response and again should be resolved within two business days.

19. DISCRETIONARY SETTLEMENT AUTHORITY

As part of their service contracts with the Group, the Group will pay workers' compensation medical and wage loss benefits when such payments are warranted and within the requirements of the law and the guidelines and policy of the Group or as ordered by a court. In the majority of cases, it will be whether or not liability exists in a particular case, and proper statutory benefits will be paid promptly.

There will be some claim, however, where either liability or the amount of benefit due is contested. It is unnecessary and unproductive to litigate every such case, as the administrative procedures are lengthy and costly. Therefore, the Group and the Executive Director must have the authority to settle such cases with claimants on behalf of the Group.

Therefore, the Board establishes the following procedures for the settlement of contested workers' compensation claims including Section 20 Settlements:

Settlement Authority		Grade Level
$1—$500	Bill Processor, Medical Claim Assistant	10-11
$501 - $60,000	Claim Rep. & Senior Claim Rep.	13-14
$60,001 - $120,000	Claim Examiner, Claim Legal Examiner & Field Claim Rep.	15-16
$120,001 - $200,000	Claim Supervisor	17
$200,001 - $299,999	Claim Manager	20
$300,000 – Up	Board of Trustees	

All of the above authorities would be given based on Claim Manager's discretion.

DISCRETIONARY SETTLEMENT AUTHORITY

On all errors & omission claims, the insurer retains all rights of settlement authority.

The Group will pay Personal Injury Protection medical, wage loss, and other benefits when such payments are warranted and within the requirements of the law and the guidelines and policy of the Group.

On all liability lines the following authority levels will apply:

	Settlement Authority	Grade Level
$1—$5,000	Bill Processor	10
$5,001 - $35,000	Claim Rep. & Senior Claim Rep.	13-14
$35,001-$60,000	Claim Examiner, Claim Legal Examiner & Field Claim Rep.	15-16
$60,001-90,000	Claim Supervisor	17
$90,001-$120,000	Claim Manager	20
$120,001-150,000	Claim Manager and Group Attorney	20
$150,001-$200,000	Claim Manager, Group Attorney & Committee Rep.	20
$200,001-Up	Board of Trustees	

All of the above authorities would be given based on Claim Manager's discretion.

Note, it is recognized that where the Board of Trustees has approved authority and certain contingencies arise that more settlement authority is required. It may be impossible to reconvene the Trustees in a timely manner to further consider previously recognized authority. The Trustees authorize the Claim Manager, NJSIG legal counsel and one member of the NJSIG Claim Committee for the purpose of extending additional incremental authority on such previously extended cases, in an incremental amount not to exceed 120% of the original extended authority. All such situations falling within the parameters of this scenario shall be reported by the Claim Manager to the Trustees at the next regularly scheduled Trustee meeting.

DISCRETIONARY SETTLEMENT AUTHORITY

Establishment of Claims Committee:

In the event settlement authority is needed before the next regularly scheduled meeting, a Claims Committee shall be established. The Claims Committee shall be comprised of the Claim Manager, the Group attorney and up to three Board of Trustee Members. The Claims Committee shall have authority to approve claims at or above the threshold established for the Board of Trustees, provided that the amount is recommended by both the Claim Manager and the Group attorney. All three Trustee participants (NJSIG Chairman, NJSIG Vice-Chairman and one of the NJSIG ASBO Trustee Representatives) will be notified of any such meetings, however, only one Trustee is required to participate in order to extend settlement authority, in addition to the Claim Manager and NJSIG legal counsel. Agreement by a simple majority of attendees, along with the recommendation of the Claim Manager and NJSIG legal counsel, be sufficient to establish claim settlement value.

20. FINANCIAL MANAGEMENT

Consistent with the objective of serving as long a term vehicle through which to stabilize the costs associated with the insurance coverages, the underlying premise of the Group's financial base shall be one of conservative up-front funding, prudent investment of idle funds, and maintenance of stringent paper and audit trails. As is the case with all other aspects of the Group, the financial assets of the Group are considered as monies held in public trust.

Treatment and handling of these funds must be accomplished in a manner which reflects the stewardship obligation of those whose hands through which they pass. All actuarial, investment, treasury and banking functions of the Group are to be accomplished in a manner outlined in the Group's bylaws.

21. SAFETY AND LOSS PREVENTION

Every dollar spent to compensate for an avoidable loss, whether it is for property, workers' compensation or any other coverage afforded through the NJSIG, is a dollar, which might better have been used to educate a student in a member district. In an effort to avoid a preventable loss and the financial and human hardships that result there from, the NJSIG (operating through the District Safety Committee) will implement safety and loss control programs and procedures directed at reducing or eliminating conditions or practices which lead to loss. These programs, implemented in progressive steps, will include items such as:

a. STANDARDS OF PARTICIPATION

The following are the minimum standards for membership in the NJSIG.

Minimum Risk Management Standards

The following are the minimum safety and loss control standards from the NJSIG Board of Trustees:

1. The district board must adopt a policy that demonstrates the district's commitment to the safety of students, employees, the public and the property and other resources of the district. This policy must clearly identify the specific accountabilities of the superintendent and other district officers.

2. The district superintendent and/or business administrator must direct the risk management, safety and loss prevention efforts (District Safety Coordinator).

3. If the superintendent and/or business administrator elects to delegate specific administrative responsibilities to other officers or staff, these responsibilities and the scope of authority must be clearly defined and documented. Top administrators will be ultimately responsible for the program regardless of delegation.

4. Each district must have a formal, documented safety and loss control program, which would contain the following minimum specific elements:

    a. The District Safety Policy.

    b. Identification of the officers, staff and specialists charged with the responsibility for the administration of the Risk Management, Safety and Loss Prevention program and description of their respective responsibilities.

    c. Procedures for, and frequency of surveys, inspections and incident reporting conducted by district personnel to identify potential exposures to loss.

    d. Procedures for continuous review and analysis of loss experience reports.

    e. Methods and criteria used by the district to monitor and evaluate the performance of the district Risk Management, Safety and Loss Prevention program. This includes the administrative and supervisory staff people to be held accountable during evaluations for meeting safety related goals.

    f. Procedures for investigating and reporting injuries or property loss in the district.

5. Each district must have a documented safety awareness program for its employees that will consist of at least the following:

   a. Indoctrination safety training for new employees.

   b. Regular in-service safety training for existing employees. (Both professional and non-professional)

   c. Monthly safety meeting or contacts for all employees.

6. Each district must adhere to the NJSIG Claims Procedures for the reporting and handling of claims.

7. Each district must have an active district level Safety Committee which at the minimum:

   a. District superintendent is chairperson.

   b. Includes principals and service department managers.

   c. Meets monthly.

   d. Documents all of its meetings and recommendations.

   e. Reviews and recommends action on all safety suggestions from safety inspections or suggestions made by employees.

   f. Reviews accidents on a regular basis.

8. Each district must have a regular and documented safety inspection policy and program for the district and individual school sites.

9. Districts must comply with Department of Education regulations relating to pupil transportation:

   a. Drivers with more than 12 points or 2 or more "at fault" accidents during the preceding five years must not be used to transport students.

   b. For non-ownership and hired automobile coverage, a contract bus company must have a minimum of $2,000,000 in automobile liability coverage.

10. Districts must have for other district vehicles:

    a. Motor Vehicle Record review at least annually on all drivers/operators.

    b. Investigation of all accidents/incidents involving a district vehicle.

    c. A documented, regular, pre-operational inspection check program for each vehicle.

11. Each district must respond to NJSIG audits and inspections in writing within 30 days after the receipt of the report.

12. Each district must have a collection and review process for Certificates of Insurance for events/projects being held/started on district property.

13. Each district will perform accident investigations. Any "lost time" accident must be investigated by a school principal or service department head. The investigation of medical-only injuries may be delegated.

14. Each district will establish and actively manage a modified duty program for both professional and non-professional employees.

15. Each district must be working toward compliance with mandated State and Federal programs (i.e., Hazardous Materials Communications, Underground Tanks, Hazardous Waste Management, AHERA Regulations, Disaster Preparedness, etc.)

16. The panel physician program will be used exclusively for medical or rehabilitative care.

Eligibility Requirements

In order to maintain continuing eligibility for NJSIG participation, as part of a geographic sub fund or the NJSIG sub fund, each district will be screened using the criteria listed below. If two of the four criteria fall out of the acceptable range, a surcharge may be added to the district's premium. If three of the four criteria fall out of the acceptable range, the district will lose its eligibility to participate in the geographic sub fund or the NJSIG sub fund.

1. Experience modification over 1.1 for three consecutive years is considered unacceptable.

2. An undeveloped Loss ratio for the most recent three years of over 80% is considered unacceptable. (Districts with less than three years of participation will be judged on their NJSIG history.)

3. A safety and loss control assessment score of less than 85 points.

4. Significant unacceptable trends of the experience modification and loss ratio.

The NJSIG Executive Director will notify the district by September of any eligibility concerns as outlined above. In each case, the district may appeal to the Board of Trustees for a one year probationary period. This appeal must be made to the NJSIG Trustees at least one week prior to the next NJSIG Board of Trustees meeting after notification has been provided to the district. If the Board of Trustees grants the district a probationary period, going forward the district will be judged on the eligibility requirements above with the exception of the safety and loss control assessment. Continuing improvement in safety and loss control programs at the district as judged by the NJSIG Loss Control Manager will be required in order to maintain Group eligibility.

In each case, the district may appeal to the Board of Trustees for a one-year probation period. If granted, the district will be judged on the same criteria as the year before with the exception of the safety and loss control assessment. Continuing improvement in safety and loss control programs at the district as judged by the NJSIG Loss Control Manager will be required in order to maintain Group eligibility.

Automobile Liability & Physical Damage

1. All schools must comply with Department of Education regulations relating to pupil transportation.

2. Motor vehicle records must be obtained for all drivers and drivers with two or more "at fault" accidents during the preceding 5 years or drivers with more than 12 points must not be used.

3. For non-ownership and hired automobile coverage, a contract bus company must have a minimum of $2,000,000 in automobile liability insurance.

Property

1. Fire detection equipment as prescribed by the Uniform Building Code in operating order.

2. All combustible materials must be properly stored.

Liability

1. Written emergency procedures including posted evacuation routes.

2. Exit doors must have automatic release and during period of occupancy must not be locked or be otherwise obstructed.

3. There must be emergency lights on stairwells and in corridors; standard illuminated exit signs.

4. All public areas must have adequate lighting.

5. Walkways must be unobstructed and all tripping hazards must be eliminated.

6. Pools must be locked when not being used. If public swimming is allowed, lifeguards must be on duty at all times.

7. Outside groups or organizations using school premises must supply evidence of at least $1,000,000 liability insurance.

8. For laboratories, chemical inventories must be current, showing expiration dates.

9. Minimum dishwasher water temperature must be 180 degrees.

IV. ASSESSMENT/DIVIDEND POLICY

ASSESSMENTS

From time to time, it is possible that the amount of premium collected in a fiscal year will not be sufficient to cover all claims and other expenses. In these cases, it will be necessary to assess additional contributions from districts, which were members during those years. The following method will be used in such cases:

I. A calculation shall be made to determine to which policy(s) the deficit can be attributed. Only that policy(s) will be assessed.

   A. In the case of the package policy, the assessment shall be made only against that line(s) of coverage, which produced the adverse loss ratio, and the loss shall be shared among those purchasing that line(s) in the following manner:

      1. The needed assessment shall be paid by all participants in direct proportion to the premium they paid for that line(s) of coverage.

2. Except for property damage, which must be assessed and collected as needed, calculations shall not be made until twelve months after the close of a fiscal year. At that time, any necessary assessments will be announced. Collections of money will be on or after the following July 1st and may be spread over as many years as the Trustees may deem advisable except that the money must be paid prior to the time that actuaries advise it will be needed to pay claims.

B. In the case of workers' compensation, assessments will be as follows:

3.

Loss Ratio as % of Discounted Premiums	Assessment as % of Discounted Premium
85.1% to 95%	2.5%
95.1% to 105%	7.5%
105.1% to 115%	12.5%
115.1% to 125%	17.5%
125.1% to 135%	22.5%
135.1% to 145%	27.5%
145.1% to 155%	32.5%
155.1% to 165%	37.5%
165.1% to 175%	42.5%
175.1% and Higher	47.5%

4. In the event that this formula raises too much money, the portion shared by all will be adjusted downward proportionately. In the event that this raised too little money, the remaining assessment shall be shared by all participants in proportion to their premiums paid.

V. DIVIDENDS

When there are more funds available for a policy during a particular year than are needed to pay all expenses, the Trustees may declare a dividend. If dividends are declared, they shall be paid as follows.

I. A calculation shall be made to determine to which policy(s) the surplus can be attributed. Only that policy(s) shall be eligible for dividends.

A. In the case of the package policy, dividends will be paid only for those lines of coverage which produced a surplus. Dividends will be shared among those districts purchasing those line(s) in the following manner.

1. The monies to be paid will go to all participants in that line in direct proportion to the premiums they paid for that line(s) of coverage(s).

2. Dividends will be calculated twenty-four months after the close of a fiscal year. They can be paid out only if the Group has an overall surplus and then only fifty percent of the available dividend can be paid at that time. The remaining fifty percent can be paid only when that year is closed out or when eight years have elapsed since the close of the fiscal year, whichever comes first.

B. In the case of the workers' compensation policy, dividends shall be paid as follows:

Loss Sensitive
Schedule of Dividends

Loss Ratio as % of Discounted Premiums	Dividend Return as % of Discounted Premium
0.1 - 10%	15.6%
10.1 - 20%	13.0%
20.1 - 30%	10.4%
30.1 - 40%	7.8%
40.1 - 50%	5.2%
50.1 - 60%	2.6%
over 60%	

C. If not all dividends can be paid with the money available, then the reduction to all shall be proportionate. Any remaining money shall be paid to all participants in proportion to their premiums.

D. Dividends shall be calculated twelve months after the close of a fiscal year. Up to fifty percent of any available amount may be declared by the Trustees at that time. The remaining fifty percent shall be paid five years after the close of the fiscal year or when the year is closed out, whichever is sooner.

E. The Trustees may approve the division of some members into sub funds for the purpose of calculating rates and dividends. In that case, dividends and assessments for the Groups will have use of the above formula, but will be adjusted for their own experience.

VI. Coverage Enhancements

A. All members are entitled to participate in the WeTip program. An 800 number is maintained and anonymous calls to this number detailing crimes or fraud which have happened or may soon happen are dealt with.

B. A legal call-in service is maintained for any district which purchases errors and omissions from the Group. These districts may discuss any situation where they intend to take any adverse action with regard to any employee and they will be advised with regard to any applicable state or federal laws.

VII. Closure of Plan Year

The plan year may be closed after all claims relating to that plan year have been paid or otherwise disposed of. Full settlement will be made with each district as per IV and V above to bring the final plan year balancing to -0-. The Department of Banking and Insurance approves all plan year closures, as well as dividends and assessments.

All records will be retained at the Group's office.