METROPOLITAN
HEALTH INSURANCE FUND

AGENDA AND REPORTS
FEBURARY 19, 2026
MAPLEWOOD, NJ
12:00 PM

MEETING LOCATION:

The Woodland
60 Woodland Rd
Maplewood, NJ 07040

OPEN PUBLIC MEETINGS ACT - In accordance with the Open Public Meetings Act, notice of this meeting was given by:

I. Sending sufficient notice to **The Record and The Star Ledger**
II. Filing advance written notice of this meeting with the Clerk/Administrator of each member municipality and school boards,
III. Posting notice on the Public Bulletin Board of all member municipalities and school boards.

METROPOLITIAN HEALTH INSURANCE FUND
AGENDA MEETING: FEBURARY 19, 2026
MAPLEWOOD, NJ
12:00 PM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ

PLEDGE OF ALLEGENCE

ROLL CALL OF 2026 EXECUTIVE COMMITTEE

Fund Commissioner	**Entity**
Jenny Mundell, Chairwoman	Bloomfield Public Library
Patrick Wherry, Secretary	Maplewood Township
Cameron Cox, Executive Committee Member	Plainfield Public Schools
Nikole Baltycki, Executive Committee Member	West Caldwell Township
Chris Hartwyk, Executive Committee Member	City of Orange
Margaret Heisey, Executive Committee Member	Scotch Plains Twp
Alexander McDonald, Executive Committee Member	Millburn Township

APPROVAL OF MINUTES, January 15, 2026 ..... Appendix I

CORRESPONDENCE – None

MONTHLY COMMITTEE REPORTS

FINANCE/CONTRACTS COMMITTEE – Cameron Cox, Chair

WELLNESS COMMITTEE – Patrick Wherry, Chair

OPERATIONS/NOMINATION COMMITTEE – Margaret Heisey, Chair

FUND EXECUTIVE DIRECTOR – PERMA
Administration and Finance Report ..... **Page 4**
Resolution 16-26: Adoption of Supplemental Assessments..... **Page 14**
Benefits Report ..... **Page 7**

FUND COODINATOR – Eagle Rock Management Group
Fund Coordinator's Report ..... **Page 18**

FUND ATTORNEY – Antonelli Kantor Rivera PC

FUND TREASURER – Laracy Associates
Voucher List February 2026..... **Page 19**

Metropolitan Health Insurance Fund
Executive Director's Report
FEBURARY 19, 2026

FINANCES AND ADMINISTRATION

PRO FORMA REPORTS

- **Fast Track Financial Reports** – As of November 30, 2025 (page 10)
  - **Historical Income Statement**
  - **Consolidated Balance Sheet**
  - **Indices and Ratios Report**

SUPPLEMENTAL ASSESSMENT – ADOPTION

At the January 15th meeting, the Fund introduced the Supplemental Assessment in the amount of $7 Million. The adoption resolution has been updated to include the fund year that the receivables will be booked within. Resolution 16-26 is included on page 14.

The initial installments were included on the March monthly invoices.

A public hearing is required, and the adoption resolution will be filed with the appropriate agencies at the State.

MOTION: *Motion to open the meeting to the public*

DISCUSSION: Supplemental Assessment, as presented

MOTION: *Motion to close the meeting to the public*

MOTION: *Motion to approve Resolution 16-26 adopting a $7 million supplemental assessment for Fund Year 2024.*

METRO Supplemental Assessment

$7,000,000- All of 2024 Deficit and Portion of Closed Year (as of 7/31/25)

Member	GRAND TOTAL FY 2024 AND CLOSED YEAR Net surplus/ Cash Collection	Monthly payments 12 months	24 months	36 months
Bloomfield Township	$ 1,693,493.65	$ 141,124.47	$ 70,562.24	$ 47,041.49
Bloomfield Library	$ 40,883.14	$ 3,406.93	$ 1,703.46	$ 1,135.64
East Amwell	$ 5,463.74	$ 455.31	$ 227.66	$ 151.77
Maplewood	$ 304,436.45	$ 25,369.70	$ 12,684.85	$ 8,456.57
Orange	$ 1,196,389.12	$ 99,699.09	$ 49,849.55	$ 33,233.03
Plainfield BOE	$ 3,155,687.78	$ 262,973.98	$ 131,486.99	$ 87,657.99
Scotch Plains	$ 328,562.77	$ 27,380.23	$ 13,690.12	$ 9,126.74
West Caldwell	$ 275,083.76	$ 22,923.65	$ 11,461.82	$ 7,641.22
	$ 7,000,000.41	$ 583,333.37	$ 291,666.68	$ 194,444.46

NEW MEMBER APROVALS

Two prospective members, Mercer County and Hillsdale BOE, have recently passed resolutions to join the METRO Fund. The underwriting details for both entities are outlined below. They are currently considering membership, with a potentially effective date of March 1, 2026. Resolution 17-26 has been prepared to approve their membership, pending the completion and submission of all required documentation.

New Member Overview	
Fund	Metropolitan Health Insurance Fund
Entity	Hillsdale BOE
County	Bergen
Effective Date	3/1/2026 - 12/31/2026
Lines of Coverage	Medical and Rx
Eligible Employees	136
Retiree Coverage	No - BOE
Current Arrangement	SHBP
Actuary Certification	Yes
Run Out Claims	SHBP
Broker	
Member approval?	Agreement received
Per employee Per Month	$3,635
Special Requests	None

New Member Overview	
Fund	Metropolitan Health Insurance Fund
Entity	County of Mercer
County	Mercer
Effective Date	3/1/2026 -12/31/2026
Lines of Coverage	Medicare Advantage Only
Eligible Employees	704
Retiree Coverage	Yes -Over 65 Coverage
Current Arrangement	Self insured
Actuary Certification	N/A
Run Out Claims	
Broker	
Member approval?	Agreement and Resolution received
Per employee Per Month	$754 Per Retiree
Special Requests	None

2026 RISK MANAGEMENT PLAN (RMP) UPDATE

As part of the Risk Management Plan Resolution approved at the last meeting, the plan has been updated to incorporate the New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, And Accountability Act (P.L. 2018, c. 32). This update

enhances protections for out-of-network services. A revised Resolution 8-26 is included in consent agenda.

QUALIFIED PURCHASING AGENT (QPA) - 2026 QUOTES

As authorized by the Executive Committee, PERMA will prepare a solicitation for quotes for QPA services for the 2026 fund year. Commissioners will be sent the link to the advertisement – we encourage you to send along to suitable bidders. Shared services with current members may also be considered.

MOTION: *Motion to allow PERMA to solicit and advertise for QPA services*

RESOLUTION 4-26: OFFICIAL NEWSPAPER UPDATE

At the previous meeting, it was decided that recommendations for the Fund's official newspaper would be submitted to Ms. Koval for inclusion in Resolution 4-26. One recommendation was received: TAPinto, headquartered in Bloomfield. The operations committee has reviewed the proposed newspapers, and further discussion is scheduled to take place.

GASB 75 REPORTING

The Fund is contracted with an actuary to prepare GASB 75 reports for its medical members. If your audit requires a complete report or an update to the previous year's report, please contact Jordyn Robinson at jrobinson@permainc.com. Please note that during peak periods, report turnaround time may be up to six weeks.

2026 MEL, MRHIF & NJCE JIF Educational Seminar:

The 16th annual seminar will be conducted virtually on 2 half-day sessions: Friday April 24th and Friday May 1st from 9AM to 12PM.

We expect the seminar to qualify for Continuing Educational Credits including CFO/CMFO, Public Works, Clerks, Insurance Producers and Purchasing Agents. There is no fee for employees, insurance producers, as well as personnel who work for services companies associated with the Municipal Excess Liability Joint Insurance Fund (MEL JIF), Municipal Reinsurance Health Insurance Fund (MRHIF) and New Jersey Counties Excess Joint Insurance Fund (NJCE JIF).

Enclosed in **Appendix II** is the latest in a series of Power of Collaboration advertisements to be published in the League of Municipalities magazine which highlights the educational seminar.

BENEFITS

TOPICS:

- Industry Update
- Fund Performance/Observations
- Client Services/Eligibility/Enrollment
- Previously Reported Information

Industry Updates

- Food and Drug Administration approved the first oral version of Wegovy, Novo Nordisk's GLP-1 weight-loss drug
- The medication currently sits in *exclude & launch* status and is being evaluated by ESI to determine placement on the formulary
- The evaluation is done from both a financial and clinical perspective

Fund Performance/Observations

Medical - Aetna

- Effective August 1, 2025, the Metro Fund Executive Committee passed a resolution to unilaterally amend the out of network provider reimbursement schedules for all Fund member plans to 150%-provider & 175%-facility of Medicare.
- The following data isolates out of network claims, based on an incurred date of August 1st, and illustrates the reduction in out of network paid claims on a PEPM basis.
- While early, the data suggests the change in out of network provider reimbursement levels is having a positive effect on the Fund financials

Month	Employee Count	Claim Count	Net Paid -OON	PEPM
Aug-25	2489	2788	$2,928,170	$1,176
Sep-25	2462	3022	$1,474,562	$599
Oct-25	2505	2871	$1,521,663	$607
Nov-25	2502	2585	$921,968	$368
Dec-25	2502	2587	$946,599	$378

Pharmacy – Express Scripts (ESI)

- Absent plan changes, it is clear the Fund needs to address the rising utilization and associate costs with GLP-1 medications used specifically for weight loss
- Shifts in the markets have begun to address current GLP-1 utilization levels most recently, Horizon BCBSNJ amended the BMI requirement for GLP-1 for weight loss to 35 effective January 1, 2026

- In addition, once the oral version of Wegovy is moved out of *exclude and launch* status by ESI, further options can be considered such formulary placement and exclusion of less clinically effective option
- The above will apply to the oral version of Zepbound anticipated to gain FDA approval later this year

Client Services/Eligibility/Enrollment Team

- Please direct all service requests to Peter Moore and Crystal Bailey
- System training (new and refresher) is provided to all contacts with WEX access every 3rd Wednesday at 10AM. Please contact HIFtraining@permainc.com for additional information or to request an invite
- **2026 WEX Coupon Book Mailing** – All coupon booklets have been produced and mailed with 2026 payment amounts

Carrier Appeals:

Submission Date	Appeal Type	Appeal Number	Reason	Determination	Determination Date
11/11/2025	Medical/Aetna	METRO 2025 11 03	Inpatient Stay	Upheld	12/05/2025
12/01/2025	Medical/Aetna	METRO 2025 12 01	In-Home Nursing	Upheld	12/10/2025
12/03/2025	Medical/Aetna	METRO 2026 01 01	Nursing Care	Upheld	01/20/2026

IRO Submissions:

Submission Date	Appeal Type	Appeal Number	Reason	Determination	Determination Date
12/05/2025	Medical/Aetna	METRO 2025 11 03	Inpatient Stay	Upheld	12/12/2025
12/10/2025	Medical/Aetna	METRO 2025 12 01	In-Home Nursing	Upheld	12/12/2025

Previously Reported Information

Express Scripts

- 2026 National Preferred Formulary (NPF) – Effective 1/1/2026
- NPF Exclusions list– Effective 1/1/2026
- SaveOn List – Effective 1/1/2026

All impacted members were sent communications from ESI letting them know about the upcoming change(s) to their medications. The communications also include preferred alternatives medication(s). We recommend impacted members share communication with their provider to discuss next steps. Those that are unable to take the preferred alternative medication(s) will need an approved PA to continue to take their current medication(s).

No Surprise Billing and Transparency Act

- Transition to State Arbitration - Effective January 1, 2026:
- As a result of the transition, enrolled members have received new ID cards from Aetna prior to January 1st. subscriber ID numbers and Fund member group numbers did not change.

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF November 30, 2025

			THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
1.	**UNDERWRITING INCOME**		**7,385,078**	**80,529,517**	**207,950,683**	**288,480,200**
2.	**CLAIM EXPENSES**					
	Paid Claims		5,917,949	73,199,610	180,131,885	**253,331,494**
	IBNR		33,540	1,135,325	6,202,000	**7,337,325**
	Less Specific Excess		(32,756)	(3,539,169)	(5,740,079)	**(9,279,247)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS		**5,918,733**	**70,795,766**	**180,593,806**	**251,389,573**
3.	**EXPENSES**					
	MA & HMO Premiums		1,021,123	11,109,788	15,510,298	**26,620,086**
	Excess Premiums		211,252	2,331,577	3,986,606	**6,318,183**
	Administrative		442,010	5,169,970	11,349,468	**16,519,437**
	TOTAL EXPENSES		**1,674,385**	**18,611,335**	**30,846,371**	**49,457,706**
4.	**UNDERWRITING PROFIT/(LOSS) (1-2-3)**		(208,040)	(8,877,584)	(3,489,494)	**(12,367,078)**
5.	**INVESTMENT INCOME**		11,875	187,503	603,103	**790,606**
6.	**DIVIDEND INCOME**		-	57,191	-	**57,191**
7.	**STATUTORY PROFIT/(LOSS) (4+5+6)**		**(196,166)**	**(8,632,890)**	**(2,886,391)**	**(11,519,282)**
8.	**DIVIDEND**		-	-	-	**-**
9.	**Transferred Surplus IN**		-	-	-	-
10.	**Transferred Surplus OUT**		-	-	-	-
	STATUTORY SURPLUS (7-8+9)		**(196,166)**	**(8,632,890)**	**(2,886,391)**	**(11,519,282)**
			SURPLUS (DEFICITS) BY FUND YEAR			
	Closed	**Surplus**	717	(406,114)	(83,541)	**(489,655)**
		Cash	717	(235,488)	937,859	**702,371**
	2024	**Surplus**	(245,810)	(4,981,992)	(2,802,851)	**(7,784,843)**
		Cash	(292,325)	(12,158,643)	2,904,238	**(9,254,406)**
	2025	**Surplus**	48,928	(3,244,784)		**(3,244,784)**
		Cash	1,219,814	11,503,129		**11,503,129**
TOTAL SURPLUS (DEFICITS)			**(196,166)**	**(8,632,890)**	**(2,886,392)**	**(11,519,282)**
TOTAL CASH			**928,205**	**(891,003)**	**3,842,097**	**2,951,094**
			CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS		**-**	**503,446**	**114,524,196**	**115,027,642**
	FUND YEAR 2024					
	Paid Claims		315,409	13,108,202	60,757,659	**73,865,861**
	IBNR		(46,515)	(6,164,788)	6,202,000	**37,212**
	Less Specific Excess		(22,805)	(1,893,934)	(890,049)	**(2,783,983)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2024 CLAIMS		**246,089**	**5,049,480**	**66,069,610**	**71,119,090**
	FUND YEAR 2025					
	Paid Claims		5,602,540	59,328,468		**59,328,468**
	IBNR		80,055	7,300,113		**7,300,113**
	Less Specific Excess		(9,951)	(1,385,741)		**(1,385,741)**
	Less Aggregate Excess		-	-		**-**
	TOTAL FY 2025 CLAIMS		**5,672,644**	**65,242,840**		**65,242,840**
COMBINED TOTAL CLAIMS			**5,918,733**	**70,795,766**	**180,593,806**	**251,389,572**

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

METRO HEALTH INSURANCE FUND

RATIOS

		FY2025											
INDICES	**2024**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Cash Position	3,842,097	$ 6,460,472	$ 7,124,681	$ 7,213,488	$ 4,709,181	$ 3,648,060	$ 939,137	$ 3,616,771	$ 1,787,528	$ 3,119,298	$ 2,022,889	$ 2,951,094	
IBNR	6,202,000	$ 6,379,664	$ 6,567,209	$ 6,793,798	$ 6,917,052	$ 6,986,595	$ 7,037,466	$ 7,195,526	$ 7,235,355	$ 7,237,496	$ 7,303,785	$ 7,337,325	
Assets	5,041,139	$ 4,666,942	$ 5,010,026	$ 4,759,502	$ 1,982,800	$ (427,505)	$ 126,652	$ 61,026	$ (1,166,235)	$ (1,174,024)	$ (833,055)	$ (645,057)	
Liabilities	7,927,531	$ 8,444,978	$ 8,687,019	$ 8,983,617	$ 9,183,079	$ 9,307,480	$ 9,401,559	$ 9,442,603	$ 9,748,239	$ 10,077,228	$ 10,490,061	$ 10,874,224	
Surplus	(2,886,392)	$ (3,778,036)	$ (3,676,994)	$ (4,224,114)	$ (7,200,279)	$ (9,734,985)	$ (9,274,908)	$ (9,381,577)	$ (10,914,474)	$ (11,251,252)	$ (11,323,116)	$ (11,519,282)	
Claims Paid -- Month	6,252,986	$ 6,353,824	$ 5,319,100	$ 5,908,283	$ 8,209,760	$ 8,059,501	$ 6,355,228	$ 6,315,245	$ 7,601,458	$ 6,922,602	$ 6,236,659	$ 5,917,949	
Claims Budget -- Month	4,614,842	$ 5,324,120	$ 5,465,452	$ 5,465,942	$ 5,474,485	$ 5,479,557	$ 5,483,301	$ 5,698,303	$ 5,690,979	$ 5,652,727	$ 5,752,404	$ 5,761,146	
Claims Paid -- YTD	72,784,814	$ 6,353,824	$ 11,672,924	$ 17,581,207	$ 25,790,967	$ 33,850,468	$ 40,205,696	$ 46,520,941	$ 54,122,399	$ 61,045,001	$ 67,281,660	$ 73,199,610	
Claims Budget -- YTD	62,899,992	$ 5,324,120	$ 10,789,572	$ 16,231,412	$ 21,709,638	$ 27,183,256	$ 32,645,163	$ 38,340,877	$ 44,031,856	$ 50,009,328	$ 55,761,806	$ 61,522,951	
RATIOS													
Cash Position to Claims Paid	0.61	1.02	1.34	1.22	0.57	0.45	0.15	0.57	0.24	0.45	0.32	0.50	
Claims Paid to Claims Budget -- Month	1.35	1.19	0.97	1.08	1.5	1.47	1.16	1.11	1.34	1.22	1.08	1.03	
Claims Paid to Claims Budget -- YTD	1.16	1.19	1.08	1.1	1.2	1.3	1.2	1.21	1.23	1.22	1.21	1.19	
Cash Position to IBNR	0.62	1.01	1.08	1.06	0.68	0.52	0.13	0.50	0.25	0.43	0.28	0.40	
Assets to Liabilities	0.64	0.55	0.58	0.53	0.22	-0.05	0.01	0.01	-0.12	-0.12	-0.08	(0.06)	
Surplus as Months of Claims	(0.63)	(0.71)	(0.67)	-0.77	-1.32	-1.78	-1.69	(1.65)	-1.92	-1.99	-1.97	(2.00)	
IBNR to Claims Budget -- Month	1.34	1.20	1.20	1.24	1.26	1.28	1.28	1.26	1.27	1.28	1.27	1.27	

METRO Fund
2025 Budget Report
as of November 30, 2025

	Cumulative	Annualized	Latest filed	Cumulative	$ Variance	% Variance
Expected Losses				Expensed		
Medical Claims Aetna	57,574,238	62,971,785	53,539,937	61,121,444	(3,547,206)	-6%
Prescription Claims - Excl Bloomfield	3,652,738	3,982,602	1,961,095	2,832,697	(266,956)	-10%
Prescription Formulary Rebates	(1,168,877)	(1,274,433)	(627,550)	Included Above in Prescription Claims		
Prescription Claims - Bloomfield	81,881	89,519	87,552	Included Above in Prescription Claims		
Dental Claims	1,382,972	1,514,625	1,023,681	1,288,698	94,274	7%
Subtotal	61,522,951	67,284,097	55,984,715	65,242,840	(3,719,888)	-6%
HMO/DMO Premiums	31,259	34,217	27,646	57,257	(25,998)	-83%
Medicare Advantage / EGWP	11,046,406	12,069,620	9,304,294	11,052,531	(6,126)	0%
Reinsurance						
Specific	2,337,803	2,552,913	2,158,296	2,331,577	6,226	0%
Total Loss Fund	74,938,419	81,940,848	67,474,950	78,684,205	(3,745,786)	-5%
Surplus Retention Regeneration	733,333	800,000	800,000	0	733,333	0%
Expenses						
Legal	28,050	30,600	30,600	72,255	(44,205)	-158%
Treasurer	20,477	22,338	22,338	24,750	(4,274)	-21%
Administrator/Benefits Consultant	859,385	938,550	793,661	858,137	1,248	0%
Risk Management Consultants	1,694,356	1,852,655	1,553,293	1,684,356	10,000	1%
Fund Coordinator	858,016	937,321	748,272	856,626	1,390	0%
TPA - Claims Agent Aetna	1,054,097	1,151,088	1,021,816	927,186	126,911	12%
Dental TPA	72,421	79,298	48,737	72,271	150	0%
Actuary	16,363	17,850	17,850	17,850	(1,488)	-9%
Auditor	20,570	22,440	22,440	20,570	-	0%
Benefits Consultant						
Board Advisor						
Claims Audit	36,667	40,000	40,000	0	36,667	100%
Medicare Advantage Implementation	0	0	0	0	-	
Subtotal Expenses	4,660,400	5,092,141	4,299,008	4,534,000	126,400	3%
Miscelleneous and Special Services						
Misc/Cont	16,544	18,048	18,048	7,219	9,325	56%
Wellness, Disease, Case Management	91,667	100,000	100,000	58,174	33,493	37%
Affordable Care Act Taxes	14,336	15,655	13,235	24,270	(9,934)	-69%
A4 Surcharge	610,984	670,222	638,598	557,523	53,461	9%
Plan Documents	9,167	10,000	10,000	0	9,167	100%
Subtotal Misc/Sp Svcs	742,698	813,924	779,881	647,186	95,511	13%
Total Expenses	5,403,098	5,906,065	5,078,888	5,181,186	221,911	4%
Total Budget	81,074,850	88,646,914	73,353,839	83,865,391	(2,790,541)	-3%

Metro Municipal Employee Benefits Fund
CONSOLIDATED BALANCE SHEET
AS OF NOVEMBER 30, 2025
BY FUND YEAR

	METRO 2025	METRO 2024	CLOSED YEAR	FUND BALANCE
ASSETS				
Cash & Cash Equivalents	11,503,129	(9,254,406)	702,371	2,951,094
Assesstments Receivable (Prepaid)	(5,023,670)	(279,096)	2,534	(5,300,233)
Interest Receivable	-	-	2,258	2,258
Specific Excess Receivable	633,313	589,053	-	1,222,367
Aggregate Excess Receivable	-	-	-	-
Dividend Receivable	-	-	-	-
Prepaid Admin Fees	-	-	-	-
Other Assets	479,457	1,196,818	(1,196,818)	479,457
Total Assets	7,592,229	(7,747,631)	(489,655)	(645,057)
LIABILITIES				
Accounts Payable	3,191,217	0	-	3,191,217
IBNR Reserve	7,300,113	37,212	-	7,337,325
A4 Retiree Surcharge	318,650	-	-	318,650
Dividends Payable	-	-	-	-
Retained Dividends	-	-	-	-
Accrued/Other Liabilities	27,032	-	-	27,032
Total Liabilities	10,837,012	37,212	-	10,874,224
EQUITY				
Surplus / (Deficit)	(3,244,784)	(7,784,843)	(489,655)	(11,519,282)
Total Equity	(3,244,784)	(7,784,843)	(489,655)	(11,519,282)
Total Liabilities & Equity	7,592,229	(7,747,631)	(489,655)	(645,057)
BALANCE	-	-	-	

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

Fund Year allocation of claims have been estimated.

RESOLUTION NO. 16-26

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION ADOPTING SUPPLEMENTAL ASSESSMENTS FOR THE 2024 FUND YEAR

WHEREAS, supplemental assessments are needed to ensure the timely and complete payment of claims that have resulted from the higher than budgeted claims expenses; and

WHEREAS, a hearing on this supplemental assessment will be held at the Fund's regularly scheduled and advertised meeting of February 19, 2026 at the Woodland – 60 Woodland Road, Maplewood, NJ 07040 at 12:00PM

NOW, THEREFORE, BEIT RESOLVED that the following supplemental assessment and financial plan be and is hereby adopted:

1. Supplemental assessments for the 2024 and closed fund years for the Fund be and are hereby declared in an amount of $7,000,000 to reduce projected deficiencies in the claims account. The assessment will be charged on Fund financials effective December 31, 2025.

2. The allocation of supplemental assessments by member shall be pro rata as contained in Appendix 1 and is based upon proportional and cumulative assessments for members for the years with the deficits.

3. Member entities with balances in the Closed Year Account are authorized to apply those balances against the supplemental assessment.

4. This supplemental assessment may be amended depending upon maturation of claims incurred in 2024 and the closed years and paid in subsequent periods, reinsurance recoveries, and the financial need of the Fund. Amendments to this supplemental assessment may occur after completion of the public hearing, after close out of the 2024 fund year, or upon material reappraisal of the status of the 2024 fund year and closed years by the Fund. All amendments shall be made with appropriate notice to Fund members and opportunity for a public hearing.

5. Supplemental assessments shall be due and payable in accordance with the following provisions:

    a. For entities (if any) that terminate membership in the Fund or terminate coverage in the medical line of coverage prior to full payment of their supplemental assessment: The remaining unpaid balance of the supplemental assessment and the unpaid balance, if any, in the Closed Year Account and in any open Fund Years, shall be paid, either upon termination or over a period not to exceed three years starting with the first month of the date of termination of membership or medical coverage. In order to qualify to pay the supplemental assessment over two years, the entity shall adopt a resolution agreeing to pay the unpaid balance, along with any administrative or

interest charges, by resolution. The resolution shall be the form approved by the Fund. Failure to pay the balance or any term payments in full shall cause the Fund to assess a late payment interest charge and to withhold payment of claims.

The Supplemental Assessment collection will be used to pay outstanding fees and premiums, including amounts owed to vendors, starting with payments to the Fund Executive Director and the Municipal Reinsurance Health Insurance Fund.

b. For members that continue to maintain membership in the Fund and in the medical line of coverage, the total net supplemental assessment such members shall be payable in equal monthly installments over a three-year period beginning on March 1, 2026 and ending on February 29, 2028. However, payment may be expedited by the Fund when and if the cash balance falls below a half a month's claims exposure.

c. Members may qualify for a 10% discount of the supplemental assessment if a payment is made in the amount no less than 3 months owed by June 30, 2026

d. The rate of interest on a late supplemental assessment installment is 10% as directed in the Cash Management Plan.

BE IT FURTHER RESOLVED that copies of this resolution shall be sent to each Fund Commissioner, each Governing Body or School Board, the New Jersey Department of Banking and Insurance, and the New Jersey Department of Community Affairs.

INTRODUCED: January 15, 2026

PUBLIC HEARING AND ADOPTION: February 19, 2026

BY:_____

CHAIRPERSON

ATTEST:

_____

SECRETARY

METROPOLITAN HEALTH INSURANCE FUND
YEAR: 2026

Monthly Items	Filing Status
Budget	**Filed**
Assessments	**Filed**
Actuarial Certification	**Filed**
Reinsurance Policies	**Filed**
Fund Commissioners	**Filed**
Fund Officers	**Filed**
Renewal Resolutions	**Filed**
Indemnity and Trust	**Filed**
New Members	**Filed as New Members are approved**
Withdrawals	**Filed as Members Withdrawal**
Risk Management Plan and By Laws	**Filed**
Cash Management Plan	**Filed**
Unaudited Financials	**Filed through Q3 2025**
Annual Audit	**2025 to be filed**
Budget Changes	**N/A**
Transfers	**N/A**
Additional Assessments	**N/A**
Professional Changes	**N/A**
Officer Changes	**N/A**
RMP Changes	**N/A**
Bylaw Amendments	**N/A**
Contracts	**Filed**
Benefit Changes	**N/A**

Contract	Professional	Contract	Insurance	Term
Administration	PERMA	Y- in progress	Y	1/1/2024 - 12/31/2026*
Attorney	Antonelli Kantor Rivera	Y- in progress	Y	1/1/2024 - 12/31/2026*
Treasurer	Matt Laracy	Y- in progress	Y	1/1/2024 - 12/31/2026*
Deputy Treasurer	Derek Macchia	Y	Y	1/1/2024 - 12/31/2026*
Auditor	Bowman & Company	Y- in progress	Y	1/1/2025 - 12/31/2026*
Actuary	John Vataha	Y- in progress	Y	1/1/2024 - 12/31/2026*
Fund Coordinator	Eagle Rock	Y- in progress	Y	1/1/2024 - 12/31/2026*
QPA				
TPA - Aetna	Aetna	Y	Y	1/1/2026 - 12/31/2026
Medicare Advantage	Aetna	Y	Y	1/1/2026 - 12/31/2026
				*2 additional one-year terms - 2027 & 2028

METROPOLITAN HEALTH INSURANCE FUND CONTACTS
Year: 2026

Executive Director Team: This team handles all the administrative and financial aspects of the Fund such as rates, state regulatory compliance, and Executive Committee and subcommittee meetings.

Role	Name	Email	Phone
Executive Director	Jim Rhodes	jrhodes@permainc.com	856-552-4920
Associate Executive Director	Emily Koval	emilyk@permainc.com	201-518-7028
Account Manager	Caitlin Perkins	cperkins@permainc.com	856-479-2192
Assistant Account Manager	Jordyn Robinson	jrobinson@permainc.com	856-446-9287

Benefits Team: This team handles all the benefits of the Fund such as plan design, claim issues, cost containment strategies, and Third-Party communications.

Role	Name	Email	Phone
Public Entity & HIF Business Leader	Tammy Brown	tbrown@connerstrong.com	856-552-4694
HIF Business Leader	John Lajewski	jlajewski@connerstrong.com	856-552-4922
Associate Consultant	Melissa Appleby	mappleby@connerstrong.com	732-736-5268
Senior Business Development Executive	Sean Critchley, Esq.	Scritchley@connerstrong.com	973-736-6511

Client Services Team: This team handles all the enrollment and billing aspects of the Fund such as sending monthly invoices, open enrollment, and adjustments throughout the year.

Role	Name	Email	Phone
Director of Client Services	Crystal Bailey	cbailey@connerstrong.com	856-552-4914
Director of Benefits Operations	Karen Kidd	kkidd@connerstrong.com	856-552-4644
Client Service Specialist	Peter Moore	pmoore@permainc.com	856-479-2158

Pursuant to N.J.A.C Title 11, Chapter 15, Subchapter 5, Conner Strong & Buckelew Companies, LLC, as a servicing organization of the ***Metropolitan Health Insurance Fund ("the Fund")****, and its employees, officers and directors hereby provide notice that they have direct and indirect financial interests in PERMA, LLC, which is the Administrator for the Fund.*

Prospective Client	Agency	Funding Type	Network	Effective Date	Note(s)
Englewood City MA	Brown & Brown	SHBP	BCBS	3/1/2026	Joining MHIF Effective 3/1/2026
Hillsdale BOE	IMAC	SEHBP	BCBS	3/1/2026	Joining MHIF effective 3/1/2026
Mercer County MA	Fairview Insurance, FRP	SHBP	BCBS	4/1/2026	Joining MHIF Effective 4/1/2026
Old Bridge Twp	Conner Strong	SHBP	BCBS	4/1/2026	Joining MHIF Effective 4/1/2026
South Orange Maplewood MA	Fairview Insurance, FRP	SHBP	BCBS	5/1/2026	Closing documents with broker
New Jersey Water Supply Authoirty	Fairview Insurance, FRP	SHBP	BCBS	5/1/2026	Closing documents with broker
Paterson City MA	Fairview Insurance, FRP	Fully Insured	BCBS	6/1/2026	Anticipated 6/1/26 Effective Date
Passaic City MA	Fairview Insurance, FRP	SHBP	BCBS	6/1/2026	Anticipated 6/1/26 Effective Date
Caldwell Township	Fairview Insurance, FRP	SHBP	BCBS	5/1/2026	Presented to broker 2/11/2026-Looks Promising
West New York	Alamo	SHBP	BCBS	4/1/2026	Quote with Broker
Rahway BOE	Going Direct	SHBP	BCBS	7/1/2026	Emailed 01/15/2026
Long Branch BOE	PERMA	SHBP	BCBS	7/1/2026	Waiting on feedback from Joe DiB-Running Hot
Nutley Public Schools	IMAC, Acrisure	Self-Funded	BCBS	7/1/2026	Broker advised to circle back 3/1/2026
Englewood BOE	Going Direct	SHBP	BCBS	7/1/2026	Requesting claims as per meeting on 01/09/2026
Millburn BOE	Brown&Brown	SHBP	BCBS	7/1/2026	Meeting in February as per broker
Bloomfield BOE	Brown&Brown	SHBP	BCBS	7/1/2026	Meeting in February as per broker
North Bergen	Going Direct	SHBP	BCBS	1/1/2027	Reach out to BA 7/1/2026
Bloomfield Township Dental	R.D. Parisi & Associates	SHBP	BCBS	1/1/2027	Mayor approved rolling in dental on 12/17/2025
South Orange Maplewood Dental	Fairview Insurance, FRP	SHBP	BCBS	TBD	Broker going to get data
Kearny BOE	IMAC, Bryan Atkinson	Fully Insured	BCBS	7/1/2026	Sent info to PERMA to evaluate

Groups that have Joined:

Prospective Client	Agency	Funding Type	Network	Effective Date	Note(s)
Maplewood Twp	David Balken	Fully Insured	Delta Dental	6/1/2025	Joined MHIF effective 6/1/25
Montclair MA	IMAC	SHBP	BCBS	1/1/2026	Joined MHIF effective 1/1/26
Secaucus Township	Fairview Insurance, FRP	SHBP	BCBS	1/1/2026	Joined MHIF effective 1/1/26
Guttenberg Township	Brown & Brown	TBD	TBD	1/1/2026	Joined MHIF effective 1/1/26
North Hudson Regional Fire	Alamo Insurance	SHBP	BCBS	1/1/2026	Joined MHIF effective 1/1/26

Contact Information	Title	Email	Phone
Joseph DiVincenzo	President	joed@eaglerockmg.com	856-420-2989 x4685
Diane Romano	Senior Account Manager	dianer@eaglerockmg.com	856-420-2989 x3633
Thomas Kelly	Account Manager	tom@eaglerockmg.com	856-420-2989 x3938

METROPOLITAN HEALTH INSURANCE FUND
BILLS LIST

FEBRUARY 2026

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

BE IT RESOLVED that the Metropolitan Health Insurance Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

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

FUND YEAR 2025

VendorName	Comment	InvoiceAmount
PERMA	PROGRAM MANAGER 03/25	44,716.10
PERMA	2025 AATRIX 1099 FILING	34.10
PERMA	ADMIN FEES 03/25	36,585.90
		81,336.10
MUNICIPAL REINSURANCE H.I.F.	SPECIFIC REINSURANCE 02/25	207,481.19
		207,481.19
	Total Payments FY 2025	**288,817.29**

FUND YEAR 2026

VendorName	Comment	InvoiceAmount
PERMA	POSTAGE 01/26	49.87
PERMA	ADMIN FEES 02/26	45,820.98
PERMA	PROGRAM MANAGER FEES 02/26	56,003.42
		101,874.27
DEREK MACCHIA	DEPUTY TREASURER FEE 02/26	625.00
		625.00
USA TODAY MEDIA CORP.	A# 1488194 ORDER# 12017461 1/23/26	36.60
		36.60
NJ ADVANCE MEDIA	A# 208875 ORDER# 11063667 1/23/26	63.76
		63.76
WELLNESS COACHES USA LLC	WELLNESS COACH INV 39878 01/26	8,816.00
		8,816.00
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 02/26	63,247.71
		63,247.71
BROWN & BROWN METRO, LLC	BROKER FEES 02/26	44,415.22
		44,415.22
MUNICIPAL REINSURANCE H.I.F.	SPECIFIC REINSURANCE 02/26	369,360.72
		369,360.72
	TOTAL CHECKS 2026	**588,439.28**
AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 02/26	1,427,169.24
		1,427,169.24
UNITED HEALTHCARE INS COMPANY	MEDICARE ADVANTAGE 02/26	113,672.79
		113,672.79
DELTA DENTAL INSURANCE COMPANY	DENTAL- BE006901747 F1-7871900000 02/26	5,827.36
		5,827.36

FAIRVIEW INSURANCE AGENCY ASSOCIATES	BROKER FEES 02/26	105,070.98
		105,070.98
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 02/26	49,095.93
		49,095.93
EAGLE ROCK MANAGEMENT GROUP, LLC	FUND COORDINATOR 02/26	101,631.00
		101,631.00
DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 02/26	6,877.06
		6,877.06
AETNA	MEDICAL TPA FEES 02/26	110,994.80
		110,994.80
INSURANCE SOLUTIONS, INC	BROKER FEES 02/26	871.08
		871.08
POINT ACCOUNTING GROUP	TREASURER FEES 02/26	2,500.00
		2,500.00
	TOTAL ACH/WIRES 2026	**1,923,710.24**
	Total Payments FY 2026	**2,512,149.52**
	TOTAL PAYMENTS ALL FUND YEAR	**2,800,966.81**

_____

Chairperson

Attest:

_____

Dated:

_____

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

_____

Treasurer

Metro Employee Benefits Fund

SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED

Current Fund Year: 2025 Month Ending: November	Medical	Dental	Rx	Vision	Run-In	Reinsurance	RSR	Admin	Dividend Reserve	BMED Interfund	TOTAL
OPEN BALANCE	(2,061,023.25)	161,487.67	(666,395.69)	0.00	0.00	2,251,170.08	930,540.77	1,407,112.01	0.00	0.00	2,022,891.59
RECEIPTS											
Assessments	6,890,104.64	136,513.84	247,596.88	0.00	0.00	229,072.95	71,695.35	495,743.06	0.00	0.00	8,070,726.72
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	7,016.50	164.92	0.00	0.00	0.00	2,299.07	950.34	1,443.88	0.00	0.00	11,874.71
Invest Adj	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal Invest	7,016.50	164.92	0.00	0.00	0.00	2,299.07	950.34	1,443.88	0.00	0.00	11,874.71
Other *	109,701.09	0.00	56,121.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	165,822.79
TOTAL	7,006,822.23	136,678.76	303,718.58	0.00	0.00	231,372.02	72,645.69	497,186.94	0.00	0.00	8,248,424.22
EXPENSES											
Claims Transfers	5,471,213.59	98,826.34	426,417.93	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,996,457.86
Expenses	1,015,807.50	5,315.65	0.00	0.00	0.00	0.00	0.00	302,638.19	0.00	0.00	1,323,761.34
Other *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL	6,487,021.09	104,141.99	426,417.93	0.00	0.00	0.00	0.00	302,638.19	0.00	0.00	7,320,219.20
END BALANCE	**(1,541,222.11)**	**194,024.44**	**(789,095.04)**	**0.00**	**0.00**	**2,482,542.10**	**1,003,186.46**	**1,601,660.76**	**0.00**	**0.00**	**2,951,096.61**

CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES

Metro Employee Benefits Fund

Month	**November**
Current Fund Year	**2025**

Policy Year	Coverage	1. Calc. Net Paid Thru Last Month	2. Monthly Net Paid November	3. Monthly Recoveries November	4. Calc. Net Paid Thru November	5. TPA Net Paid Thru November	6. Variance To Be Reconciled	7. Delinquent Unreconciled Variance From	8. Change This Month
2025	Medical	50,264,688.59	5,155,804.34	0.00	55,420,492.93	0.00	55,420,492.93	50,264,688.59	5,155,804.34
	Dental	1,092,424.20	98,826.34	0.00	1,191,250.54	0.00	1,191,250.54	1,092,424.20	98,826.34
	Rx	3,388,468.90	426,417.93	0.00	3,814,886.83	0.00	3,814,886.83	3,388,468.90	426,417.93
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	**54,745,581.69**	**5,681,048.61**	**0.00**	**60,426,630.30**	**0.00**	**60,426,630.30**	**54,745,581.69**	**5,681,048.61**

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS			
Metro Employee Benefits Fund			
ALL FUND YEARS COMBINED			
CURRENT MONTH		**November**	
CURRENT FUND YEAR		**2025**	
		Description:	**CHECKING**
		ID Number:	
		Maturity (Yrs)	
		Purchase Yield:	
		TOTAL for All Accts & instruments	
Opening Cash & Investment Balance		**$2,022,891.56**	**2,022,891.56**
Opening Interest Accrual Balance		**$0.00**	**-**
1	Interest Accrued and/or Interest Cost	$0.00	$0.00
2	Interest Accrued - discounted Instr.s	$0.00	$0.00
3	(Amortization and/or Interest Cost)	$0.00	$0.00
4	Accretion	$0.00	$0.00
5	Interest Paid - Cash Instr.s	$11,874.71	$11,874.71
6	Interest Paid - Term Instr.s	$0.00	$0.00
7	Realized Gain (Loss)	$0.00	$0.00
8	Net Investment Income	$11,874.71	$11,874.71
9	Deposits - Purchases	$8,236,549.51	$8,236,549.51
10	(Withdrawals - Sales)	-$7,320,219.20	-$7,320,219.20
Ending Cash & Investment Balance		$2,951,096.58	$2,951,096.58
Ending Interest Accrual Balance		$0.00	$0.00
Plus Outstanding Checks		$1,493,597.42	$1,493,597.42
(Less Deposits in Transit)		$0.00	$0.00
Balance per Bank		$4,444,694.00	$4,444,694.00

METRO CLAIMS

Monthly Claim Activity Report

February 19, 2026

METRO

	MEDICAL CLAIMS PAID 2024	# OF EES	PER EE	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$724,016	2,682	$ 270	$4,688,076	2,369	$ 1,979
FEBRUARY	$3,974,566	2,658	$ 1,495	$4,919,355	2,436	$ 2,019
MARCH	$5,419,303	2,666	$ 2,033	$5,699,838	2,426	$ 2,349
APRIL	$6,007,197	2,624	$ 2,289	$7,407,692	2,431	$ 3,047
MAY	$4,346,049	2,630	$ 1,652	$7,222,409	2,434	$ 2,967
JUNE	$5,971,793	2,627	$ 2,273	$6,588,676	2,433	$ 2,708
JULY	$6,220,272	2,649	$ 2,348	$4,979,246	2,440	$ 2,041
AUGUST	$4,753,326	2,643	$ 1,798	$6,844,995	2,438	$ 2,808
SEPTEMBER	$4,750,184	2,627	$ 1,808	$6,588,652	2,405	$ 2,740
OCTOBER	$5,943,377	2,713	$ 2,191	$5,868,857	2,451	$ 2,394
NOVEMBER	$5,722,476	2,719	$ 2,105	$5,395,907	2,471	$ 2,184
DECEMBER	$6,521,762	2,118	$ 3,079	$6,381,769	2,469	$ 2,585
TOTALS	**$60,354,319**			**$72,585,471**		
				2025 Average	**2,434**	**$ 2,485**
				2024 Average	**2,613**	**$ 1,945**

RUN OUT

	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$194,623	2,369	$ 82
FEBRUARY	$106,504	2,436	$ 44
MARCH	$67,081	2,426	$ 28
APRIL	$75,116	2,431	$ 31
MAY	$278,804	2,434	$ 115
JUNE	$40,812	2,433	$ 17
JULY	-$9,448	2,440	$ (4)
AUGUST	$5,435	2,438	$ 2
SEPTEMBER	$2,085	2,405	$ 1
OCTOBER	-$1,954	2,451	$ (1)
NOVEMBER	$18,483	2,471	$ 7
DECEMBER	$5,063	2,469	$ 2
TOTALS	**$782,603**		

Large Claimant Report (Drilldown) - Claims Over $100000

Plan Sponsor Unique ID :	All	**Paid Dates:**	12/01/2025 - 12/31/2025
Customer:	**METRO**	**Service Dates:**	01/01/2011 - 12/31/2025
Group / Control:	00232370,00232371 - METRO FUND	**Line of Business:**	All

	Paid Amt	**Diagnosis/Treatment**
	$159,070.81	NONRHEUMATIC AORTIC (VALVE) STENOSIS WITH
	$135,014.91	NEUROPATHIC HEREDOFAMILIAL
	$111,460.42	SPONDYLOSIS WITHOUT MYELOPATHY OR
	$109,092.13	SEPSIS, UNSPECIFIED ORGANISM
Total:	**$514,638.27**	

aetna™

Metropolitan Health Insurance Fund
1/1/25 thru 12/31/25 (unless otherwise noted)

Dashboard

Medical Claims Paid:
January 2025 thru December 2025

Total Medical Paid per EE: **$2,485**
** Claims Run-Out under old BMED control*

Network Discounts

Inpatient:	**64.6%**
Ambulatory:	**65.6%**
Physician/Other:	**64.1%**
TOTAL:	**64.7%**

Provider Network

% Admissions In-Network:	**94.4%**
% Physician Office:	**91.6%**

Aetna Book of Business:
Admissions 97.6%; Physician 91.8%

Top Facilities Utilized
(by total Medical Spend)

- JFK University Medical Center
- Overlook Medical Center
- Morristown Medical Center
- Cooperman Barnabas Medical Ctr
- RWJUH New Brunswick

Catastrophic Claim Impact
January 2025 – December 2025

Number of Claims Over $50,000: **252**
Claimants per 1000 members: **44.7**
Avg. Paid per Claimant: **$145,978**
Percent of Total Paid: **53.8%**

- **Aetna BOB- HCC account for an average of 46.1% of total Medical Cost**

Aetna One Flex Care Mgmt Member Outreach:

Total Members Identified: **1,541** (25.3%)
Members Targeted for 1:1 Nurse Support : **293** (**20.0%** engaged)
Members identified for Digital Activity: **1,237 (83.4%)**
Members receiving Aetna Advice: **414 (8.4%)**
Average Aetna Advice outreaches per member: **1.1**

CVS Health. CVS Virtual Care
January 2025 – December 2025

Completed Visits: **33**
Unique Patients : **30**
Completed Visits in 2025 : **211**
Unique Patients in 2025: **123**
Total Scheduled Visits in 2025: **278**
Average visit duration: **10** Minutes
BoB: Average First Available: **38** minutes
BoB: Average First Available (6am-6pm)
36 Minutes

Service Center Performance Goal Metrics YTD 2025

Customer Service Performance

1st Call Resolution:	**93.68%**
Abandonment Rate:	**0.43%**
Avg. Speed of Answer:	**12.0 sec**

Claims Performance

Financial Accuracy:	**97.76%**
*Q3 2025	
-	
90% processed w/in:	**7.4 days**
95% processed w/in:	**15.3 days**

****

Claims Performance (Monthly)
(December 2025)

90% processed w/in:	**6.9 days**
95% processed w/in:	**13.6 days**

(Note: This is not a PG metric)

****

Performance Goals

1st Call Resolution:	**90%**
Abandonment Rate less than:	**3.0%**
Average Speed of Answer:	**30 sec**
Financial Accuracy:	**99%**
Turnaround Time	
90% processed w/in:	**14 days**
95% processed w/in:	**30 days**


EXPRESS SCRIPTS®

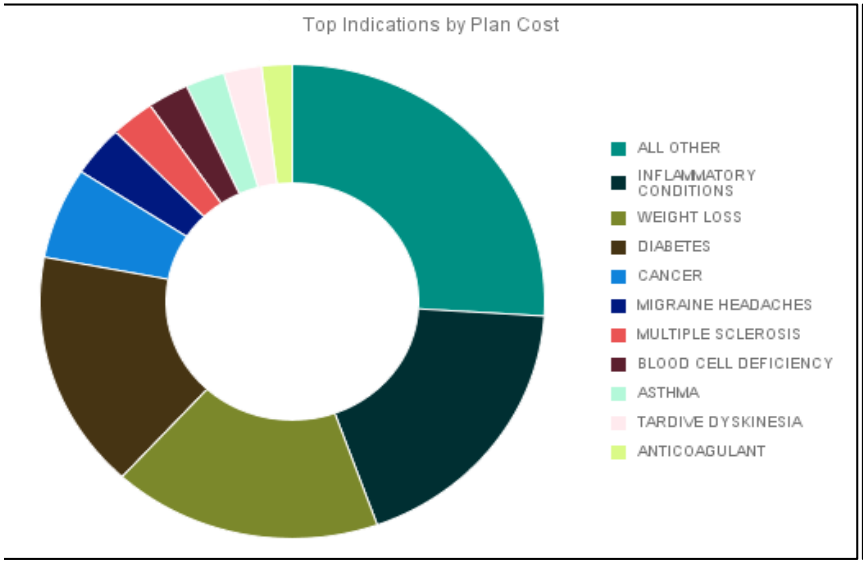
Metropolitan Health Insurance Fund

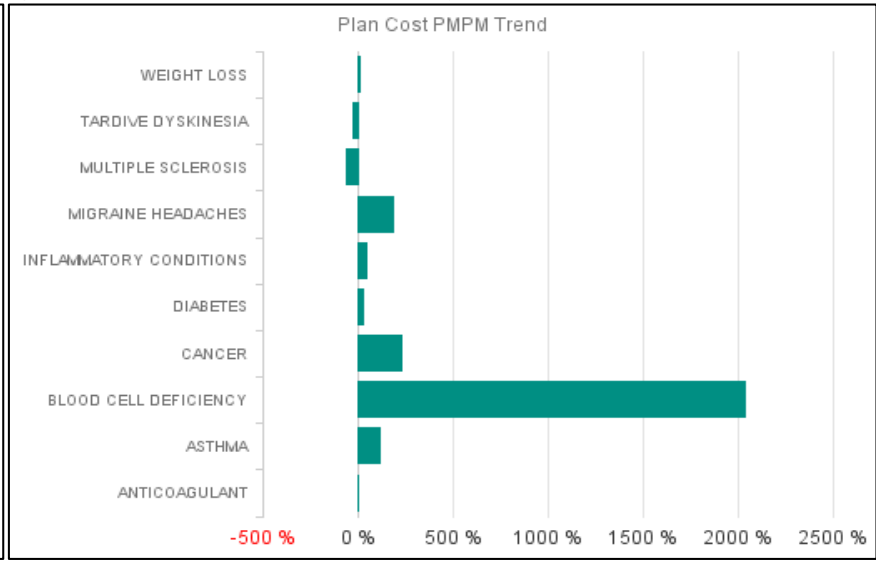
Total Component/Date of Service (Month)	2024 01	2024 02	2024 03	2024 Q1	2024 04	2024 05	2024 06	2024 Q2	2024 07	2024 08	2024 09	2024 Q3	2024 10	2024 11	2024 12	2024 Q4	2024 YTD
Membership	972	963	960	965	970	965	957	964	946	947	952	948	968	990	984	981	965
Total Days	24,314	27,528	27,455	79,297	29,053	32,052	27,820	88,925	30,797	29,467	30,030	90,294	34,030	32,808	35,417	102,255	360,771
Total Patients	284	292	308	465	318	308	301	485	303	307	315	469	357	353	362	539	715
Total Plan Cost	$153,801	$106,316	$117,731	$377,849	$138,031	$171,454	$156,213	$465,697	$205,353	$187,823	$167,234	$560,409	$274,108	$179,016	$214,628	$667,752	$2,071,708
Generic Fill Rate (GFR) - Total	86.2%	85.8%	86.1%	86.0%	86.5%	84.1%	84.0%	84.9%	83.7%	80.2%	80.4%	81.5%	81.2%	84.4%	81.9%	82.5%	83.6%
Plan Cost PMPM	$158.23	$110.40	$122.64	$130.52	$142.30	$177.67	$163.23	$161.03	$217.07	$198.33	$175.67	$196.98	$283.17	$180.82	$218.12	$226.97	$179.00
Total Specialty Plan Cost	$80,389	$23,717	$27,003	$131,108	$54,301	$37,700	$48,055	$140,057	$76,068	$71,220	$48,563	$195,851	$161,184	$53,548	$70,817	$285,549	$752,565
Specialty % of Total Specialty Plan Cost	52.3%	22.3%	22.9%	34.7%	39.3%	22.0%	30.8%	30.1%	37.0%	37.9%	29.0%	34.9%	58.8%	29.9%	33.0%	42.8%	36.3%

Total Component/Date of Service (Month)	2025 01	2025 02	2025 03	2025 Q1	2025 04	2025 05	2025 06	2025 Q2	2025 07	2025 08	2025 09	2025 Q3	2025 10	2025 11	2025 12	2025 Q4	2025 YTD
Membership	1,583	1,745	1,738	1,689	1,736	1,735	1,736	1,736	1,736	1,739	1,737	1,737	1,730	1,734	1,735	1,733	1,724
Total Days	59,833	60,345	70,456	190,634	65,736	61,053	61,382	188,171	58,914	60,428	60,555	179,897	59,136	56,002	64,893	179,779	738,841
Total Patients	550	598	602	927	596	543	555	895	540	544	557	866	568	549	654	944	1,306
Total Plan Cost	$360,333	$263,585	$400,194	$1,024,112	$369,565	$337,451	$414,442	$1,121,458	$415,010	$369,278	$335,711	$1,119,999	$438,857	$345,729	$458,151	$1,247,658	4,513,240
Generic Fill Rate (GFR) - Total	85.1%	84.0%	82.7%	83.9%	84.6%	84.0%	84.2%	84.3%	83.7%	83.5%	79.5%	82.2%	78.1%	81.7%	82.9%	81.0%	82.9%
Plan Cost PMPM	$227.63	$151.05	$230.26	$202.15	$212.88	$194.50	$238.73	$215.38	$239.06	$212.35	$193.27	$214.89	$253.67	$199.38	$264.06	$239.98	218.20
% Change Plan Cost PMPM	43.9%	36.8%	87.8%	54.9%	49.6%	9.5%	46.3%	33.7%	10.1%	7.1%	10.0%	9.1%	-10.4%	10.3%	21.1%	5.7%	21.9%
Total Specialty Plan Cost	$144,724	$50,528	$138,310	$333,561	$144,054	$107,491	$196,191	$447,736	$165,644	$132,113	$111,477	$409,234	$197,300	$134,209	$198,117	$537,961	$1,728,492
Specialty % of Total Specialty Plan Cost	40.2%	19.2%	34.6%	32.6%	39.0%	31.9%	47.3%	39.9%	39.9%	35.8%	33.2%	36.5%	45.0%	38.8%	43.2%	43.1%	38.3%

Top Indications

Metropolitan Health Insurance (Current Period 01/2025 - 12/2025 vs. Previous Period 01/2024 - 12/2024) Peer = Government - National Preferred Formulary





			Current Period						Previous Period						Trend
Rank	Peer Rank	Indication	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Plan Cost PMPM
1	2	INFLAMMATORY CONDITIONS	25.1 %	321	$837,577	$40.49	52.0 %	28.7 %	22.3 %	129	$322,148	$27.83	52.7 %	32.1 %	45.5 %
2	4	WEIGHT LOSS	23.3 %	716	$777,662	$37.60	1.7 %	3.7 %	26.7 %	350	$384,623	$33.23	0.3 %	5.0 %	13.1 %
3	1	DIABETES	21.9 %	2,206	$732,294	$35.40	32.3 %	23.3 %	21.9 %	1,003	$315,612	$27.27	34.9 %	25.4 %	29.8 %
4	3	CANCER	8.4 %	86	$280,908	$13.58	84.9 %	75.1 %	3.3 %	55	$47,492	$4.10	96.4 %	75.7 %	231.0 %
5	5	MIGRAINE HEADACHES	4.7 %	216	$155,461	$7.52	34.3 %	50.7 %	2.1 %	53	$30,184	$2.61	58.5 %	52.7 %	188.2 %
6	7	MULTIPLE SCLEROSIS	3.8 %	19	$126,986	$6.14	47.4 %	46.8 %	12.1 %	29	$174,301	$15.06	48.3 %	48.6 %	-59.2 %
7	9	BLOOD CELL DEFICIENCY	3.6 %	13	$119,118	$5.76	53.8 %	17.9 %	0.2 %	1	$3,127	$0.27	0.0 %	0.7 %	2031.7 %
8	6	ASTHMA	3.4 %	949	$112,797	$5.45	86.3 %	88.0 %	2.0 %	489	$29,001	$2.51	89.6 %	88.2 %	117.6 %
9	10	TARDIVE DYSKINESIA	3.3 %	15	$109,594	$5.30	0.0 %	6.7 %	6.0 %	13	$86,159	$7.44	0.0 %	6.6 %	-28.8 %
10	8	ANTICOAGULANT	2.6 %	183	$88,322	$4.27	9.8 %	18.3 %	3.4 %	134	$49,246	$4.25	6.7 %	18.7 %	0.4 %
		Total Top 10		**4,724**	**$3,340,719**	**$161.51**	**40.1 %**	**38.2 %**		**2,256**	**$1,441,892**	**$124.58**	**42.7 %**	**41.4 %**	**29.6 %**

Top Drugs

Metropolitan Health Insurance (Current Period 01/2025 - 12/2025 vs. Previous Period 01/2024 - 12/2024) Peer = Government - National Preferred Formulary

					Current Period				Previous Period				Trend
Rank	Peer Rank	Brand Name	Indication	Specialty Drug	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Plan Cost PMPM
1	6	ZEPBOUND	WEIGHT LOSS	N	448	57	$457,514	$22.12	166	23	$163,368	$14.12	56.7 %
2	12	WEGOVY	WEIGHT LOSS	N	252	35	$318,787	$15.41	177	26	$220,376	$19.04	-19.1 %
3	199	SCEMBLIX	CANCER	Y	13	1	$280,432	$13.56	2	1	$31,555	$2.73	397.3 %
4	1	MOUNJARO	DIABETES	N	184	22	$186,672	$9.02	51	9	$50,300	$4.35	107.7 %
5	8	SKYRIZI PEN	INFLAMMATORY CONDITIONS	Y	22	2	$159,254	$7.70	4	1	$29,042	$2.51	206.8 %
6	4	OZEMPIC	DIABETES	N	171	19	$156,389	$7.56	121	16	$105,839	$9.14	-17.3 %
7	24	SKYRIZI ON-BODY	INFLAMMATORY CONDITIONS	Y	14	2	$142,802	$6.90	10	1	$91,274	$7.89	-12.5 %
8	189	INGREZZA	TARDIVE DYSKINESIA	Y	15	1	$109,594	$5.30	13	1	$86,159	$7.44	-28.8 %
9	9	JARDIANCE	DIABETES	N	188	22	$108,321	$5.24	71	8	$39,446	$3.41	53.7 %
10	128	VUMERITY	MULTIPLE SCLEROSIS	Y	10	1	$92,255	$4.46	15	1	$99,444	$8.59	-48.1 %
11	177	SOTYKTU	INFLAMMATORY CONDITIONS	Y	12	1	$74,501	$3.60	NA	NA	NA	NA	NA
12	214	ELTROMBOPAG OLAMINE	BLOOD CELL DEFICIENCY	Y	7	1	$69,521	$3.36	NA	NA	NA	NA	NA
13	17	ENBREL SURECLICK	INFLAMMATORY CONDITIONS	Y	10	2	$63,974	$3.09	NA	NA	NA	NA	NA
14	175	ACTEMRA ACTPEN	INFLAMMATORY CONDITIONS	Y	13	1	$60,603	$2.93	14	1	$50,704	$4.38	-33.1 %
15	31	NURTEC ODT	MIGRAINE HEADACHES	N	37	10	$55,305	$2.67	11	3	$19,571	$1.69	58.1 %
16	298	HUMIRA(CF)	INFLAMMATORY CONDITIONS	Y	9	1	$52,954	$2.56	NA	NA	NA	NA	NA
17	21	ELIQUIS	ANTICOAGULANT	N	104	14	$52,434	$2.53	85	9	$28,492	$2.46	3.0 %
18	151	PROMACTA	BLOOD CELL DEFICIENCY	Y	5	1	$48,957	$2.37	NA	NA	NA	NA	NA
19	23	FARXIGA	DIABETES	N	94	11	$48,813	$2.36	19	3	$9,665	$0.84	182.6 %
20	41	QULIPTA	MIGRAINE HEADACHES	N	44	5	$46,956	$2.27	5	2	$4,992	$0.43	426.4 %
21	45	XOLAIR	ASTHMA	Y	18	2	$45,496	$2.20	NA	NA	NA	NA	NA
22	11	RINVOQ	INFLAMMATORY CONDITIONS	Y	4	1	$43,303	$2.09	NA	NA	NA	NA	NA
23	33	TRULICITY	DIABETES	N	41	6	$38,014	$1.84	25	3	$22,754	$1.97	-6.5 %
24	163	DIMETHYL FUMARATE	MULTIPLE SCLEROSIS	Y	9	1	$34,730	$1.68	14	1	$74,858	$6.47	-74.0 %
25	39	HUMIRA(CF) PEN	INFLAMMATORY CONDITIONS	Y	6	1	$33,999	$1.64	13	1	$74,665	$6.45	-74.5 %
			Total Top 25		**1,730**		**$2,781,581**	**$134.48**	**816**		**$1,202,502**	**$103.90**	**29.4 %**

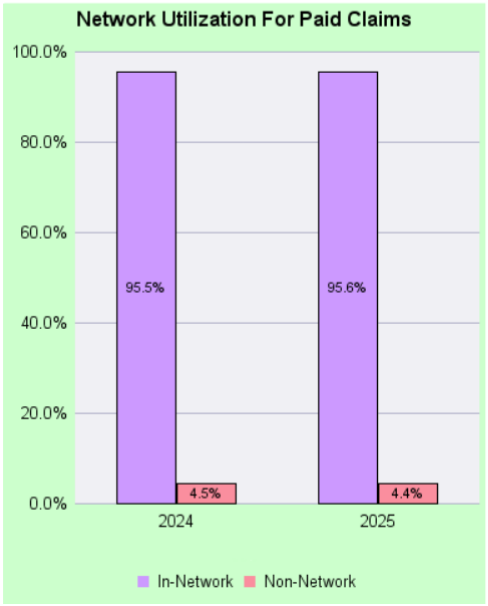
DELTA DENTAL

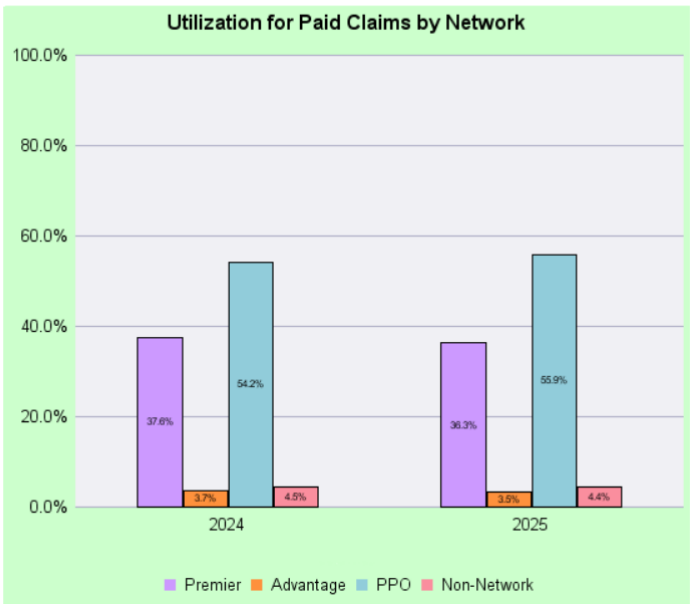
DELTA DENTAL

Network Utilization

METROPOLITAN HEALTH INSURANCE FUND - 03606

January 2025 - December 2025





METROPOLITAN HEALTH INSURANCE FUND
CONSENT AGENDA
FEBURARY 19, 2026

The following Resolutions listed on the Consent Agenda will be enacted in one motion. Copies of all Resolutions are available to any person upon request. Any Commissioner wishing to remove any Resolution(s) to be voted upon, may do so at this time, and said Resolution(s) will be moved and voted separately.

RESOLUTION NO. 4-26

METROPOLITAN HEALTH INSURANCE FUND
DESIGNATING
THE OFFICIAL NEWSPAPER(S) FOR THE FUND YEAR 2026

WHEREAS, pursuant to P.L. 2025, c.72, effective March 1, 2026, public entities are required to publish all legal notices on their official websites, with a hyperlink to such notices prominently displayed on the homepage; and

WHEREAS, said law further requires public entities, for Fund Year 2026, to advertise at least twice per month in an eligible online news publication that legal notices may be viewed on the public entity's official website and to provide a hyperlink to the New Jersey Secretary of State's legal notice portal; and

WHEREAS, the Executive Committee of the Metropolitan Health Insurance Fund desires to designate official media for the advertising of legal notices in compliance with P.L. 2025, c.72;

NOW, THEREFORE, BE IT RESOLVED by the Executive Committee of the Metropolitan Health Insurance Fund that _____, being an eligible online news publication, is hereby designated as the official media for the required twice-monthly advertisement of legal notices for Fund Year 2026; and

BE IT FURTHER RESOLVED that the official website of the Metropolitan Health Insurance Fund, located at www.metrohif.com, is hereby designated as the official electronic media site for the publication of all legal notices in accordance with applicable law.

ADOPTED: FEBURARY 19, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

REVISED RESOLUTION NO. 8-26

METROPOLITAN HEALTH INSURANCE FUND

RISK MANAGEMENT PLAN

Effective: JANUARY 1, 2026

Adopted: JANUARY 15, 2026

Revised: FEBRUARY 19, 2026

METROPOLITAN HEALTH INSURANCE FUND
2026 RISK MANAGEMENT PLAN

BE IT RESOLVED that the following shall be the Fund's Risk Management Plan for the 2026 Fund year:

1.) COVERAGE OFFERED

- Medical

  The Fund offers a "point of services" and "open access" plan designs. These plans have both in network and out of network benefit. The Fund can offer other plans as may meet the needs of the members. Starting in 2012, the Fund also offered "low cost plans" to allow members options to comply with contribution requirements under Chapter 78 and for those covered under Chapter 44. Included as options are a health savings account-consumer directed health plan, a core PPO program, a buy up PPO program, an HMO plan and the plans for those covered under Chapter 44. The Fund also offers Medicare Advantage plans for Medicare eligible retirees.

- Dental

  The Fund offers customized dental plans as required by the members.

- Prescription

  The Fund offers customized prescription plans as required by the members, including plans that are coordinated with the low cost medical plan options. The Fund also offers "Employer Group Waiver Plans" for Medicare eligible retirees.

- Vision

  The Fund offers customized vision plans as required by the members.

2.) LIMITS OF COVERAGE

Limits of coverage vary by member plan design.

3.) RISK RETAINED BY THE FUND

The FUND provides coverage on a self-insured basis and secures excess insurance and/or reinsurance to cap the specific (i.e. per enrolled covered person per policy year) retention. The FUND is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The

MRHIF retains claims above the FUND's local specific retention and purchases an excess insurance policy and/or reinsurance that is filed with the Department of Banking and Insurance in accordance with the applicable regulations.

The Fund takes no risk on Medicare Advantage and Employer Group Waiver Plan fully-insured policies purchased for Medicare retirees.

Pre-Medicare retirees and active employees and their dependents are covered by self-insured plans. Risk retained by the Fund for these plans is summarized as follows:

Medical and Prescription:

- **Specific Coverage:** The Fund self-insures for the first $425,000 per person per agreement year and obtains reinsurance through its membership in the Municipal Reinsurance Health Insurance Fund "MRHIF" for claims in excess of its Self-Insured Retention "SIR" to an unlimited maximum per person per contract period (incurred in 12 months paid in 24 months).
- **Specific Limit:** Unlimited
- **Basis**: Incurred 12 months, paid 24 months.

- **Aggregate Coverage:** The Fund does not purchase aggregate coverage given its surplus position and as a result of long term cost-benefit analysis of the effectiveness of such coverage for joint insurance funds in New Jersey.

- **Dental Specific and Aggregate Claims Coverage:** The FUND does not purchase either aggregate or specific coverage for dental claims.

Extra contractual claims are excluded from reinsurance coverage.

4.) ASSUMPTIONS AND METHODOLOGY TO CALCULATE CLAIM RESERVES.

The Fund complies with statutory accounting standards and establishes reserves on the probable total claim costs at conclusion. Each month, the accrual in the general ledger for claim reserves, including IBNR, is adjusted based on earned underwriting income and the number of months since the inception of the Fund year. This accrual is the adjusted at the end of each quarter in accordance with the actuary's projections.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the year, the Fund adopts a budget for the upcoming year based on the most recent census. Per employee rates are computed for each line of coverage for

each Fund member, and are approved by the Fund as a part of the budget adoption and rate certification process. These rates are used to compute the members' monthly assessment based on the updated census, and are mailed to the members approximately 15 days before the beginning of the month. The billing also includes the member's updated census for verification each month by the local entity. Retroactive adjustments for enrollment changes are limited to 2 months. Former participants (COBRA, Conversion and some retirees) and, in some cases, Dependents under age 31, are billed directly by the Fund. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the fiscal impact to the Fund. The Committee will approve/deny the request within 45 days.

6.) COVERAGE PURCHASED FROM INSURERS AND PARTICIPATION IN THE MUNICIPAL REINSURANCE HEALTH INSURANCE FUND (MRHIF)

The Fund provides coverage on a self-insured basis, and secures excess insurance to cap the Funds' specific (i.e. per covered person per policy year) retention. The Fund is a member of the Municipal Reinsurance Health Insurance Fund (MRHIF). The MRHIF retains claims above the Fund's local specific retention and purchases an excess insurance policy that is filed with the Department of Banking and Insurance in accordance with the applicable regulations.

7.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, the prospective member's benefit program is reviewed by the actuary to determine its projected claim cost. In this evaluation, the actuary takes into consideration:

a.) age/sex factor as compared to the average for the existing Fund membership;
b.) the plan of benefits for the prospective member; and
c.) loss data if available.

The actuary then recommends a relativity factor and estimated assessment for the entity. This recommendation requires Fund approval before the prospective member is admitted to the Fund.

Rates for all members are adjusted at the beginning of each Fund year to reflect the new budget. The Fund may also adopt mid Fund year rate changes to reflect changes in plan design, participation in lines of coverage, or a budget amendment. Additionally, if a member terminates a line of coverage but continues membership for other lines of coverage, the rates for the remaining lines of coverage may be adjusted and the entity shall not be eligible for membership in the dropped line of coverage for a three year period.

Unless otherwise authorized as part of the offer of membership, when a member joins during a FUND year, the member's initial rates are only valid through the end of the then current FUND year at which time the rates are adjusted for all members to reflect the new budget.

Prospective members may be offered entry rates of up to eighteen (18) months to allow for the alignment of renewals with the fiscal years of the FUND or of the entity.

Loss experience used by the Fund to determine loss ratio adjustments will be made available twice per year to members at no additional cost. For entities with loss ratios of 100% or greater, rate adjustments of up to +2.5% may be considered. For entities with loss ratios below 100%, rate adjustments of up to -2.5% may be considered. Additional adjustments can be considered for plans lacking standard utilization management features.

"Loss experience data" is defined as monthly claims and assessments for a three year period including de-identified specific claims at 50% of the Fund's self-insured retention. Requests for additional claims data can be considered based upon the availability of data, the feasibility of extracting the data, and the reimbursement to the Fund or its vendors of data extraction and formatting costs.

8.) RATING PERIODS

All rating periods for municipal members coincide with the Fund year while rating periods for school members can coincide with their fiscal year (July 1 to June 30).

9.) FACTORS IF RATES FOR MEMBERS JOINING THE FUND DURING A FUND YEAR ARE TO BE ADJUSTED.

Unless otherwise authorized as part of the offer of membership, where a member joins during a Fund year, the member's initial rates are only valid through the end of that Fund year or, for schools, fiscal year, at which time the rates are adjusted for all members to reflect the new budget.

10.) PROVISION FOR PPOs, etc.

The Fund offers employees the option of selecting various plans depending upon member bargaining agreements. Generally, it is the policy of the Fund to encourage selection of lower cost plan designs as opposed to traditional indemnity plans, and the Fund provides promotional material to assist members in employee communication programs concerning optional plan designs.

11.) OPEN ENROLLMENT PROCEDURES

Open enrollment periods shall be scheduled by the Fund at least yearly for each member and as is otherwise required to comply with plan document requirements and to effectuate plan design, network changes, and plan migrations that may take place.

12.) COBRA AND CONVERSION OPTIONS

The Fund provides COBRA coverage at a rate equal to the member's current rate and benefit plan design, plus the appropriate administrative charge. The Fund has arranged for a COBRA administrator to enroll eligible participants and to collect the premium. Where provided for in a member's plan document, the Fund provides a conversion option at rates established by the Fund. Unless otherwise specified in the member's plan document, the conversion option duplicates the conversion option offered by the SHBC. The Fund's coverage for individuals covered under COBRA or conversion options shall terminate effective the date the member withdraws from the Fund, or otherwise ceases to be a member of the Fund.

13.) DISCLOSURE OF BENEFIT LIMITS

The Fund discloses benefit limits in plan booklets provided to all covered employees.

14.) PARTICIPATION RULES WHEN ALL OR PART OF THE PREMIUM IS DERIVED FROM EMPLOYEE CONTRIBUTIONS

All assessments, including additional assessments and dividends, are the responsibility of the member, not the employee or former employee. Employee contributions, if any, are solely an internal policy of the member which shall not impact on the member's obligations to the Fund or confer any additional rights to the employees. Where the Fund directly bills an employee, (i.e. COBRA, etc.), this shall be considered as a service to reduce the member's administrative burden, and the member shall be responsible in the event of non-payment.

15.) RETIREES

The Fund duplicates coverage for eligible retirees. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund, or otherwise ceases to be a member of the Fund.

16.) NEWBORN CHILDREN

All plan documents will have the following language:
"You may remove family members from the policy at any time, but you may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is your responsibility to notify your employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until you have formally requested that change. Newborn children, but not grandchildren of an eligible employee, shall be automatically covered from birth for sixty (60) days, even if not enrolled within the required sixty (60) days. In the event of an eligible dependent giving birth to a child, (a grandchild) benefits for any hospital length of stay in connection with childbirth for the mother or newborn grandchild will apply for up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn grandchild's attending provider, after consulting with the mother, may discharge the mother or her newborn grandchild earlier than 48 hours (or 96 hours as applicable). Pursuant to

N.J.A.C. 11:15-3.6 (d) 17, automatic coverage of a newborn child or an adopted child is provided for a period of 60 days from the date of birth or the date of adoption."

17.) PLAN DOCUMENT

The Fund prepares a detailed plan document for each member local unit (or each employee bargaining group within a member local unit as the case may be), and an employee handbook provides a summary of the coverage provided by the plan. Each booklet (or certificate) shall contain at least the following information and be provided to all covered employees within thirty (30) days of coverage being effective.

A.) General Information

- Enrollment procedures and eligibility.
- Dependent eligibility.
- When coverage begins.
- When can coverage be changed.
- When does coverage end.
- COBRA provisions.
- Conversion privilege
- Enrollment forms and instructions.

B.) Benefits

- Definitions.
- Description of benefits.
- Eligible services and supplies.
- Deductibles and co-payments.
- Examples as needed.
- Exclusions.
- Retiree coverage, before age 65 or after (if any)

C.) Claims Procedures

- Submission of claim.
- Proof of loss.
- Appeal procedures. Shall be in accordance with applicable governing law. See also Plan Document and FUND Risk Management Plan and Bylaws

D.) Cost Containment Programs

- Pre-admission.
- Second surgical opinion.

- Case Management
- Other cost containment programs
- Application and level of employee penalties.

18.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately every six months after the end of a Fund year, the Fund evaluates the results to determine if dividends or additional assessments are warranted. Most claims are paid within twelve months of year end, and at that time the Fund begins to consider closing the year, unless excess insurance recoveries are pending or litigation is likely.

Fully insured plans are not considered in surplus retention. Entities with only Medicare Advantage/Employer Group Waiver Programs are not included in closed year balance shares.

When the Fund determines that a Fund year should be closed:

- A reserve is established by the actuary to cover any unpaid claims or IBNR
- The Fund decides on the final dividend or supplemental assessment.
- A closure resolution is adopted transferring all remaining assets and liabilities of that Fund year to the "Closed Fund Year/Contingency Account".
- Each member's pro rata share of the residual assets are computed and added to its existing balance in the Closed fund Year/Contingency Account. Any member who has withdrawn from the Fund shall receive its remaining share of the Closed fund Year/Contingency Account six years after the date of its withdrawal.

19.) "RUN-IN" or "RUN-OUT" LIABILITY

The Fund covers the "run-out" liability of all members - i.e., liability for claims incurred but not reported by a former Fund member during the period it was a member. Upon approval of the Executive Committee, the Fund may also cover the run-in liability of a perspective member (i.e., the liability for claims incurred but not reported by a prospective member in connection with the provision of health benefits during the period prior to joining the Fund). When the Fund covers run-in liability, the prospective member shall be assessed the expected ultimate cost of run-in claims, as certified by the Fund's actuary and approved by the Executive Committee. The assessment shall be paid entirely within the Fund year the member joined the Fund.

20.) CLAIMS, OPERATIONS AND ENROLLMENT AUDITS

The Fund retains a claim auditor experienced in auditing self-insured claims and operations. Claims and/or operational audits will be performed after the first year of operation and at least every three (3) years thereafter.

The FUND may require enrollment audits for new and existing members to ensure that benefits are paid only for persons meeting eligibility requirements.

21.) CLAIM APPEALS

- The third party administrator (TPA) shall initially review all appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

- The TPA shall provide the Executive Director and the Fund Attorney with a copy of the memo, which has been prepared concerning the appeal.

- The TPA, Executive Director and Fund Attorney shall confer concerning the merits of an appeal and they shall render a decision concerning the appeal provided that the appeal is

    - (a) In an amount not greater than $5,000.00 and/or

    - (b) Has been reviewed and recommended for approval by an independent, third party medical review consultant..

- If the decision of the TPA, Executive Director and Fund Attorney is to pay the claim, then the TPA is hereby authorized to issue the necessary check in payment of the claim.

- The Executive Committee of the Fund shall formally confirm the decision of the TPA, Executive Director and Fund Attorney to pay the claim and ratify the payment issued pursuant to that decision at the next meeting of the Executive Committee.

    - If the decision of the TPA, Executive Director and Fund Attorney is to deny the claim, the appeal shall be subject to the "adverse benefit determination" appeal process that is required pursuant to applicable law. The plan participant (hereinafter sometimes referred to as "claimant") shall at that time be advised that the adverse benefit determination may be appealed to the Fund's Independent Review Organization ("IRO"). The claimant's identity shall be revealed only upon the written request of the claimant. A copy of such written request with respect to disclosure of the claimant's name shall be sent to the Executive Director.

a. An appeal of an adverse benefit determination must be filed by the claimant within four (4) months from the date of receipt of the notice of the adverse benefit determination. The claimant shall submit a written request to the Executive Director to appeal an adverse benefit determination and/or final internal adverse benefit determination made by the TPA and the written request, shall be accompanied by a copy of the determination letter issued by the TPA.

1. The Executive Director will conduct a preliminary review within five (5) business days of the receipt of the request for an external review. There is no right to an external review by the IRO if (i) the claimant is or was not eligible for coverage at the time in question or (ii) the adverse benefit determination or final internal adverse benefit determination is based upon the failure of the claimant or covered person to met requirements for eligibility under the Plan or (iii) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit. The Executive Director shall notify the claimant if (a) the request is not eligible for external review; (b) that additional information is needed to make the request complete and what is needed to complete the request; or (c) the request is complete and is being forwarded to the IRO.

2. The Executive Director shall then forward an eligible, complete request for external review to the IRO designated by the Fund who shall be required to conduct its review in an impartial, independent and unbiased manner and in accordance with applicable law.

3. The assigned IRO will provide timely written notice to the claimant of the receipt and acceptance for external review of the claimant's request and shall include a statement that the claimant may submit, in writing and within ten (10) business days of the receipt of the notice, additional information which shall be considered by the IRO when conducting the external review. Upon receipt of any information submitted by the claimant, the IRO, within one (1) business day, shall forward the information to the Program Manager who may reconsider the adverse benefit determination or final internal adverse benefit determination and, as a result of such reconsideration, modify the adverse benefit determination or final internal adverse benefit determination. The Program Manager shall provide prompt written notice of any such modification to the claimant and the IRO.

4. The Executive Director, within five (5) business days of the assignment of the IRO, shall deliver to the IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. The IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination if the Executive Director does not provide such information in a timely manner. In such event, the IRO shall notify the claimant and the Program Manager of the decision within one (1) business day.

5. The IRO shall complete the external review and provide written notice of its final external review decision within forty-five (45) days of receipt of the request for the external review. In the case of a request for expedited external review of an adverse benefit determination or final internal adverse benefit determination where delay would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, the IRO shall provide notice of the final external review decision as expeditiously as possible but in no event more than 72 hours after the receipt of the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the Program Manager within 48 hours of providing that notice in the case of an expedited external review. The IRO shall deliver notice of its final external review decision to both the claimant and the Executive Director for all external reviews conducted. The notice of decision shall contain:

(i) a general description of reason for the external review with sufficient information to identify the claim, claim amount, diagnosis and treatment codes and reason for previous denial;

(ii) the date the IRO was assigned and date of the IRO's decision;

(iii) references to the documentation/information considered;

(iv) a discussion of the rationale for the IRO's decision and any evidence-based standards relied upon in making the decision;

(v) a statement that the decision is binding on the claimant and the Fund subject to the claimant's right to seek judicial review of the same; and

(vi) that the claimant may contract the New Jersey health insurance consumer assistance office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625, phone (800) 446-7467 or (888) 393-1062 (appeals) website: http://wwww.state.nj.us/dobi/consumer.htm e-mail: ombudsman@dobi.state.nj.us/

22.) ENROLLMENTS AND TERMINATIONS PAST 60 DAYS

Enrollments and terminations can be processed up to 60 days in the past. Should there be a need to enroll or terminate an employee past 60 days due to a missed open enrollment period or a qualified life event, the member must submit this request in writing. The Fund Small Claims Committee will anonymously review each request, including the financial impact to the Fund. The Committee will approve/deny the request within 45 days.

23.) PARTIAL MONTH ENROLLMENTS

When processing enrollments and terminations, the Fund will charge a member for a full month rate for an employee that is enrolled between the 1st and the 15th of the month but will charge the member in the following month if an enrollment occurred between the 16th and the 31st of the month. If a member should term between the 1st and the 15th of the month, the Fund will not charge

the member a rate for the enrollment but will charge a full month rate if a member terms between the 16th and the 31st of the month.

24.) **MEDICARE ADVANTAGE/EGWP ONLY**

The Fund may offer retiree coverage with a fully insured Medicare Advantage and/or Employer Group Waiver Program membership to an entity that does not have its active members in the Fund. The carrier will provide the Fund with a per employee, per month cost for a plan that matches equal to, or better to the current retiree plan. The Fund may add additional expenses to the price per employee. The entity would be required to sign an Indemnity and Trust agreement.

25.) **DIRECT DEBIT**

Members have the option to allow the Fund to collect monthly premium through a direct debit to the Fund Operating Account initiated by the Fund Treasurer. The direct debit will equal the month's premium invoice and can be debited on the date of the member's choosing.

26.) OUT OF NETWORK MEDICARE SCHEDULE APPEAL PROCESS

Once the member appeal has been submitted, the Executive Director's Office shall initially review all OON payment appeals and shall prepare a memo summarizing the relevant facts and issues involved in the appeal.

An Out of Network benefit appeal must be filed by the claimant within 30 days from the date of receipt of the Explanation of Benefits (EOB) reflecting the 175/150% of Medicare

The Executive Director will conduct a preliminary review within five (5) business days of receipt of the request for a Third-party review and notify the member and/or representing broker, the request is being forwarded to a Third-Party Review Organization solely responsible for reviewing Out of Network claims reimbursement.

The Executive Director shall then forward an eligible, complete request for external review to the Out of Network Third Party Review Organization.

The Third-Party Review Organization designated by the FUND will be required to conduct its review in an impartial, independent, and unbiased manner and in accordance with applicable law within thirty (30) business days after receipt.

If the decision of the Third-Party Review Organization responsible for the final determination is to pay the additional reimbursement at a level above the FUND approved 175%/150% Medicare, then the TPA is hereby authorized to issue the adjusted payment to the provider.

If the decision of the Third-Party Review Organization responsible for the final determination is to NOT pay the additional reimbursement in excess of the FUND approved 175%/150% of Medicare, then the Program Manager will notify the member and/or representing broker within five (5) business days.

Regardless of the determination, the Third-Party Review Organization will provide on their letterhead the reason for the determination in addition to any specific data and metrics supporting that determination.

27.) QUALITY AND CLINICAL PLAN MANAGEMENT

The FUND shall have right to review, evaluate, and then implement certain Quality and Clinical Management programs related to the Medical, Pharmacy and Dental plans, as may be warranted from time to time, to address new and emerging issues related to the effective administration of the FUND. None of the programs shall constitute a change in benefit and shall not increase participant cost sharing. These programs may include and is not limited to Pharmacy and Medical quality and utilization programs that require a plan member to participate in a program intended to manage quality and improve outcome. If adopted by the FUND, such programs shall apply to all members of the FUND. The FUND shall utilize a formulary of preferred medications. The formulary will change from time to time as managed by the FUND's contracted Pharmacy Benefit Manager. Any changes to the formulary impacting a plan member will be addressed through advance notice to plan members. There will always be alternative medications available in each therapeutic class.

- Drug Utilization Management – The FUND may adopt or amend drug utilization management programs intended to impact the appropriate use of medications. These may include and are not limited to step therapy, generics preferred, formulary, retail network, prior authorization, and other programs provided for by the FUND's contracted Pharmacy Benefit Manager.

- Medical Care Management – The FUND may adopt or amend medical management plans intended to ensure member safety and efficacy of the health care program. This may include and not be limited to programs provided by the FUND's contracted Third-Party Administrator or others that can administer such programs.

- Out of Network Fee Schedules - The FUND shall adopt and amend the out of network fee schedule ("the schedule") used from time to time. The schedule shall be based on an independent methodology, generally Medicare plus a markup (i.e., 150% of Medicare) that ensures fairness and reasonableness related to the provider type, type of procedure and geography. If adopted by the FUND such programs shall apply to all members of the FUND. Individual members may separately be exempted from the application of such programs only with the express approval of the TRUSTEES and after agreeing to an appropriate rate adjustment.

28.) New Jersey Protections for Involuntary, Inadvertent and Emergency Out of Network Claims

The below information is applicable to New Jersey residents who are enrolled in the plan. In response to surprise bill concerns, the New Jersey Department of Insurance enacted the Out-Of-Network Consumer Protection, Transparency, Cost, Containment and Accountability Act (Act) (N.J.S.A. 26:2SS-1). This Act provides certain consumer protections for surprise bills for out-of-network health care services. Your employer has voluntarily elected that the plan participates in this Act.

The Act provides protections for the two types of claims specified below:

1. Involuntary and inadvertent out-of-network services

You are protected from balance bills by a New Jersey out-of-network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) located in New Jersey and, for any reason, in-network health care services are unavailable at that facility (an "inadvertent out-of-network service"). This includes laboratory testing (e.g., imaging, X-rays, blood tests and anesthesia).

Except as provided below, you should not be balance billed by an out-of-network health care professional or facility, for any amount in excess of what your deductible, copayment, or coinsurance amounts (also known as "cost-sharing") would be if you received the same service in-network. If you receive a bill for any other amount, please contact us at the number on your Identification Card and we will help address it. You may also file a complaint with the Department of Banking and Insurance by visiting https://www.state.nj.us/dobi/consumer.htm.

If you receive a bill for an amount above of your cost-sharing responsibilities for an inadvertent out-of-network service, Aetna and the out-of-network health care professional or facility may negotiate and settle on an amount for the service. If that negotiated amount exceeds what was shown on your initial Explanation of Benefits (EOB), your out-of-pocket cost-sharing responsibility may increase. If this occurs, you will be provided a second EOB showing your total cost-sharing responsibility.

If an agreement cannot be reached, Aetna or the out-of-network health care professional or facility may initiate binding arbitration to determine the amount to be paid for the inadvertent out-of-network service. The amount awarded by the arbitrator may exceed what Aetna has already paid to the out-of-network health care professional or facility; however, any additional payment for the arbitration award **will not** increase your cost-sharing responsibility above the amount indicated on your second EOB. In addition, if an arbitration takes place, you will also receive a final EOB showing the total allowed charge/amount for the service(s).

2. Medically necessary treatment on an emergency or urgent basis

You have additional protections from balance bills by any New Jersey facility involving medically necessary treatment on an emergency or urgent basis. Under this heading, "emergency and urgent

care basis" means all emergency and urgent care services including, but not limited to, the services required pursuant to N.J.A.C. 11:24-5.3, which includes: (1) medical and psychiatric care, which shall be available 24 hours a day, seven days a week; (2) coverage for trauma services at any designated Level I or II trauma center as medically necessary (such coverage shall continue at least until, in the judgment of the attending physician, you are medically stable, no longer require critical care, and can be safely transferred to another facility; (3) coverage for out-of-service area medical care when medically necessary for urgent or emergency conditions where you cannot reasonably access in-network services; (4) prehospital care and hospital services regardless of location when medically necessary for injury or emergency illness; and (5) upon a your arrival in a hospital, coverage of a medical screening examination, as required by the Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, and as specified in N.J.A.C. 8:43G-12.

Except as discussed below, you should not be billed by any facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") would be if you received the same service in-network. If you receive a bill for any other amount, please contact us at the number on your Identification Card and we will help address it. You may also file a complaint with the Department of Banking and Insurance by visiting http://www.state.nj.us/dobi/consumer.htm.

If you receive a bill from an out-of-network health care professional or facility for an amount above of your cost-sharing responsibilities involving medically necessary treatment on an emergency or urgent basis, Aetna and the out-of-network health care professional or facility may negotiate and settle on an amount for the service. If that negotiated amount exceeds what was shown on your initial Explanation of Benefits (EOB), your out-of-pocket cost-sharing responsibility may increase. If this occurs, you will be provided a second EOB showing your total cost-sharing responsibility.

If an agreement cannot be reached, Aetna or the out-of-network health care professional or facility initiate binding arbitration to determine the amount to be paid for the medically necessary treatment on an emergency or urgent basis. The amount awarded by the arbitrator may exceed what Aetna has already paid to the out-of-network health care professional or facility; however, any additional payment for the arbitration award **will not** increase your cost-sharing responsibility above the amount indicated on your second EOB. In addition, if an arbitration takes place, you will also receive a final EOB showing the total allowed charge/amount for the service(s).

ADOPTED: FEBURARY 19, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 17-26

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION TO OFFER MEMBERSHIP

WHEREAS, the **Metropolitan Health Insurance Fund** held a Public Meeting on **February 19, 2026** for the purposes of conducting the official business of the Fund; and

WHEREAS, the Executive Director and Actuary of the Fund has reviewed the risk, underwriting detail, and actuarial projections for the Mercer County and Hillsdale BOE and recommend an offer of membership; and

WHEREAS, the Executive Committee has reviewed the following new member submissions and has approved membership to the following entities that will submit a fully executed Indemnity and Trust agreement to join the Fund:

1. Hillsdale BOE – on or around 3/1/2026 – Medical and Rx
2. Mercer County – on or around 3/1/2026 – Medicare Advantage Only

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

BE IT RESOLVED, that the Metropolitan Health Insurance Fund hereby offers membership to the above mentioned entities for Medicare Advantage coverage contingent upon receipt of the Fund's authorizing resolution to join the Fund and its executed Indemnity and Trust agreement.

ADOPTED: February 19, 2026

BY:_____

CHAIRPERSON

ATTEST:_____

SECRETARY

RESOLUTION NO. 18-26

METROPOLITAN HEALTH INSURANCE FUND
APPROVAL OF THE FEBURARY 2026 BILLS LIST

WHEREAS, the **Metropolitan Health Insurance Fund** held a Public Meeting on **February 19, 2026** for the purposes of conducting the official business of the Fund; and

WHEREAS, The Treasurer for the Fund presented bills lists to satisfy outstanding costs incurred for operating the Fund during the month of February 2026 for consideration and approval of the Executive Committee and

WHEREAS, a quorum of the Commissioners was present thereby conforming with the Policies and Procedures of the Fund to conduct official business of the Fund,

NOW THEREFORE BE IT RESOLVED the of the Metropolitan Health Insurance Fund hereby approve the Bills List for February 2026 prepared by the Treasurer of the Fund and duly authorize and concur said bills to be paid expeditiously, in accordance with the laws and regulations promulgated by the State of New Jersey for Insurance Funds.

ADOPTED: FEBURARY 19, 2026

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

APPENDIX I

METROPOLITIAN HEALTH INSURANCE FUND
MINUTES
OPEN MEETING: JANUARY 15, 2026
CONFERENCE CALL – ZOOM
12:00 P.M.

Meeting called to order by Chair Mundell. The Open Public Meeting Notice was read into the record.

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

Jenny Mundell, Chairwoman	Bloomfield Public Library	Present
Kimberly Duva, Secretary	Bloomfield Township	Absent
Cameron Cox, Executive Committee Member	Plainfield Public Schools	Present
Nicole Baltycki, Executive Committee Member	West Caldwell Township	Present
Chris Hartwyk, Executive Committee Member	City of Orange	Absent
Margaret Heisey, Executive Committee Member	Scotch Plains Twp	Present
Patrick Wherry, Executive Committee Member	Maplewood Township	Present

APPOINTED OFFICIALS PRESENT:

Executive Director/ Administrator	**PERMA Risk Management Services**	James Rhodes Emily Koval John Lajewski
Fund Coordinator	**Eagle Rock Management Group**	Diane Romano Jennifer McHugh
Attorney	**Antonelli Kantor Rivera**	Asia Hartgrove Ramon Rivera
Treasurer	**Point Accounting Group (Formerly Laracy Associates)**	Matt Laracy
Third Party Administrator	**Aetna**	Jason Silverstein
Dental Claims Administrator	**Delta Dental of NJ, Inc.**	Crista O'Donnell
Auditor	**Donohue, Gironda, Doria & Tomkins**	Absent
Actuary	**John Vataha**	Absent
RX Administrator	**Express Scripts**	Hiteksha Patel

Others Present:	Jordyn Robinson	Caitlin Perkins
Joseph DiBella	Brandon Lodics	Julie Servidio
Katherine Polanco	K. Capriglione	Thomas Kelly
Jacob Krakower	Jackie Ortiz	Elizabeth Dash

Brady Johnson		

APPROVAL OF MINUTES: November 10, 2025, November 12, 2025: Finance Committee, and November 24, 2025: Finance Committee

Motion: Commissioner Wherry
Second: Commissioner Heisey
Vote: All In Favor

Motion to Adjourn the Sine Die meeting:

Motion: Commissioner Heisey
Second: Commissioner Cox
Vote: All in Favor

MEETING OF FUND COMMISSIONERS CALLED TO ORDER
ROLL CALL OF ALL 2026 FUND COMMISSIONERS

Group	Fund Commissioner	Attendance
Bloomfield Public Library	Jenny Mundell, Chair	Present
Bloomfield Township	Alyssa Sauchelli	Present
East Amwell	Yolaika Gonzalez VinaMarte	Absent
East Orange Township		
East Hanover Township	Kenny Huelbig	Absent
Irvington Township	Musa A. Malik	Present
Maplewood Township	Patrick Wherry	Present
Millburn	Alexander McDonald	Present
Morristown Township	Jillian Barrick	Absent
Orange Township	Christopher Hartwyk	Absent
Plainfield Public Schools	Cameron Cox	Present
Scotch Plains	Margaret Heisey	Present
Union Township	Donald Travisano	Absent
West Caldwell	Nikole H. Baltycki	Present
West Orange Township	John Ditinyak	Present
North Hudson Regional Fire		
Chester Twp	Robin Collins	Absent
Secaucus	Gary Jeffas	Present
Guttenberg	Cosmo Cirillo	Present
Montclair	Stephen Marks	Present

ELECTION OF OFFICERS – EXECUTIVE COMMITTEE AND ALTERNATES
Executive Director asks for nominations.
Motion to open the floor to nominations:

Motion: Commissioner Marks

Second: Commissioner Cox
Vote: All in Favor

RECOMMENDED SLATE:

Fund Commissioner	**Entity**
Jenny Mundell, Chairwoman	Bloomfield Public Library
Patrick Wherry, Secretary	Maplewood Township
Cameron Cox, Executive Committee Member	Plainfield Public Schools
Nikole Baltycki, Executive Committee Member	West Caldwell Township
Chris Hartwyk, Executive Committee Member	City of Orange
Margaret Heisey, Executive Committee Member	Scotch Plains Twp
Alexander McDonald, Executive Committee Member	Millburn Township

MOTION AND ROLL CALL OF 2026 FUND COMMISSIONERS TO ELECT OFFICERS AND EXECUTIVE COMMITTEE

Motion: Commissioner Heisey
Second: Commissioner Cirillo
Vote: 12 Ayes, 0 Nays

Group	**Fund Commissioner**	**Present/Vote**
Bloomfield Public Library	Jenny Mundell, Chair	Yes
Bloomfield Township	Alyssa Sauchelli	Yes
East Amwell	Yolaika Gonzalez VinaMarte	
East Orange Township		
East Hanover Township	Kenny Huelbig	
Irvington Township	Musa A. Malik	Yes
Maplewood Township	Patrick Wherry	Yes
Millburn	Alexander McDonald	Yes
Morristown Township	Jillian Barrick	
Orange Township	Christopher Hartwyk	
Plainfield Public Schools	Cameron Cox	Yes
Scotch Plains	Margaret Heisey	Yes
Union Township	Donald Travisano	
West Caldwell	Nikole H. Baltycki	Yes
West Orange Township	John Ditinyak	Yes
North Hudson Regional Fire		
Chester Twp	Robin Collins	
Secaucus	Gary Jeffas	Yes
Guttenberg	Cosmo Cirillo	Yes
Montclair	Stephen Marks	Yes

Motion to close the floor to nominations:

Motion: Commissioner Heisey
Second: Commissioner Cox
Vote: All in Favor

OATH OF OFFICE – Executed by Fund Attorney

ROLL CALL OF 2026 EXECUTIVE COMMITTEE –

Jenny Mundell, Chairwoman	Bloomfield Public Library	Present
Patrick Wherry, Secretary	Maplewood Township	Present
Cameron Cox, Executive Committee Member	Plainfield Public Schools	Present
Nikole Baltycki, Executive Committee Member	West Caldwell Township	Present
Chris Hartwyk, Executive Committee Member	City of Orange	Absent
Margaret Heisey, Executive Committee Member	Scotch Plains Twp	Present
Alexander McDonald, Executive Committee Member	Millburn Township	Present

CORRESPONDENCE – Department of Banking and Insurance: Questionnaire and Response

The Executive Director, Ms. Koval, summarized the questionnaire that was received from the Department of Banking and Insurance regarding the 2024 audit that was filed. The response that was sent from PERMA was reviewed by the Fund Attorney and Chair Mundell. Ms. Koval noted there has not been a response from the Department of Banking and Insurance.

EXECUTIVE DIRECTOR'S REPORT

ADMINISTRATION

2026 ORGANIZATIONAL RESOLUTIONS – Ms. Koval described the specific information in the organization resolutions that were including in the agenda, noting that the resolutions have been reviewed by the Fund Attorney. She highlighted specific details for the following Resolutions:

Resolution 1-26 does not include a QPA, as it was previously discussed to get further quotes from other qualified candidates.

Resolution 6-26 includes three additional sections in the Cash Management Plan: Monthly Member Billing Policy, Maximum approval Amount for Certifying & Approving Officer, and Direct Debit. The Fund Treasurer, Mr. Laracy, commented that majority of entities in the Fund are paying in a timely manner and this is to help any entities that may be consistently late with their payments. He notified the entities that there may be situations that may delay a payment that is out of their control, and if so, to reach out to him directly to create a plan to ensure cash flow is sufficient. He noted this is formalizing the process.

Resolution 8-26 includes some minor changes to the Risk Management Plan that clarifies and documents in more detail. There were two additions to the Risk Management Plan: the Out of Network Medicare

Appeal Process, which was discussed in August but is formalized in this resolution, and the Quality and Clinical Plan Management, which allows PERMA to make changes for cost containment measures for the Fund.

Resolution 9-26 appoints the MRHIF Fund Commissioner and Alternate Fund Commissioner for 2026. The Fund Commissioners agree to the reappointment of Commissioner Cox as the MRHIF Fund Commissioner and Commissioner Baltycki as the Alternate Fund Commissioner.

Motion to open discussion on Resolution 1-26:

Motion: Commissioner Wherry
Second: Commissioner Heisey
Vote: All in Favor

In response to Commissioner Wherry, Ms. Koval described the process for recommending the professional contracts. She noted that the contracts committee work directly with the QPA to make the recommendations for the professionals. A discussion occurred noting that not all the professionals are awarding new contracts for Fund year 2026, but the rates have been updated to reflect the compensation of the contracts that were agreed upon based on the Request for Proposal (RFP) responses. Ms. Koval clarified that there will be a RFP's being released for Medicare Advantage for Fund Year 2027 and there was emergency procurement for a one year contract with Aetna.

Motion to close discussion on Resolution 1-26:

Motion: Commissioner Cox
Second: Commissioner Wherry

Motion to open discussion on Resolution 4-26:

Motion: Commissioner Wherry
Second: Commissioner Cox
Vote: All in Favor

In response to Chair Mundell, Ms. Koval confirmed that there are advertisements being placed in the official newspapers that provide information on where to access the advertisements on the Fund website. Chair Mundell questioned if a bidding process was needed to select the official newspaper and the Fund Attorney, Mr. Rivera, commented there was never a bid for the selection of the newspaper. Ms. Koval noted that the recommendations are provided by recommendations. Mr. Rivera commented that the only legal obligation is the re-organization resolution designating the official newspaper.

Mr. DiBella commented that any Fund Commissioner can provide a recommendation for a newspaper. He recommended that a motion be made to comply as is and before the next meeting, Fund Commissioners will submit their recommendations to Ms. Koval, who can work with Mr. Rivera to complete due diligence to ensure that the recommendation meets necessary requirements.

Motion to have Fund Commissioners submit recommendations for an additional official newspaper within the next two weeks to Ms. Koval for due diligence to be completed:

Motion: Commissioner Cox
Second: Commissioner Heisey
Vote: All in Favor

Motion to open discussion on Resolution 4-26:

Motion: Commissioner Wherry
Second: Commissioner Cox
Vote: All in Favor

Mr. Jim Rhodes commented that the METRO Fund website is already set up with a link to post public and legal notices on the homepage, which complies with the new law that goes into effect on March 1, 2026.

CORRECTION OF RESOLUTION NUMBER ASSIGNMENT - Ms. Robinson, the Assistant Account Manager, stated that it was discovered that a resolution number was inadvertently assigned to two separate actions. Resolution 12-26 reassigns the resolution numbers to maintain accurate records.

FAST TRACK FINANCAL REPORT – Mrs. Koval presented the financial fast track report, noting there are two fast tracks included, September and October of 2025. She stated there were deficits in both of the months but the deficits have been a smaller amount than the previous months, which is mostly due to the actions taken at the August meeting regarding the Out-of-Network fee schedule. It is hopeful that this trend will continue but still focus on the overall deficit for the end of year 2024.

Mr. Joseph DiBella, the National Employee Benefits Practice Leader, provided some details regarding the supplemental assessment to address some of the financial conditions that the Fund has been confronted with. He reminded that there is a healthcare cost crisis that is plaguing the market. He commented that the strategic decisions that were implemented in the summer are beginning to take effect and trending in the appropriate direction. Multiple discussions occurred with the Finance Committee and the recommendation is to declare a $7 million supplemental assessment over a thirty-six-month period or pay 90% with a 10% discount in full. Mr. DiBella confidently stated that this will be some of the last requirements that the Fund needs to put in place to address the surging healthcare costs. Lastly, he noted that there will be transparent communication with the Department of Banking and Insurance so they are aware of the responsible measures the Fund is taking to ensure the financial solvency and strength of the Fund.

Commissioner Cox commented, as a member of the Finance Committee, that this was not an easy discussion and the committee did our due diligence and did not take these decisions lightly. Ms. Koval commended the Finance Committee for their time to review and meet to discuss.

Motion to declare a supplemental assessment based on calendar year 2024 in the amount of $7 million, according to Resolution 13-26:

Motion: Commissioner Cox
Second: Commissioner Wherry
Vote: 6 Ayes, 0 Nays

COMMITTEE APPOINTMENTS – The Executive Director reviewed the subcommittees that were included in the agenda, highlighting that any Fund Commissioner can reach out to join a subcommittee if interested.

Commissioner Malik and Commissioner Heisey have volunteered to join the Wellness Committee for 2026.

Motion to approve the Subcommittee appointments:
Motion: Commissioner Cox
Second: Commissioner Wherry
Vote: All in favor

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND – MEETING REPORT – The Executive Director provided a high level overview of the MRHIF meeting in September and stating that an update of the Express Script claims audit will be provided.

POPULATION HEALTH RFP – The Executive Director noted that the RFP 25-03 responses did expire and the new Wellness Committee will re-evaluate this matter, highlighting that there is a line item in the 2026 budget for wellness.

QUALIFIED PURCHASING AGENT (QPA) 2026 QUOTES – The Executive Director stated that PERMA will begin preparing solicitation for quotes for QPA services and requested any Commissioners to provide details of qualifying candidates to PERMA.

NEW MEMBERS – Ms. Koval noted there are two new members interested in joining the Fund, potentially February 1st, 2026. City of Paterson and Passaic City, which both are joining for Medicare Advantage only, which is fully insured and will not risk to the Fund.

2026 PERMA MANAGEMENT UPDATES – Ms. Koval formally introduced Jim Rhodes as the new Executive Director, highlighting that Brandon Lodics transitioned into a financial role under the Executive Director team.

Chair Mundell welcomed Jim.

PROGRAM MANAGERS REPORT - Mr. Lajewski began his report by providing an industry update, stating that Food and Drug Administration (FDA) approved an oral version of Wegovy, a GLP-1 weight-loss drug. He noted it is anticipated that there will be an impact of the overall cost moving

forward. He commented there will are new innovative programs and strategies that can be implemented with the new oral drug that will be released.

Mr. Lajewski discussed the Fund Performance, noting there are initial benefits from the out of network fee schedule against the Medicare Schedule, but highlighted along with the overall percentage declining, the claims are also decreasing.

Mr. Lajewski reminded that any service requests can be sent to Peter Moore and Crystal Bailey along with the monthly system training. He verbally provided an update that there is a delay in the coupons that are released to direct billed members due to a systemic issue and it is currently being monitored.

Mr. Lajewski ended his report by reviewing the carrier appeals and the IRO submissions.

FUND COODINATOR – Ms. Jennifer McHugh stated there are nine new members joining the HIF, highlighting the four that started as of January 1, 2026. She reviewed the amount of contracts that are included in the new members.

ATTORNEY – Mr. Rivera noted that is no current report but an update regarding the OSC will be available at the February meeting.

TREASURER – Mr. Laracy presented the December bill, in the amount of $1.3 million and January bill lists, in the amount of $2.4 million for approval. Resolution 15-26 will be moved in the consent agenda.

AETNA – Mr. Silverstein reviewed the October and November claims, highlighting the per employee per month claims for October came in at $2,394 and November came in at $2,184. He stated there were no high-cost claims exceeding $100,000 for October and four high-cost claims for November. Dashboard metrics indicated strong performance across all service goals. He provided an updated that there is current contract negotiations with Hackensack Meridian for July 1st, 2026.

EXPRESS SCRIPTS – Ms. Patel presented the pharmacy report, noting a plan cost per member per month of $199.38 for November, representing a 10% increase from the previous year. Specialty drug costs accounted for 38% of total spend, with a notable increase in blood cell deficiency and cancer indications. Weight loss drug utilization remains high.

DELTA DENTAL – No report.

MOTION TO MOVE CONSENT AGENDA, WITH THE EXCEPTION FOR RESOLUTION 4-26 AND 13-26:

Motion: Commissioner Cox
Second: Commissioner Heisey
Vote: All in Favor

OLD BUSINESS - None

NEW BUSINESS – Commissioner Gary Jeffas, from Secaucus, thanked the Fund as they are a new member. In regards to his question, Ms. Koval noted that a meeting can be scheduled with the Fund Coordinator and broker regarding their assessment. Commissioner Cirillo also requested a meeting for Guttenberg as well.

PUBLIC COMMENT –

Motion to open public comment

Motion: Commissioner Wherry
Second: Commissioner Cox
Vote: All in Favor

Motion to close public comment

Motion: Commissioner Cox
Second: Commissioner Heisey
Vote: All in Favor

MOTION TO ADJOURN THE MEETING:

Motion: Commissioner Cox
Second: Commissioner Heisey
Vote: All in Favor

MEETING ADJOURNED

NEXT MEETING: February 19, 2026, 12:00PM at Maplewood

_____
Caitlin Perkins, Assisting Secretary

for

_____
PATRICK WHERRY, SECRETARY

APPENDIX II

16TH ANNUAL
MEL, MRHIF & NJCE EDUCATIONAL SEMINAR

SAVE THE DATES

FRIDAY, APRIL 24 ▸ 9:00 AM – 12:00 PM
FRIDAY, MAY 1 ▸ 9:00 AM – 12:00 PM

Available Online at No Cost to Members

Designed specifically for elected officials, commissioners, municipal, county and authority personnel, risk managers and related professionals

This online seminar is pending approval for the following continuing education credits:

- CFO/CMFO Public Works and Clerks
- Insurance Producers
- Accountants (CPA) and Lawyers (CLE)
- Water Supply and Wastewater Licensed Operators (Total Contract Hours)
- Registered Public Purchasing Officials (RPPO)
- Qualified Purchasing Agents (QPA)

SPONSORED BY

MEL

MRHIF Municipal Reinsurance Health Insurance Fund

NJCE

NEW JERSEY COUNTIES EXCESS JOINT INSURANCE FUND

AGENDA

FRIDAY, APRIL 24

- Local Government Health Benefits Crisis
- Police Accreditation Plus Initiative
- Controlling Workers Compensation Costs

FRIDAY, MAY 1

- Anti-Harassment Programs for Volunteer Organizations
- Cyber JIF at 3
- Local Government Ethics Act

TO REGISTER

Connect to njmel.org or email Jaine Testa at jainet@permainc.com

THE POWER OF COLLABORATION

njmel.org