



AGENDA & REPORTS

MARCH 30, 2026

12:30 PM

LOCATION:

THE GREENVIEW INN AT EASTLYN GOLF COURSE

4049 ITALIA AVE

VINELAND, NJ 08361

STATEMENT OF COMPLIANCE WITH OPEN PUBLIC MEETINGS ACT

NOTICE OF THIS MEETING WAS GIVEN BY **(1)** POSTING THE ANNUAL MEETING NOTICE ON THE FUND'S OFFICIAL WEBSITE WHERE ALL LEGAL NOTICES ARE MAINTAINED **(2)** FILING ADVANCE WRITTEN NOTICE OF THIS MEETING WITH THE CLERK/ ADMINISTRATOR OF EACH MEMBER MUNICIPALITY AND SCHOOL BOARD, AND **(3)** PUBLISHING THE NOTICE IN THE FUND'S DEISGNATED NEWSPAPER DIRECTING THE PUBLIC TO THE WEBSITE WHERE LEGAL NOTICES ARE AVAILABLE

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND AGENDA
MEETING: MARCH 30, 2026
12:30 PM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ

FLAG SALUTE

ROLL CALL OF THE 2026 EXECUTIVE COMMITTEE

- Richard Davidson, Chair
- Pasquale Yacovelli, Secretary
- Jerry Velazquez, Executive Committee
- Megan Duffield, Executive Committee
- Laurie Ryan, Executive Committee
- Scott Musterel, Executive Committee
- Mark Mallet, Executive Committee
- Frank Badessa, Executive Committee Alternate
- Dennis Zakroff, Executive Committee Alternate
- Kevin Smaniotto, Executive Committee Alternate
- Thomas D'Intino, Executive Committee Alternate

APPROVAL OF MINUTES: January 28, 2026..... Appendix I

CORRESPONDENCE - None

PUBLIC COMMENT - *Agenda Items Only*

REPORTS:

EXECUTIVE DIRECTOR (PERMA)

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PROGRAM MANAGER- (Shared Health Alliance)

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GUARDIAN NURSES

Monthly Report.....Page 22

TREASURER - (Laracy Associates LLC / Verrill & Verrill)

February and March 2026 Bills List.....Page 24

January 2026 Treasurers Report.....Page 28

Confirmation of Claims Paid/Certification of Transfers

Ratification of Treasurers Report

ATTORNEY - (Marmero Law, LLC)

Monthly Report

**Southern Coastal Regional Employee Benefits Fund
Executive Director's Report
March 30, 2026**

FINANCES & CONTRACTS

PRO FORMA REPORTS

- **Fast Track Financial Reports** – as of January 31, 2026 (Page 5)
 - **Historical Income Statement**
 - **Consolidated Balance Sheet**
 - **Indices and Ratios Report**
 - **Budget Status Report**

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 addition strengthens the protections related to out-of-network services. A revised Resolution 8-26 is included in consent agenda.

BROKER PAYMENTS

Beginning with the March vouchers, the Fund is now paying broker partners directly rather than being collected by the Program Manager and dispersed. The Program Manager reached out to all brokers to inform them on this switch and collect required documents. The commissions are included in the bills list being approved today.

2027 PROFESSIONALS CONTRACTS

The following EUS contracts expire December 31, 2026. This will be a discussion item at the next Finance and Contracts Committee meeting.

Nurse Advocacy
Wellness Vendor

FINANCIAL DISCLOSURE STATEMENTS

The Financial Disclosure notice emails will be sent out in April. The deadline for filing is April 30, 2026. Please file as soon as you get the email.

Reminder: A separate filing will need to be done for each position – HIF Fund Commissioner, JIF Fund Commissioner, Local Elected Official, etc.

2026 MEL, MR HIF & 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.

The seminar is pending approval 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 (MR HIF) and New Jersey Counties Excess Joint Insurance Fund (NJCE JIF).

A copy of the invitation with a registration link was emailed to members, risk managers, and professionals on March 2nd. If you did not receive it, please contact HIFadmin@permainc.com for the registration link.

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.

LOCKBOXES

As previously reported, the lockbox is now posted on the monthly invoices and is live for remittance of assessments.

Lockbox Name	Southern Coastal Regional EBF
Remit to Address	PO Box 4721 Lancaster, PA 17604

GASB 102 DISCLOSURE

Enclosed in **Appendix III** is an informational memo regarding the GASB 102 requirements for reporting periods ending December 31, 2025, and thereafter. While GASB 102 established updated guidance, our Auditors do not believe these disclosures apply to the Health Insurance Funds.

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.

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
FINANCIAL FAST TRACK REPORT

		AS OF	January 31, 2026			
		THIS	YTD	PRIOR	FUND	
		MONTH	CHANGE	YEAR END	BALANCE	
1.	UNDERWRITING INCOME	18,077,063	18,077,063	1,091,244,940	1,109,322,003	
2.	CLAIM EXPENSES					
	Paid Claims	12,613,606	12,613,606	964,122,158	976,735,764	
	IBNR	2,416,630	2,416,630	14,013,181	16,429,811	
	Less Specific Excess	(18,708)	(18,708)	(28,625,431)	(28,644,139)	
	Less Aggregate Excess	-	-	-	-	
	TOTAL CLAIMS	15,011,528	15,011,528	949,509,908	964,521,437	
3.	EXPENSES					
	MA & HMO Premiums	152,319	152,319	3,872,890	4,025,209	
	Excess Premiums	649,861	649,861	34,399,340	35,049,202	
	Administrative	1,264,246	1,264,246	94,650,604	95,914,850	
	TOTAL EXPENSES	2,066,426	2,066,426	132,922,834	134,989,260	
4.	UNDERWRITING PROFIT/(LOSS) (1-2-3)	999,109	999,109	8,812,198	9,811,307	
5.	INVESTMENT INCOME	23,607	23,607	4,705,186	4,728,793	
6.	DIVIDEND INCOME	-	-	4,391,262	4,391,262	
7.	STATUTORY PROFIT/(LOSS) (4+5+6)	1,022,716	1,022,716	17,908,646	18,931,361	
8.	DIVIDEND	-	-	28,208,936	28,208,936	
9.	Transferred Surplus IN	-	-	-	-	
10.	Transferred Surplus OUT	-	-	9,855,397	9,855,397	
	STATUTORY SURPLUS (7-8+9)	1,022,716	1,022,716	(444,893)	577,823	
SURPLUS (DEFICITS) BY FUND YEAR						
	Closed	Surplus	(21,864)	(21,864)	7,249,745	7,227,881
		Cash	(1,776)	(1,776)	19,364,291	19,362,515
	2024	Surplus	(239,710)	(239,710)	(2,508,066)	(2,747,776)
		Cash	(250,518)	(250,518)	(2,721,716)	(2,972,234)
	2025	Surplus	(1,145,400)	(1,145,400)	(5,186,572)	(6,331,972)
		Cash	(791,943)	(791,943)	(652,782)	(1,444,724)
	2026	Surplus	2,429,689	2,429,689		2,429,689
		Cash	(1,178,783)	(1,178,783)		(1,178,783)
	TOTAL SURPLUS (DEFICITS)	1,022,716	1,022,716	(444,893)	577,823	
	TOTAL CASH	(2,223,020)	(2,223,020)	15,989,793	13,766,773	
CLAIM ANALYSIS BY FUND YEAR						
	TOTAL CLOSED YEAR CLAIMS	33,912	33,912	661,661,714	661,695,626	
	FUND YEAR 2024					
	Paid Claims	256,522	256,522	-	256,522	
	IBNR	-	-	-	-	
	Less Specific Excess	(10,808)	(10,808)	-	(10,808)	
	Less Aggregate Excess	-	-	-	-	
	TOTAL FY 2024 CLAIMS	245,713	245,713	-	245,713	
	FUND YEAR 2025					
	Paid Claims	7,324,654	7,324,654	-	7,324,654	
	IBNR	(6,165,800)	(6,165,800)	-	(6,165,800)	
	Less Specific Excess	(7,900)	(7,900)	-	(7,900)	
	Less Aggregate Excess	-	-	-	-	
	TOTAL FY 2025 CLAIMS	1,150,955	1,150,955	-	1,150,954	
	FUND YEAR 2026					
	Paid Claims	4,998,518	4,998,518	-	4,998,518	
	IBNR	8,582,430	8,582,430	-	8,582,430	
	Less Specific Excess	-	-	-	-	
	Less Aggregate Excess	-	-	-	-	
	TOTAL FY 2026 CLAIMS	13,580,948	13,580,948	-	13,580,948	
	COMBINED TOTAL CLAIMS	15,011,528	15,011,528	661,661,714	676,673,241	

Southern Coastal Regional Employee Benefits Fund
CONSOLIDATED BALANCE SHEET
AS OF JANUARY 31, 2026
BY FUND YEAR

	COASTAL 2026	COASTAL 2025	COASTAL 2024	CLOSED YEAR	FUND BALANCE
ASSETS					
Cash & Cash Equivalents	(1,178,783)	(1,444,724)	(2,972,234)	19,362,515	13,766,773
Assesments Receivable (Prepaid)	12,155,725	2,466,026	185,013	-	14,806,764
Interest Receivable	-	-	-	40	40
Specific Excess Receivable	-	1,418,110	39,445	4,759	1,462,314
Aggregate Excess Receivable	-	-	-	-	-
Dividend Receivable	-	-	-	-	-
Prepaid Admin Fees	-	-	-	-	-
Other Assets	284,965	404,285	-	-	689,250
Total Assets	11,261,906	2,843,697	(2,747,776)	19,367,314	30,725,142
LIABILITIES					
Accounts Payable	-	-	-	-	-
IBNR Reserve	8,582,430	7,847,381	-	-	16,429,811
A4 Retiree Surcharge	187,498	986,612	-	-	1,174,110
Dividends Payable	-	-	-	-	-
Retained Dividends	-	-	-	12,139,433	12,139,433
Accrued/Other Liabilities	62,289	341,676	-	-	403,965
Total Liabilities	8,832,217	9,175,669	-	12,139,433	30,147,319
EQUITY					
Surplus / (Deficit)	2,429,689	(6,331,972)	(2,747,776)	7,227,881	577,823
Total Equity	2,429,689	(6,331,972)	(2,747,776)	7,227,881	577,823
Total Liabilities & Equity	11,261,906	2,843,697	(2,747,776)	19,367,314	30,725,142
BALANCE	-	-	-	-	-

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

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

RATIOS

		FY2026
INDICES	2025	JAN
Cash Position	15,989,793	\$ 13,766,773
IBNR	14,013,181	\$ 16,429,811
Assets	27,028,324	\$ 30,725,142
Liabilities	27,473,218	\$ 30,147,319
Surplus	(444,893)	\$ 577,823
Claims Paid -- Month	12,972,841	\$ 12,613,606
Claims Budget -- Month	12,018,770	\$ 15,369,637
Claims Paid -- YTD	155,182,136	\$ 12,613,606
Claims Budget -- YTD	143,307,143	\$ 15,369,637
RATIOS		
Cash Position to Claims Paid	1.23	1.09
Claims Paid to Claims Budget -- Month	1.08	0.82
Claims Paid to Claims Budget -- YTD	1.08	0.82
Cash Position to IBNR	1.14	0.84
Assets to Liabilities	0.98	1.02
Surplus as Months of Claims	(0.04)	0.04
IBNR to Claims Budget -- Month	1.17	1.07

Southern Coastal Regional Employee Benefits Fund

2026 Budget Report

AS OF JANUARY 31, 2026

				Cumulative	\$ Variance	% Variance
Expected Losses	Cumulative	Annual	Latest Filed	Expensed		
Medical Claims Aetna 12/31 Renewal	7,756,677	92,267,921	74,977,896			
Medical Claims Aetna 6/30 Renewal	3,733,158	44,189,590	50,393,383			
Medical Claims AmeriHealth 12/31 Renewal	2,000,524	24,006,288	24,267,085			
Medical Claims AmeriHealth 6/30 Renewal	1,331,705	15,944,130	11,447,065			
Subtotal Medical Claims	14,822,064	176,407,929	161,085,429	12,933,209	1,888,855	13%
Prescription Claims 12/31 Renewal	319,945	3,843,802	2,920,283			
Prescription Claims 6/30 Renewal	474,392	5,656,332	4,797,563			
Prescription Formulary Rebates	(254,188)	(3,040,047)	(2,469,711)			
Subtotal Prescription	540,149	6,460,087	5,248,135	641,008	(100,859)	-19%
Dental Claims 12/31 Renewal	2,018	23,578	24,211			
Dental Claims 6/30 Renewal	5,406	64,480	61,935			
Subtotal Dental	7,424	88,058	86,146	6,731	693	9%
Vision Claims 12/31 Renewals	0	0	0			
Vision Claims 6/30 Renewals	0	0	0			
Subtotal Vision	0	0	0	Included in Medical		
Subtotal Claims	15,369,637	182,956,074	166,419,710	13,580,948	1,788,689	12%
Loss Fund Contingency	250,000	3,000,000	3,000,000	0	250,000	100%
DMO Premiums	0	0	0	75	(75)	#DIV/0!
Medicare Advantage / EGWP	170,215	2,052,103	920,298	152,244	17,971	11%
Reinsurance						
Specific	700,915	8,334,158	7,089,088			
Subtotal Reinsurance	700,915	8,334,158	7,089,088	649,861	51,053	7%
Total Loss Fund	16,490,766	196,342,336	177,429,096	14,383,128	2,107,638	13%
Expenses						
Legal	2,211	26,530	26,530	2,211	(0)	0%
Treasurer	632	7,589	21,339	1,778	0	0%
Deputy Treasurer	1,146	13,750	21,339	Included above in Treasurer		
Administrator	165,475	1,969,069	1,648,882	153,488	11,987	7%
Program Manager	321,324	3,823,598	3,201,849	298,048	23,277	7%
Risk Management Consultants	245,410	3,350,391	2,481,467	245,410	-	0%
TPA - Aetna	190,674	2,263,320	1,936,990	Included below in Med AmerihealthAdmin		
TPA - AmeriHealth	68,191	814,991	680,499	240,399	18,466	7%
Nurse Advocates	69,037	820,878	698,244	60,862	8,175	6%
TPA - Dental	354	4,187	3,843	358	(3)	-1%
TPA - Vision	0	0	0	Included below in Med AmerihealthAdmin		
Actuary	1,021	12,250	12,250	1,021	(0)	0%
Auditor	1,785	21,420	21,420	1,785	0	0%
Retiree First	0	0	0	10,968	(10,968)	-100%
QPA	250	0	0	250	-	0%
Subtotal Expenses	1,067,509	13,127,973	10,754,652	1,016,577	50,933	5%
Misc/Cont	10,294	123,527	123,527	2,899	7,395	72%
Wellness, Disease, Case Management	49,225	584,306	500,060	49,234	(9)	0%
Claims Audit	3,333	40,000	40,000	3,333	0	0%
Plan Documents	1,042	12,500	12,500	1,042	(0)	0%
Affordable Care Act Taxes	3,662	43,547	37,041	3,663	(1)	0%
A4 Surcharge	187,375	2,252,959	1,941,580	187,498	(123)	0%
Total Expenses	1,322,440	16,184,812	13,409,360	1,264,246	58,194	4%
Total Budget	17,813,207	212,527,147	190,838,456	15,647,374	2,165,832	12%

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

Year: 2026

<u>Yearly Items</u>	<u>Filing Status</u>
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	To Be Filed
Withdrawals	N/A
Risk Management Plan and By Laws	Filed
Cash Management Plan	Filed
Unaudited Financials	Filed
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	To be filed
Bylaw Amendments	N/A
Contracts	Filed
Benefit Changes	N/A

Contract	Professional	Contract	Insurance	Contract Term
Executive Director	PERMA	Y	Y	1/1/2025-12/31/2027
Program Manager	Shared Health Alliance	Y	Y	1/1/2025-12/31/2027
Attorney	Marmero Law	Y	Y	1/1/2025-12/31/2027
Auditor	Bowman & Company	Y	Y	1/1/2025-12/31/2027
Actuary	John Vataha	Y	Y	1/1/2025-12/31/2027
Treasurer	Matt Laracy	Y	Y	1/1/2025-12/31/2027
Deputy Treasurer	Verrill & Verrill	Y	Y	1/1/2025-12/31/2027
Medical TPA	Aetna	Y	Y	1/1/2026-12/31/2026
Medical TPA	AHA	Y	Y	1/1/2026-12/31/2026
Nurse Advocacy	Guardian Nurses	Y	Y	Subproducer of PM
Wellness	Advanta	Y	Y	1/1/2024 -12/31/2026

Pursuant to N.J.A.C Title 11, Chapter 15, Subchapter 5, PERMA, LLC (“PERMA”), as administrator of the Southern Coastal Regional Employee Benefits Fund (“the Fund”), and its employees, officers and directors hereby provide notice that they have direct and indirect

financial interests in Conner Strong & Buckelew Companies, LLC, and Guardian Nurses which are servicing organizations for the Fund.

CONTACTS

Executive Director Team:

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
Assistant Account Manager	Jordyn Robinson	jrobinson@permainc.com	856-446-9287



March 30, 2026

Prospects:

GROUPS WITH CLAIMS REQUESTED/PENDING	0
NUMBER OF GROUPS UNDER REVIEW WITH UNDERWRITING	1
PROPOSALS PENDING	1
PROPOSALS RELEASED	4
GROUPS SOLD	1 – pending resolutions
GROUPS WITH UNFAVORABLE CLAIMS/POOR RISK	3

Coastal Fund Meeting Dates:

- January 26, 2026
- March 30, 2026
- June 1, 2026
- July 27, 2026
- September 28, 2026
- October 26, 2026
- January 25, 2027

Coastal Fund Brokers:

- Allen Associates
- AR Fanucci Insurance
- Brown & Brown
- J Byrne Agency
- Conner Strong & Buckelew
- Cornerstone Insurance Group
- Glenn Insurance
- Hardenbergh Insurance Group
- Hafetz Insurance
- Insurance Solutions Inc
- PBC (Professional Benefit Consultants)

Executive Committee:

- Richard Davidson, Chair
- Pat Yacovelli, Secretary
- Jerry Velazquez, Executive Committee
- Megan Duffield, Executive Committee
- Laurie Ryan, Executive Committee
- Scott Musterel, Executive Committee
- Mark Mallet, Executive Committee
- Frank Badessa, Executive Committee Alternate
- Dennis Zakroff, Executive Committee Alternate
- Kevin Smaniotto, Executive Committee Alternate
- Thomas D'Intino, Executive Committee Alternate

2025 Committees:

FINANCE & CONTRACTS

- Richard Davidson – Chair
- Jerry Velazquez
- Scott Musterel

OPERATIONS & NOMINATIONS

- Pat Yacovelli – Chair
- Jerry Velazquez
- Mark Mallet

WELLNESS & CLAIMS

- Laurie Ryan – Chair
- Megan Duffield
- Pat Yacovelli

WELLNESS COMMITTEE UPDATE:

Please visit www.coastalhif.com/wellness to review the wellness grant guidelines and information needed to submit a new application. You can also find information on programs like Biometric Screenings from Health Fairs Direct, the wellness tracking app from Advanta Health Solutions, and many other resources at www.coastalhif.com/wellness/resources. If you have any questions, feel free to contact us.

2026 GRANT SPRING SUBMISSION DATE: MAY 15

2025 was an outstanding year for wellness across our HIF, with record participation and engagement. Building on that success, we've already received eight applications this cycle and anticipate similar interest again. Our budget planning ensures that every group can apply without concern about funding availability, with any unused funds returning to the contingency pool.

If your wellness program began last summer or you missed the winter submission deadline, *you can apply by May 15, 2026*. Applications submitted by this date will be reviewed at the June meeting, with approved programs set to launch on July 1, 2026.

It is still early but we have already received a few applications. So, just as a reminder, the groups with expiring grants from last spring that have not yet been resubmitted (and this year's grant amounts) are as follows:

Bridgeton BOE \$24,745	The Authority \$4,350
Lower Twp BOE \$11,340	CC Charter School Network \$5,625
Salem County \$20,080	Penns Grove-Carneys Point \$13,350
CCTEC \$8,060	City of Absecon \$2,550
Waterford BOE \$6,955	Woodstown \$1,275

If you would like to know your grant allotment or submit a grant you can reach out to corey@shanj.com or visit www.coastalhif.com

RAMP HEALTH PILOT PROGRAM:

2026 has brought exciting new wellness initiatives, including the launch of the Ramp Health Pilot Program. Just a few months in, both Millville BOE and The Authority are already seeing great results. Representatives from Ramp Health will once again be joining us to share more about how the program operates and to answer any questions you may have.

ACTIVEFIT+ PAYMENT SYSTEM IS NOW FULLY AUTOMATED:

We've been working with PERMA and Advanta behind the scenes to streamline the monthly payment process for Advanta's ActiveFit+ program.

We are thrilled to share that this change will take effect starting in April! This means that any charges for incentives or additional buy-up plans that were previously billed to any group utilizing these upgrades will now be directly paid by the Coastal HIF. This adjustment should also expedite the incentive payments for employees by eliminating the middleman and reducing the administrative workload.

If you are one of these groups, you should no longer receive any financial communications or bills from Advanta after April.

REIMBURSEMENT REMINDER:

We have observed that some groups applying for grants are not requesting reimbursements, indicating they may not be proceeding with their wellness plans. This is unfair to other groups who wish to apply when funds are depleted. If you haven't requested funds for previous years, please do so by filling out the form on coastalhif.com and sending to corey@shanj.com. Below are the guidelines for how to submit. We have included the entire form on the following page.

Submission Checklist

- *The Fund will reimburse approved expenses by submitting this completed voucher with required documents. Please include this signed voucher along with required back up documents/receipts. Without the below items, reimbursement will be denied:*
 - *Signed Purchase Orders for all items & Vendor Invoices if applicable OR purchase receipts (must match PO) & Check Copies or proof of payment for each item listed on voucher*

MORE PROOF THAT WELLNESS WORKS:

We analyzed the Medical L/R of groups active in the wellness program from 2021 to 2023 and found the following:

Groups that applied in 2022-2023:	Groups that <u>did not</u> apply in 2022-2023:	Groups that applied between 2021-2023: *	Groups <u>not</u> consistent between 2021-2023:	Groups w/ over 20% Advanta participation:
87%	111%	93%	119%	82%

*had to apply for at least 2 years

- **There is a 24% difference between groups that applied in 2022-2023 and those that did not.**
- **There is a 26% difference between groups that applied consistently over three years versus those that did not.**

Advanta, with the help of the Validation Institute, studied our Medical Loss Ratio data relative to their active users and found that **groups utilizing Advanta Health’s ActiveFit+ platform report**

an average MLR savings of 10.4% in the first year, with increased savings correlating to higher participant enrollment.

Reminder: Please visit the Coastal HIF website for more details on how to apply, what is eligible, ideas for an application and additional resource information. You can always contact corey@shanj.com us for any assistance that you might need. Here's the website link: <https://coastalhif.com/wellness/application>

GUARDIAN NURSES:

MEET THE COASTAL FUND DEDICATED GUARDIAN NURSES

Paula Spector, RN

609-276-5001

pspector@guardiannurses.com

Rebecca Parkerson, RN

609-276-4990

rparkerson@guardiannurses.com

Sarah Fiske, RN

856-239-3823

sfiske@guardiannurses.com

Also attached is the most recent Guardian Nurses newsletter "*The Flame*"

ADMINISTRATIVE REMINDERS & UPDATES:

- **Broker Contact Information** - Please direct any escalated claims, benefit coverages, prescription coverage, Medicare advantage or appeal related questions to our dedicated Benefit Specialists as follows: MaryBeth Anglani marybeth@allenassoc.com , or Annie Jimenez annie@allenassoc.com .
- **Monthly Billing** -As a reminder, please be sure to check your monthly invoice for accuracy. If you find a discrepancy, please report it to the Coastal Fund enrollment team. The Fund's policy is to limit retro corrections, including terminations, to 60 days. We have noticed an increase in requests for enrollment changes, billing changes, terminations and additions well past the 60-day time frame. Moving forward, it is of the utmost importance to review bills for rate and enrollment accuracy on a monthly basis. If there is an error, please bring it to our attention.
- 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.
 - *In the subject line of the email, please include: Training - Fund Name and Client Name. Please be sure to add the date of the training you would like to attend in your email so an invite can be sent.*

- **PARTIAL MONTH ENROLLEMNTS REMINDER>>**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.
- **WEX PORTAL AND BILLING ISSUES:** The following emails should be used:
 - Marlene Robinson, mrobinson@permainc.com, 856-552-4818
 - Michele McKeever, mmckeever@permainc.com, 856-479-2160

OPERATIONAL UPDATES:

Retiree First: The Coastal Fund is now working with Retiree First. Retiree First will add another layer of support for the Medicare Retiree population. Letters were mailed out to the current Medicare Advantage population making them aware of Retiree First as a resource.

Attached is a Retiree First flyer sharing their toll-free number 1-855-257-7195.

They will be available to help the Medicare Advantage population. Just some of the support they will offer is:

- Plan Questions
- Outreach to Providers and Pharmacies (if applicable)
- Mail Order Assistance
- Formulary Lookup
- Medical and Prescription Billing Issues (if applicable)
- Updating Personal Information Changes

NEW MEMBERS: Below is a new member joining the Coastal effective 7/1/2026 pending receipt of Resolution to Join and Indemnity & Trust Agreement. Resolution 14-26 is included in consent.

New Member Overview	
Fund	Coastal HIF
Entity	Weymouth Twp BOE
County	Atlantic
Effective Date	7/1/2026-6/30/2027
Lines of Coverage	Medical & Rx
Eligible Employees	23
Retiree Coverage	None
Current Arrangement	State Health Benefits
Actuary Certification	Yes: Standard Underwriting Methodology

Broker	Allen Associates
Broker Fee	2%
Claims PEPM (comb'd)	\$3194
Run Out Claims	State Health Benefits
Member approval?	Indemnity and Trust Agreement pending
Special Requests	None

LEGISLATIVE UPDATES:

2025 LEGISLATIVE REVIEW

MEDICAL AND RX REPORTING: None

NO SURPRISE BILLING AND TRANSPARENCY ACT -

Effective January 1, 2026:

As previously reported, the Federal No Surprises Act has resulted in the reprocessing of several Million dollars of claims for the HIFs statewide. While the State program does not remove the exposure to these types of claims reprocessing, it should allow for more predictability and less backlog and surprise cash exposure going forward. As a result of the transition, enrolled members will be receiving new ID cards from Aetna prior to January 1st. subscriber ID numbers and Fund member group numbers will not be changing.

INDUSTRY UPDATES

- Wegovy (Pill Form) - Express Scripts has completed their initial review of the new medication (standard practice) and determined the following:

On December 22, 2025, the FDA approved the Wegovy pill (oral semaglutide) for chronic weight management in adults. Beginning March 1, oral Wegovy will be added to all commercial formularies and removed from Exclude at Launch (EAL).

Oral Wegovy will remain blocked for clients enrolled in EncircleRx (ECRx) Weight Loss solution.

As the oral GLP 1 landscape continues to evolve, we will closely monitor new developments and keep you informed.

Fund Performance/Observations

Medical - Aetna & AmeriHealth

- Meeting with Fund Strategic Planning Committee to review program year 2025 Fund medical utilization and recommendations on cost containment strategies is pending scheduling.

Pharmacy - Express Scripts (ESI)

- Meeting with Fund Strategic Planning Committee to review program year 2025 Fund pharmacy utilization and recommendations on cost containment strategies is pending scheduling.
- With absence from plan changes, it is clear the Fund needs to address the rising utilization and associated costs with GLP-1 medications used specifically for weight loss. The following strategies are being evaluated for their efficacy and will be presented formally upon the conclusion of the evaluation
 - Implement tighter, clinically grounded utilization management protocols for GLP-1 medications used specifically for weight loss
 - Plan design options to exclude GLP-1 medications for weight loss on the Fund member level
 - Plan design options for increased member cost share for GLP-1 medications for weight loss on the Fund member level
 - Direct to consumer GLP-1 acquisition channel options

VENDOR UPDATES

AETNA UPDATES: NONE

AMERIHEALTH UPDATE: NONE

EXPRESS-SCRIPTS UPDATE:

Previously Reported Information

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

APPEALS & IRO’s (Independent Review Organization) (as of 3/24/26) -

Carrier Appeals

<u>Submission Date</u>	<u>Appeal Type</u>	<u>Appeal Number</u>	<u>Reason</u>	<u>Determination</u>	<u>Determination Date</u>
12/30/2025	Medical/Aetna	COASTAL 2025 12 03	Surgery	Upheld	01/13/2026
01/27/2026	Medical/Aetna	COASTAL 2026 01 07	Imaging	Upheld	03/11/2026

IRO Submissions:

<u>Submission Date</u>	<u>Appeal Type</u>	<u>Appeal Number</u>	<u>Reason</u>	<u>Determination</u>	<u>Determination Date</u>
01/13/2026	Medical/Aetna	COASTAL 2025 12 03	Surgery	Upheld	01/15/2026

Healthcare News and Tips

March 17, 2026

One of the side effects of being a nurse for many years is that people feel comfortable asking you health questions almost anywhere.

At a dinner party. In the grocery store. Standing in line for coffee.

And lately, I've noticed a pattern in many of those conversations. Someone will mention a lingering symptom or a screening they know they should schedule. When I ask what their primary care provider recommends, I often hear the same answer: "Well... I don't actually have one."

It's surprisingly more common than many people realize. In today's healthcare environment, it's easy to rely on urgent care centers, telehealth visits, or specialists when something specific comes up. Those services can be incredibly helpful, but they don't replace the role of a primary care provider who understands your overall health picture.

A good primary care provider helps coordinate care, track preventive screenings, and serve



Finding the Right Primary Care Provider

Choosing a primary care provider is one of the most important decisions you make about your health. Yet, many people choose one the same way they choose a restaurant---whatever is nearby, takes their insurance and has an opening this week.

That strategy works reasonably well for pizza. For healthcare, I'd say it might be worth a little more thought. Consider these suggestions when choosing a primary care provider.

1. Start with the practical details

Before diving into credentials and reviews, make sure the basics work for you.

Check whether the provider participates in your insurance network, how far the office is from your home or work, and how long it typically takes to schedule an appointment. Some practices also offer evening hours or telehealth visits, which can make routine care much easier to manage.

as a steady guide through the complexities of modern medicine.

In this special St. Patrick's Day issue of *The Flame*, we're sharing some suggestions on how to choose a primary care provider who can truly serve as your partner in health—someone who helps you stay well, not just treat illness when it appears.

Because in healthcare, as all of us at Guardian Nurses knows, having a trusted guide can make all the difference.



Happy St. Patrick's Day!

Betty
Betty Long
President/CEO



Convenience may sound minor, but it matters more than people think. If getting to the doctor requires rearranging half your week, many people end up postponing the very visits that help keep them healthy.

Also consider if you want a provider who is connected to a larger health system and if that is a health system you would be OK being sent to for additional care.

2. Understand the Different Types of Providers

Primary care is delivered by several types of clinicians. Internal medicine physicians focus on adult health, while family medicine physicians care for patients of all ages. Many practices also include nurse practitioners and physician assistants who diagnose conditions, prescribe treatment, and provide preventive care. In collaborative practices, patients often receive excellent care from these clinicians working together as a team.

3. Look for a Provider Who Values Prevention

One of the most important roles of a primary care provider is preventive care.

A strong provider will emphasize routine screenings, vaccinations, and lifestyle factors such as sleep, nutrition, exercise, and stress management. Preventive care may not feel urgent in the moment, but it plays a critical role in identifying health issues early—when they are often easier to treat.

In addition, upon an initial visit to a new primary care provider, take note of your initial physical exam? Does the provider make eye contact or just type answers? An initial exam should be 'stem to stern' meaning everything...listen to your heart, your lungs, your abdomen.

4. Pay Attention to Communication Style

Medical expertise matters, but communication matters just as much.

During your first visit, notice whether the provider truly listens, explains things clearly, and welcomes your questions. A good primary care provider should make you feel comfortable raising concerns and involved in decisions about your care.



Greetings to Joann and Jennifer!

Joann Martin, BSN, RN-BC, BIS and Jennifer Wilson, BSN, RN are the newest members to join the Guardian Nurses' team on the east coast.

Together, they have a combined 38 years of nursing experience between them. They both shared that that they are VERY MUCH looking forward to having their photo on a new Creamsicle!

Cars are being wrapped every quarter so stay tuned!

Your clinician doesn't have to be your best friend—but you should leave the visit feeling like you've been heard, respected, and confident that you're working toward the same goal: your health and well being.

5. Consider the Whole Practice

Healthcare today is delivered by teams, not individuals. Pay attention to how the office runs. Are employees at the front desk pleasant and helpful? What are you hearing as you sit in the waiting room or in an exam room? How are test results communicated? Is there a secure patient portal for messaging questions? Ask what happens if you have a test result that's concerning? Will the provider contact you or do you have to call them once you see the results?

Even excellent clinicians can be hampered by a poorly organized office. Practices with strong support teams often provide faster follow-up and better coordination of care.

6. Use Recommendations Wisely

Friends, family members, and trusted specialists can be valuable sources of recommendations. Online reviews can also offer insights, but it's best to look for patterns rather than focusing on one or two extreme comments.

7. Trust Your Instincts

This cannot be stressed enough. After your first visit, ask yourself a simple question: Would I feel comfortable bringing a serious health concern to this person?

Trust and communication are essential in a long-term healthcare relationship.

Finding the right primary care provider isn't just about having someone to call when you're sick. It's about building a relationship with someone who can help guide your health over time.

When you find the right match, the office becomes less like a place you visit only when something goes wrong—and more like a resource that helps keep you well. Take your time to find the right match!

Lighting your way
through the
healthcare maze.®

**Guardian Nurses Healthcare
Advocates**

215-836-0260 | Toll Free 888-836-0260

info@guardiannurses.com |
GuardianNurses.com



Board Report **Reporting on Dates: 10/1/25 – 12/31/25**

This report shows how our nurses improve care, enhance member experience, and reduce costs. Interventions and outcomes estimate projected cost savings/avoidance and are **highlighted in green**.

Highlights:

- Significant reduction in avoidable readmissions (see below)
- Strong projected cost savings related to expert care coordination - **\$263,985.00**

Improving Care: Cost Avoidance

Goals: Improve timeliness, appropriateness, and quality of care

Acute and Chronic Care Programs

- **394 cases supported (328 unique members); 70%Engagement Rate**
- **277 referrals; 199 mobilizations**
- **167 inpatients**

Inpatient Impact: Among **167 inpatients with a 67% engagement rate**, nurses coordinated in hospital/facility care interventions for **112 members**, including transfers to appropriate levels of care, preventing projected readmissions. Significance of high engagement and proactive coordination reduce readmissions, ensure safe transitions, and improves the quality outcomes for hospitalized members.

Improving Members' Experience: Cost Avoidance & Containment

Goals: Positive clinical outcomes, accessibility and equality, patient centered goals

- Coordinating outpatient care for **161 members** including pediatric and complex/chronic diagnosis
- One referral to Guardian Nurses Social Worker

Impact of Care Coordination: Nurses delivered **346 clinical and social interventions** — This work shows the breadth of clinical advocacy: timely access, preventing delays, connecting members to the right care, reflects both immediate impact (expedited/urgent needs, second opinions) and long-term support (addressing prevention, gaps in care, appropriate level of care, clinical and community resources,).

Managing or Reducing Cost Interventions & Outcomes: Cost Savings & Avoidance

Goals: Prevent unnecessary hospitalizations, ICU admissions and bounce backs

Projected Cost Savings

- **19 Prevented/Projected ER Visit: avg. cost per visit \$2,715- Projected savings of \$51,585** (Smith, 2025)
- **5 Prevented/Projected Admissions: avg cost per admission \$30,000-Projected savings of \$150,000** (Bengfort, 2024)
- **4 Prevented/Projected Readmissions: avg cost per readmission \$15,000- Projected savings of \$60,800** (Weiss & Jiang, 2018)
- **4 Prevented/Projected UC Visits: avg. cost of per visit \$400- Projected savings of \$1,600** (FAIR Health Consumer, 2025)

Projected Cost Avoidance

- **18 readmissions -- out of 167 admissions (11% readmission rate). Commercial benchmark -14.6% expected vs. actual (24 vs 18)**
- **Projected Cost Avoidance: \$91,200 (based on \$15,200 average admission) (Weiss & Jiang, 2018)**

Respectfully submitted,

Rebecca Czarkowski

Rebecca Czarkowski, MSN, RN

Vice President

References:

Bengfort, H. (2024, January 18). *Infographic: How much does a hospital stay cost?* Health Benefits: PeopleKeep. <https://www.peoplekeep.com/blog/infographic-how-much-does-a-hospital-stay-cost>

Definitive Healthcare. (2024, October 28). *Top U.S. hospitals by readmission scores.* Definitive Healthcare. <https://www.definitivehc.com/resources/healthcare-insights/top-hospitals-readmission-scores>

FAIR Health Consumer. (2025). *Medical cost lookup: ZIP 11790 – Suffolk County, NY.* FAIR Health. <https://fairhealthconsumer.org>

Smith, B. (2025, February 25). *Emergency room visit cost with and without insurance (2025 update).* Mira Health. <https://www.talktomira.com/post/how-much-does-an-er-visit-cost>

Weiss, A. J., & Jiang, H. J. (2018). *Overview of clinical conditions with frequent and costly hospital readmissions by payer (Statistical Brief #278).* Agency for Healthcare Research and Quality. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Clinical-Conditions-Readmissions-by-Payer.pdf>

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND BILLS LIST

FEBRUARY 2026

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

BE IT RESOLVED that the Southern Coastal Regional Employee Benefits 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

<u>Vendor Name</u>	<u>Comment</u>	<u>Invoice Amount</u>
PERMA	2025 AATRIX 1099 FILING FEE	21.70
		21.70
	TOTAL CHECKS 2025	21.70
	Total Payments FY 2025	21.70

FUND YEAR 2026

<u>Vendor Name</u>	<u>Comment</u>	<u>Invoice Amount</u>
PERMA	ADMIN FEES 02/26	177,356.36
PERMA	RETIREE FIRST INV 03012026	6,204.00
PERMA	POSTAGE 02/26	72.56
		183,632.92
MARMERO LAW, LLC	LEGAL FEES 1/1/26-1/28/26 INV 32553	2,346.00
		2,346.00
THE CANNING GROUP LLC	QPA SERVICES 02/26 INV 2026-02	250.00
		250.00
PRESS OF ATLANTIC CITY	INV A10F521C-0011 GEN LED 2/26-12/26	288.18
		288.18
ADVANTA HEALTH SOLUTIONS	JAN ACTIVIFIT & MGMT FEE INV 3131	8,150.94
		8,150.94
ACCESS	INV 12013797 01/31/26 FOR 02/26	22.54
		22.54
MUNICIPAL REINSURANCE HIF	SPECIFIC REINSURANCE 02/26	755,093.35
		755,093.35
	TOTAL CHECKS 2026	949,783.93
AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 02/26	164,564.59
		164,564.59
DELTA DENTAL INSURANCE COMPANY (DELTACARE USA)	DENTAL- A#7872000000 BE006901748 02/26	74.90
		74.90
AETNA	MEDICAL TPA FEES 02/26	209,641.60
		209,641.60
AMERIHEALTH ADMINISTRATORS	WELLNESS/MARKETING 02/26	-2,790.00
AMERIHEALTH ADMINISTRATORS	MEDICAL TPA FEES 02/26	71,684.40
		68,894.40

DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 02/26	347.48 347.48
VERRILL & VERRILL	TREASURER FEES 02/26	1,145.83 1,145.83
POINT ACCOUNTING GROUP	TREASURER FEES 02/26	632.41 632.41
SHARED HEALTH ALLIANCE	PROGRAM MANAGER 02/26	344,395.92 344,395.92
SHARED HEALTH ALLIANCE	GUARDIAN NURSES INV 5198 02/26	60,861.90 60,861.90
ALLEN ASSOCIATES	BROKER FEES 02/26	299,338.42 299,338.42
ACTUARIAL SOLUTIONS, LLC	1ST QTR 2026 FUND ACTUARY FEES	3,250.00 3,250.00
	TOTAL WIRES 2026	1,153,147.45
	Total Payments FY 2026	2,102,931.38
	TOTAL PAYMENTS ALL FUND YEARS	2,102,953.08

Chairperson

Attest:

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

Treasurer

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND BILLS LIST

MARCH 2026

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

BE IT RESOLVED that the Southern Coastal Regional Employee Benefits 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

<u>Vendor Name</u>	<u>Comment</u>	<u>Invoice Amount</u>
CUMBERLAND COUNTY BOARD OF VOCATIONAL EDUCATION	2025 WELLNESS REIMB 07/25-12/25	3,890.93
		3,890.93
CUMBERLAND COUNTY IMPROVEMENT AUTHORITY	2025 WELLNESS REIMB 03/26	3,919.92
		3,919.92
VINELAND PUBLIC CHARTER SCHOOL	2025 WELLNESS REIMB 03/26	1,290.00
		1,290.00
BUENA REGIONAL SCHOOL DISTRICT	25 WELL REIMB 10/25-12/25 LUNCHES	1,952.80
		1,952.80
	TOTAL CHECKS 2025	11,053.65
AETNA	MEDICARE TPA FEES 12/25	165,909.10
		165,909.10
	TOTAL WIRES 2026	165,909.10
	Total Payments FY 2025	176,962.75

FUND YEAR 2026

<u>Vendor Name</u>	<u>Comment</u>	<u>Invoice Amount</u>
PERMA	ADMIN FEES 03/26	165,306.09
PERMA	POSTAGE 02/26	50.39
PERMA	RETIREE FIRST INV 04012026	5,640.00
		170,996.48
MARMERO LAW, LLC	SPECIAL LEGAL SERVICES 02/26 INV32659	1,395.00
MARMERO LAW, LLC	LEGAL FEES 2/2/26-2/27/26 INV 32658	2,346.00
		3,741.00
THE CANNING GROUP LLC	QPA SERVICES 03/26 INV 2026-03	250.00
		250.00
ADVANTA HEALTH SOLUTIONS	FEB ACTIVIFIT & MGMT FEE INV 3199	8,150.94
ADVANTA HEALTH SOLUTIONS	MARCH ACTIVIFIT & MGMT FEE INV 3228	9,548.28
		17,699.22
HQSI, INC	REVIEW CASE INV 260131-MRHIF-1	900.00
		900.00
ACCESS	INV 12060824 02/28/26 DEPT 963 FOR 03/26	23.89
		23.89
MUNICIPAL REINSURANCE HIF	SPECIFIC REINSURANCE 03/26	698,736.00
		698,736.00

AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 03/26	164,869.64 164,869.64
DELTA DENTAL INSURANCE COMPANY (DELTACARE USA)	DENTAL- A#7872000000 BE006956087 03/26	74.90 74.90
AETNA	MEDICAL TPA FEES 03/26	190,570.80 190,570.80
AMERIHEALTH ADMINISTRATORS AMERIHEALTH ADMINISTRATORS	MEDICAL TPA FEES 03/26 WELLNESS/MARKETING 03/26	70,181.34 -2,731.50 67,449.84
DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 03/26	357.72 357.72
VERRILL & VERRILL	TREASURER FEES 03/26	1,145.83 1,145.83
POINT ACCOUNTING GROUP	TREASURER FEES 03/26	632.41 632.41
SHARED HEALTH ALLIANCE	PROGRAM MANAGER 03/26	320,996.34 320,996.34
SHARED HEALTH ALLIANCE	GUARDIAN NURSES INV 5246 03/26	60,861.90 60,861.90
ALLEN ASSOCIATES ALLEN ASSOCIATES	BROKER FEES 03/26 MARCH MULLICA FEES 03/26	169,138.29 -2,662.56 166,475.73
A.R FANUCCI INSURANCE AGENCY LLC	BROKER FEES 03/26	2,461.35 2,461.35
BROWN & BROWN METRO LLC	BROKER FEES 03/26	9,955.20 9,955.20
BROWN & BROWN METRO LLC	BROKER FEES 03/26	6,884.97 6,884.97
THE GRAHAM GROUP INC	BROKER FEES 03/26	8,051.75 8,051.75
CONNER STRONG & BUCKELEW	BROKER FEES 03/26	12,880.84 12,880.84
GLENN INSURANCE, INC	BROKER FEES 03/26	1,598.85 1,598.85
HAFETZ AND ASSOCIATES LLC	BROKER FEES 03/26	7,201.92 7,201.92
HARDENBERGH INSURANCE GROUP, INC	BROKER FEES 03/26	1,407.60 1,407.60
INSURANCE SOLUTIONS INC	BROKER FEES 03/26	17,947.96
INTEGRITY CONSULTING GROUP	BROKER FEES 03/26	6,570.78 6,570.78
J BYRNE AGENCY, INC.	BROKER FEES 03/26	17,526.76 17,526.76
PROFESSIONAL BENEFIT CONSULTANTS, INC.	BROKER FEES 03/26	13,261.15 13,261.15
	TOTAL WIRES 2026	#REF!
	Total Payments FY 2026	1,971,530.83
	TOTAL PAYMENTS ALL FUND YEARS	2,148,493.58

Chairperson

Attest:

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

Dated: _____

Treasurer

**CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES
COASTAL HEALTH BENEFITS FUND**

Month		January							
Current Fund Year		2026							
Policy Year	Coverage	1.	2.	3.	4.	5.	6.	7.	8.
		Calc. Net Paid Thru Last Month	Monthly Net Paid January	Monthly Recoveries January	Calc. Net Paid Thru January	TPA Net Paid Thru January	Variance To Be Reconciled	Delinquent Unreconciled Variance From	Change This Month
2026	Medical	0.00	11,808,527.14	0.00	11,808,527.14	0.00	11,808,527.14	0.00	11,808,527.14
	Dental	0.00	2,107.30	0.00	2,107.30	0.00	2,107.30	0.00	2,107.30
	Rx	0.00	1,042,820.47	0.00	1,042,820.47	0.00	1,042,820.47	0.00	1,042,820.47
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	12,853,454.91	0.00	12,853,454.91	0.00	12,853,454.91	0.00	12,853,454.91

**COASTAL HEALTH BENEFITS FUND
SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED**

Current Fund Year: 2026										
Month Ending: January										
	Medical	Dental	Rx	Vision	Reinsurance	Admin	LFC	Closed Year	Retained Dividend	TOTAL
OPEN BALANCE	(4,814,404.69)	(12,488.12)	(5,049,092.93)	59,825.44	(472,018.39)	4,329,405.01	2,584,276.15	7,244,945.62	12,119,345.24	15,989,793.33
RECEIPTS										
Assessments	11,447,914.57	1,752.46	157,834.72	0.00	184,044.03	374,564.24	66,762.98	0.00	0.00	12,232,873.00
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	0.00	0.00	0.00	99.16	0.00	7,175.88	4,283.38	12,048.76	20,087.53	43,694.71
Invest Adj	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal Invest	0.00	0.00	0.00	99.16	0.00	7,175.88	4,283.38	12,048.76	20,087.53	43,694.71
Other Receipts	389.20	0.00	182,520.47	0.00	0.00	33.28	0.00	0.00	0.00	182,942.95
TOTAL	11,448,303.77	1,752.46	340,355.19	99.16	184,044.03	381,773.40	71,046.36	12,048.76	20,087.53	12,459,510.66
EXPENSES										
Claims Transfers	11,808,527.14	2,107.30	1,042,820.47	0.00	0.00	0.00	0.00	0.00	0.00	12,853,454.91
Expenses	152,244.15	74.90	0.00	0.00	649,861.46	1,026,893.66	0.00	0.00	0.00	1,829,074.17
Other Expenses	0.00	0.00	0.00	0.00	0.00	1.67	0.00	0.00	0.00	1.67
TOTAL	11,960,771.29	2,182.20	1,042,820.47	0.00	649,861.46	1,026,895.33	0.00	0.00	0.00	14,682,530.75
END BALANCE	(5,326,872.21)	(12,917.86)	(5,751,558.21)	59,924.60	(937,835.82)	3,684,283.08	2,655,322.51	7,256,994.38	12,139,432.77	13,766,773.24

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS								
COASTAL HEALTH BENEFITS FUND								
ALL FUND YEARS COMBINED								
CURRENT MONTH	January							
CURRENT FUND YEAR	2026							
Description:		OceanFirst Investment Account	OceanFirst Operating Account	Fulton Bank Investment Account	Wilmington Trust Investment Account	NJ Cash Management Investment Account	Fulton Bank Checking Account	
ID Number:								
Maturity (Yrs)								
Purchase Yield:		2.79	2.79	3.83	3.44	3.58	3.73	
TOTAL for All Accts & instruments								
Opening Cash & Investment Balance	\$ 15,989,793.33	\$ 13,176.63	\$ 5,257,669.39	\$ 9,982,592.79	\$ 13,401.49	\$ 589,463.54	\$ 133,489.49	
Opening Interest Accrual Balance	\$ 40.44	\$ -	\$ -	\$ -	\$ 40.44	\$ -	\$ -	
1 Interest Accrued and/or Interest Cost	\$39.35	\$0.00	\$0.00	\$0.00	\$39.35	\$0.00	\$0.00	
2 Interest Accrued - discounted Instr.s	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
3 (Amortization and/or Interest Cost)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
4 Accretion	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
5 Interest Paid - Cash Instr.s	\$43,654.27	\$30.81	\$12,662.20	\$28,720.12	\$0.00	\$1,811.89	\$429.25	
6 Interest Paid - Term Instr.s	\$40.44	\$0.00	\$0.00	\$0.00	\$40.44	\$0.00	\$0.00	
7 Realized Gain (Loss)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
8 Net Investment Income	\$43,693.62	\$30.81	\$12,662.20	\$28,720.12	\$39.35	\$1,811.89	\$429.25	
9 Deposits - Purchases	\$18,414,988.65	\$0.00	\$11,437,180.00	\$5,978,635.95	\$0.00	\$0.00	\$999,172.70	
10 (Withdrawals - Sales)	-\$20,681,703.45	\$0.00	-\$13,683,356.38	-\$5,999,172.70	-\$1.67	\$0.00	-\$999,172.70	
		OK	OK	OK	OK	OK	OK	
Ending Cash & Investment Balance	\$13,766,773.24	\$13,207.44	\$3,024,155.21	\$9,990,776.16	\$13,440.26	\$591,275.43	\$133,918.74	
Ending Interest Accrual Balance	\$39.35	\$0.00	\$0.00	\$0.00	\$39.35	\$0.00	\$0.00	
Plus Outstanding Checks	\$829,901.47	\$0.00	\$829,901.47	\$0.00	\$0.00	\$0.00	\$0.00	
(Less Deposits in Transit)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Balance per Bank	\$14,596,674.71	\$13,207.44	\$3,854,056.68	\$9,990,776.16	\$13,440.26	\$591,275.43	\$133,918.74	



SOUTHERN COASTAL HEALTH INSURANCE FUND

Monthly Claim Activity Report

March 30, 2026



SOUTHERN COASTAL HEALTH INSURANCE FUND

	MEDICAL CLAIMS + CAP			MEDICAL CLAIMS + CAP		
	PAID 2025	# OF EES	PER EE	PAID 2026	# OF EES	PER EE
JANUARY	\$7,212,499	4,813	\$ 1,499	\$9,385,586	5,575	\$1,684
FEBRUARY	\$7,981,639	4,817	\$ 1,657			
MARCH	\$8,575,969	4,796	\$ 1,788			
APRIL	\$10,230,178	4,798	\$ 2,132			
MAY	\$10,136,230	4,806	\$ 2,109			
JUNE	\$10,105,217	4,820	\$ 2,097			
JULY	\$10,624,134	4,764	\$ 2,230			
AUGUST	\$11,405,481.52	4,724	\$ 2,414			
SEPTEMBER	\$10,042,626.65	4,845	\$ 2,073			
OCTOBER	\$8,401,661.48	4,828	\$ 1,740			
NOVEMBER	\$8,996,850.57	4,835	\$ 1,861			
DECEMBER	\$9,774,596.42	4,840	\$ 2,020			
TOTALS	\$113,487,083			\$9,385,586		
				2026 Average	5,575	\$ 1,684
				2025 Average	4,807	\$ 1,968

Plan Sponsor Unique ID : All
Customer: Southern Coastal Health Insurance Fund
Group / Control: 00108431,00169660,00737420,00737421

Paid Dates: 12/01/2025 - 12/31/2025
Service Dates: 01/01/2011 - 12/31/2025
Line of Business: All

	Paid Amt	Diagnosis/Treatment
	\$149,996.03	COMPRESSION OF BRAIN
	\$126,922.06	HEREDITARY FACTOR VIII DEFICIENCY
	\$117,937.62	OTHER COMPLICATIONS OF LUNG TRANSPLANT
	\$117,510.85	ATHEROSCLEROTIC HEART DISEASE OF NATIVE
	\$115,749.72	SEPSIS, UNSPECIFIED ORGANISM
	\$102,592.21	CERVICAL DISC DISORDER WITH MYELOPATHY, HIGH
	\$100,601.43	NONTRAUMATIC INTRACEREBRAL
Total:	\$831,309.92	

Large Claimant Report (Drilldown) - Claims Over \$100000

Plan Sponsor Unique ID : All
Customer: Southern Coastal Health Insurance Fund
Group / Control: 00108431,00169660,00737420,00737421

Paid Dates: 01/01/2026 - 01/31/2026
Service Dates: 01/01/2011 - 01/31/2026
Line of Business: All

	Paid Amt	Diagnosis/Treatment
	\$522,378.26	ENCOUNTER FOR ANTINEOPLASTIC
	\$280,879.89	CERVICAL DISC DISORDER WITH MYELOPATHY
	\$121,999.26	SINGLE LIVEBORN INFANT, DELIVERED VAGINALLY
	\$111,198.96	HEREDITARY FACTOR VIII DEFICIENCY
Total:	\$831,309.92	



Medical Claims Paid:
January 2026 – January 2026

Total Medical Paid per EE: **\$1,684**

Network Discounts

Inpatient:	65.3%
Ambulatory:	62.6%
Physician/Other:	61.9%
TOTAL:	63.0%

Provider Network

% Admissions In-Network: **97.9%**
% Physician Office in network: **98.9%**

Aetna Book of Business:
Admissions 98.1%; Physician 90.6%

Top Facilities Utilized
(by total Medical Spend)

- Inspira Medical Center –Vineland
- Cooper Hospital
- Inspira Medical Center- Mullica Hill
- University of Pennsylvania
- Virtua West Jersey Health System

Catastrophic Claim Impact
(January 2026- January 2026)

Number of Claims Over \$50,000 **18**
Claimants per 1000 members: **1.4**
Avg. Paid per Claimant: **\$107,487**
Percent of Total Paid: **21.3%**

- Aetna BOB- HCC account for an average of **45.8%** of total Medical Cost

Aetna One Flex Care Mgmt
Member Outreach:

Total Members Identified: **3,395**
Members Targeted for 1:1 Nurse Support : **790**
Members identified for Digital Activity: **2,605**
Members receiving Aetna Advice: **2,187**
Average Aetna Advice outreaches per member: **1.5**

CVSHealth. CVS Virtual Care

Completed Visits: **97**
Unique Patients: **91**
Completed Visits in 2026 : **97**
Unique Patients in 2026: **91**
Total Scheduled Visits in 2026: **104**
BoB: Average First Available 24/7 Care: **24** minutes
BoB: Average First Available MH: **7** Days

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**





2026 Coastal HIF

2025 Coastal HIF

	MEDICAL CLAIMS PAID 2026	# OF EES	PER EE		MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	\$ 962,271.88	1,853	\$ 519.30	JANUARY	\$ 2,647,672.70	1618	\$ 1,636.38
FEBRUARY	\$ 3,759,409.00	1,856	\$ 2,025.54	FEBRUARY	\$ 2,610,983.87	1,601	\$ 1,630.84
MARCH				MARCH	\$ 2,718,987.70	1,608	\$ 1,540.06
APRIL				APRIL	\$ 2,476,426.33	1,607	\$ 1,541.02
MAY				MAY	\$ 3,264,140.97	1,598	\$ 2,042.64
JUNE				JUNE	\$ 2,294,421.78	1,601	\$ 1,433.11
JULY				JULY	\$ 3,498,661.68	1,543	\$ 2,267.44
AUGUST				AUGUST	\$ 3,301,519.26	1,553	\$ 2,125.89
SEPTEMBER				SEPTEMBER	\$ 2,413,139.97	1,539	\$ 1,567.99
OCTOBER				OCTOBER	\$ 3,261,488.98	1,532	\$ 2,363.89
NOVEMBER				NOVEMBER	\$ 2,543,847.12	1,539	\$ 1,652.92
DECEMBER				DECEMBER	\$ 2,566,800.33	1,534	\$ 1,673.27
TOTALS	\$4,721,680.88			TOTALS	\$ 33,598,090.69		\$ 1,789.62
				36			
2024 Average		2026 Average	\$ 1,272.42				



EXPRESS SCRIPTS®

Southern Coastal Health Insurance Fund

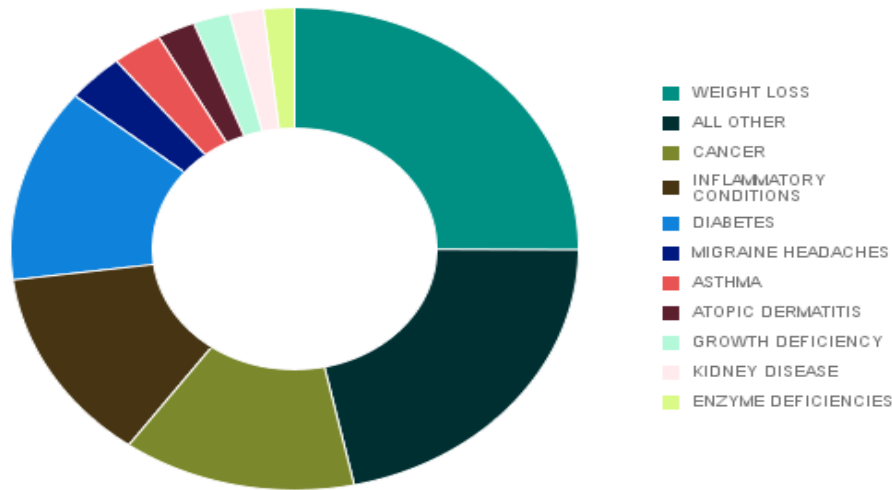
Total Component/Date of Service (Month)	2025 01	2025 02	2025 03	2025 Q1	2025 04	2025 05	2025 06	2025 Q2	2025 07	2025 08	2025 09	2025 Q3	2025 10	2025 11	2025 12	2025 Q4	2025 YTD
Membership	2,643	2,621	2,606	2,623	2,600	2,596	2,608	2,601	2,602	2,561	2,648	2,604	2,646	2,661	2,662	2,656	2,621
Total Days	102,714	89,787	101,595	294,096	93,046	97,681	94,960	285,687	94,539	89,945	97,269	281,753	98,718	93,389	102,118	294,332	1,056,366
Total Patients	1,065	1,038	1,032	1,554	1,012	991	999	1,463	973	982	993	1,486	1,078	989	1,141	1,590	2,176
Total Plan Cost	\$556,217	\$612,671	\$608,210	\$1,777,098	\$743,532	\$779,323	\$741,628	\$2,264,483	\$772,403	\$687,539	\$793,221	\$2,253,163	\$757,714	\$791,360	\$934,977	\$2,484,182	\$8,236,105
Generic Fill Rate (GFR) - Total	86.8%	83.9%	84.4%	85.1%	84.2%	83.1%	84.7%	84.0%	83.6%	82.9%	83.1%	83.2%	79.5%	80.2%	83.5%	81.1%	83.0%
Plan Cost PMPM	\$210.45	\$233.75	\$233.39	\$225.81	\$285.97	\$300.20	\$284.37	\$290.17	\$296.85	\$268.46	\$299.55	\$288.46	\$286.36	\$297.39	\$351.23	\$311.73	\$261.85
Total Specialty Plan Cost	\$200,212	\$247,988	\$185,556	\$633,756	\$330,464	\$346,193	\$357,502	\$1,034,159	\$367,628	\$270,757	\$396,041	\$1,034,426	\$323,451	\$357,646	\$472,268	\$1,153,365	\$3,660,447
Specialty % of Total Specialty Plan Cost	36.0%	40.5%	30.5%	35.7%	44.4%	44.4%	48.2%	45.7%	47.6%	39.4%	49.9%	45.9%	42.7%	45.2%	50.5%	46.4%	44.4%

Total Component/Date of Service (Month)	2026 01	2026 02	2026 03	2026 Q1	2026 04	2026 05	2026 06	2026 Q2	2026 07	2026 08	2026 09	2026 Q3	2026 10	2026 11	2026 12	2026 Q4	2026 YTD
Membership	3,912	3,752															
Total Days	144,406	133,835															
Total Patients	1,644	1,573															
Total Plan Cost	\$950,330	\$948,985															
Generic Fill Rate (GFR) - Total	85.0%	85.6%															
Plan Cost PMPM	\$242.93	\$252.93															
% Change Plan Cost PMPM	15.4%	8.2%															
Total Specialty Plan Cost	\$358,604	\$397,099															
Specialty % of Total Specialty Plan Cost	37.7%	41.8%															

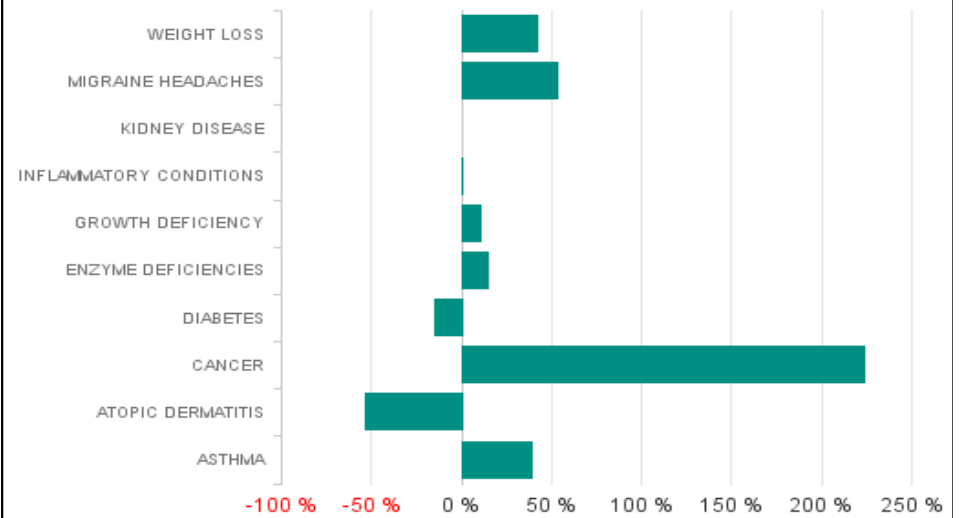
Top Indications

SOUTHERN COASTAL HLTH INS FUND (Current Period 01/2026 - 02/2026 vs. Previous Period 01/2025 - 02/2025) Peer = Government - National Preferred Formulary

Top Indications by Plan Cost



Plan Cost PMPM Trend



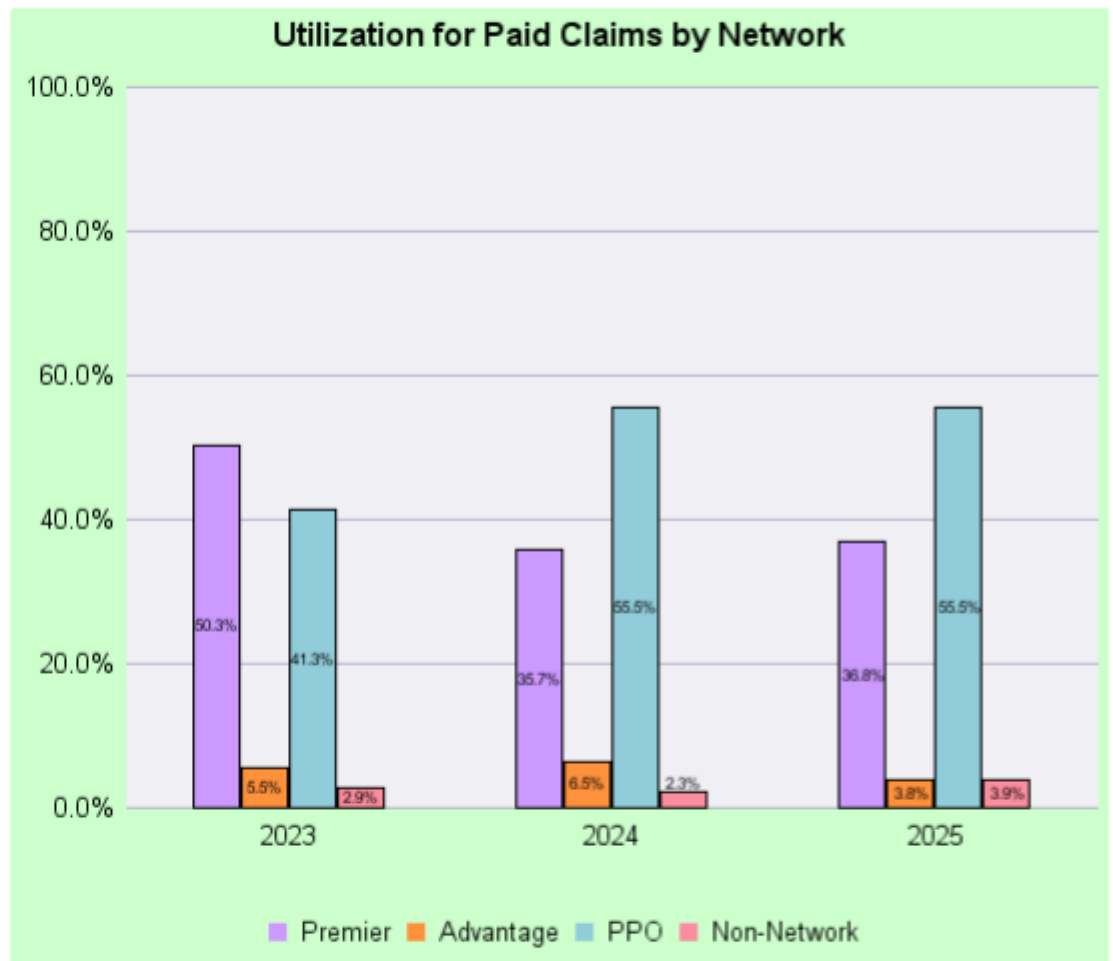
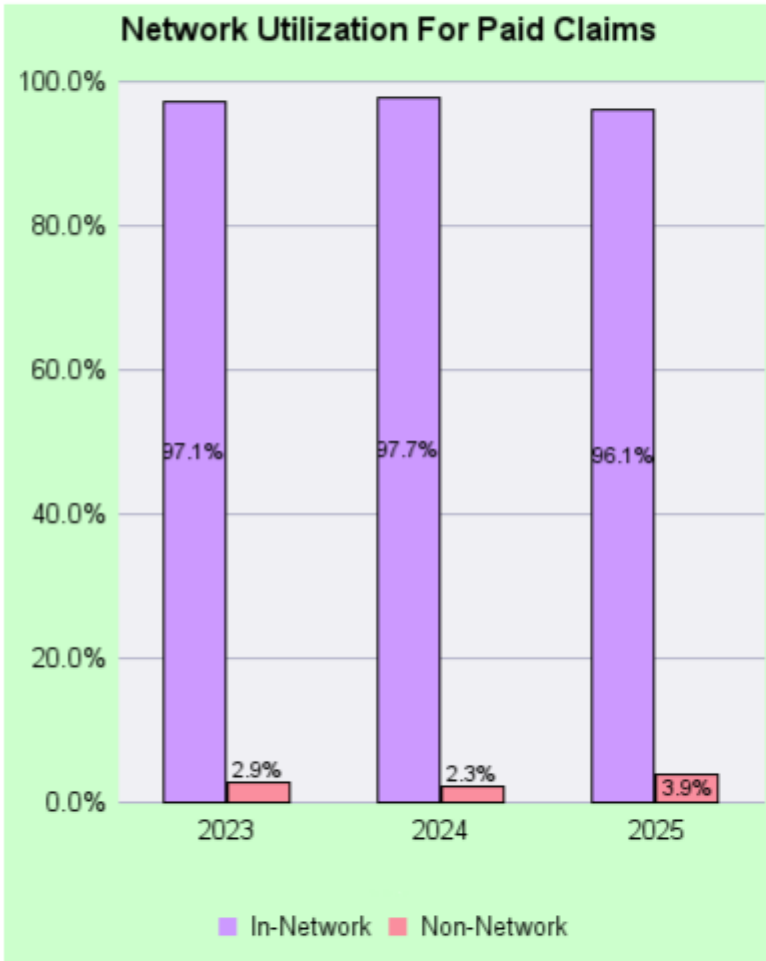
Rank	Peer Rank	Indication	Current Period						Previous Period					Trend	
			Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Plan Cost PMPM
1	3	WEIGHT LOSS	32.0 %	447	\$480,779	\$62.73	1.6 %	3.5 %	28.3 %	205	\$231,893	\$44.05	1.5 %	5.9 %	42.4 %
2	4	CANCER	16.9 %	44	\$254,781	\$33.24	59.1 %	80.1 %	6.6 %	20	\$53,999	\$10.26	80.0 %	77.8 %	224.1 %
3	2	INFLAMMATORY CONDITIONS	16.6 %	83	\$249,904	\$32.61	36.1 %	33.1 %	20.8 %	48	\$170,370	\$32.37	37.5 %	33.6 %	0.7 %
4	1	DIABETES	16.6 %	647	\$249,028	\$32.49	23.8 %	25.8 %	24.5 %	496	\$201,199	\$38.22	25.6 %	26.6 %	-15.0 %
5	6	MIGRAINE HEADACHES	4.2 %	90	\$62,580	\$8.17	42.2 %	52.4 %	3.4 %	46	\$28,117	\$5.34	45.7 %	55.2 %	52.9 %
6	7	ASTHMA	3.7 %	386	\$54,956	\$7.17	82.6 %	90.2 %	3.3 %	252	\$27,197	\$5.17	83.7 %	89.9 %	38.8 %
7	5	ATOPIC DERMATITIS	2.8 %	100	\$41,533	\$5.42	84.0 %	82.0 %	7.5 %	103	\$61,300	\$11.65	79.6 %	83.9 %	-53.5 %
8	9	GROWTH DEFICIENCY	2.7 %	9	\$40,310	\$5.26	0.0 %	0.0 %	3.1 %	6	\$25,099	\$4.77	0.0 %	0.0 %	10.3 %
9	10	KIDNEY DISEASE	2.4 %	6	\$36,801	\$4.80	50.0 %	39.9 %	NA	NA	NA	NA	NA	41.2 %	NA
10	8	ENZYME DEFICIENCIES	2.3 %	4	\$33,884	\$4.42	75.0 %	7.3 %	2.5 %	5	\$20,386	\$3.87	80.0 %	7.6 %	14.2 %
Total Top 10				1,816	\$1,504,555	\$196.31	36.6 %	43.7 %		1,181	\$819,561	\$155.69	40.8 %	46.2 %	26.1 %

Top Drugs

SOUTHERN COASTAL HLTH INS FUND (Current Period 01/2026 - 02/2026 vs. Previous Period 01/2025 - 02/2025) Peer = Government - National Preferred Formulary

Rank	Peer Rank	Brand Name	Indication	Specialty Drug	Current Period				Previous Period				Trend
					Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Plan Cost PMPM
1	3	ZEPBOUND	WEIGHT LOSS	N	332	171	\$343,470	\$44.82	94	47	\$95,822	\$18.20	146.2 %
2	8	WEGOVY	WEIGHT LOSS	N	108	56	\$137,298	\$17.91	105	56	\$133,673	\$25.39	-29.5 %
3	1	MOUNJARO	DIABETES	N	73	31	\$75,831	\$9.89	46	21	\$46,035	\$8.75	13.1 %
4	5	OZEMPIC	DIABETES	N	57	26	\$54,512	\$7.11	57	25	\$51,620	\$9.81	-27.5 %
5	10	SKYRIZI PEN	INFLAMMATORY CONDITIONS	Y	7	3	\$48,779	\$6.36	NA	NA	NA	NA	NA
6	218	CALQUENCE	CANCER	Y	3	1	\$45,695	\$5.96	2	1	\$27,933	\$5.31	12.4 %
7	185	VENCLEXTA	CANCER	Y	3	1	\$45,093	\$5.88	NA	NA	NA	NA	NA
8	90	LYNPARZA	CANCER	Y	2	1	\$36,589	\$4.77	NA	NA	NA	NA	NA
9	18	ENBREL SURECLICK	INFLAMMATORY CONDITIONS	Y	6	2	\$35,616	\$4.65	2	1	\$10,964	\$2.08	123.1 %
10	113	TOLVAPTAN	KIDNEY DISEASE	Y	2	1	\$34,808	\$4.54	NA	NA	NA	NA	NA
11	71	NGENLA	GROWTH DEFICIENCY	Y	8	3	\$32,932	\$4.30	3	1	\$14,846	\$2.82	52.4 %
12	197	ALECENSA	CANCER	Y	3	1	\$31,368	\$4.09	NA	NA	NA	NA	NA
13	170	BRUKINSA	CANCER	Y	2	1	\$29,422	\$3.84	NA	NA	NA	NA	NA
14	25	TALTZ AUTOINJECTOR	INFLAMMATORY CONDITIONS	Y	5	2	\$28,232	\$3.68	7	3	\$34,671	\$6.59	-44.1 %
15	62	VERZENIO	CANCER	Y	2	1	\$23,410	\$3.05	NA	NA	NA	NA	NA
16	115	BENLYSTA	INFLAMMATORY CONDITIONS	Y	6	2	\$22,528	\$2.94	3	1	\$10,206	\$1.94	51.6 %
17	33	STELARA	INFLAMMATORY CONDITIONS	Y	1	1	\$20,878	\$2.72	4	2	\$39,767	\$7.55	-63.9 %
18	300	PALYNZIQ	ENZYME DEFICIENCIES	Y	1	1	\$20,375	\$2.66	1	1	\$2,569	\$0.49	444.8 %
19	52	OMNIPOD 5 DEXG7G6 PODS (GEN 5)	DIABETES	N	26	10	\$20,023	\$2.61	21	8	\$14,128	\$2.68	-2.7 %
20	190	EBGLYSS PEN	ATOPIC DERMATITIS	Y	4	2	\$18,553	\$2.42	NA	NA	NA	NA	NA
21	28	NURTEC ODT	MIGRAINE HEADACHES	N	11	8	\$17,793	\$2.32	5	4	\$8,531	\$1.62	43.3 %
22	42	QULIPTA	MIGRAINE HEADACHES	N	15	6	\$16,751	\$2.19	3	2	\$3,191	\$0.61	260.5 %
23	47	XOLAIR	ASTHMA	Y	8	4	\$16,706	\$2.18	6	2	\$11,420	\$2.17	0.5 %
24	23	SKYRIZI ON-BODY	INFLAMMATORY CONDITIONS	Y	2	1	\$16,260	\$2.12	NA	NA	NA	NA	NA
25	16	RINVOQ	INFLAMMATORY CONDITIONS	Y	3	1	\$15,367	\$2.01	NA	NA	NA	NA	NA
Total Top 25					690		\$1,188,287	\$155.05	359		\$505,374	\$96.01	61.5 %





**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
CONSENT AGENDA
MARCH 30, 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.

Motion _____ **Second** _____

REVISED Resolution 8-26: Approval of Risk Management Plan **Page 45**
Resolution 14-26: Approving New Membership **Page 61**
Resolution 15-26: Approval of the February and March 2026 Bills List **Page 62**

REVISED RESOLUTION NO. 8-26

SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND

2026 RISK MANAGEMENT PLAN

Effective: January 1, 2026

Adopted: January 28, 2026

Revised: March 30, 2026

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

1.) COVERAGE OFFERED

- Medical

The medical plans offered by the Fund include standard "preferred provider organization", "traditional", "point of services", and "health maintenance organization" plan designs. These plans have both in network and out of network benefits and are customized to the needs and specifications of the members. The Fund also offers "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, a core PPO program, and a buy up PPO program, an HMO program, a Consumer Directed Health Plan and the plans for those covered under Chapter 44. The Fund also offers Medicare Advantage programs.

- 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 plans. 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 and plan design.

3.) RISK RETAINED BY THE FUND

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 \$500,000 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.

Extra contractual claims are excluded from reinsurance coverage.

Dental Specific and Aggregate Claims Coverage:

The FUND does not purchase either aggregate or specific coverage for dental claims.

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 the conclusion of the Fund Year. 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 periodically adjusted, but not less frequently than annually, in accordance with the actuary's certifications.

5.) METHODS OF ASSESSING CONTRIBUTIONS TO MEMBERS

At least one month before the end of the Fund Year, the Fund adopts a budget for the upcoming year based on the most recent census, the claims experience for the current Fund Year and other applicable accounting and actuarial factors. 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 process. These rates are used to compute the members' monthly assessment based on the updated census, and monthly billings 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 employees (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.

Members that renew on January 1 have the option of taking a payment deferment by paying their December assessment in the subsequent month of January. Members that renew on July 1 have the option of taking a payment deferment by paying their June assessment in the subsequent month of July. Members that choose to take such deferments shall advise the Fund Executive Director's office in writing at least one month prior to taking the deferment

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 enrolled covered person per policy year) retention and aggregate 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. The MRHIF also purchases an aggregate excess insurance policy on behalf of the Fund and the other members.

7.) REINSURANCE

Reinsurance will be provided by the Fund obtaining membership in the Municipal Reinsurance Health Insurance Fund. Risk will be retained by the Fund in accordance with Section 3.) above.

8.) THE INITIAL AND RENEWAL RATING METHODOLOGIES

Upon application to the Fund, a 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 to either the Fund's base rates or to the rates being paid by 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 adjustment reflects the overall cash flow needs of the Fund, and actuarial factors needed to assure that individual entity rates reflect the risk profile of the member. The Fund may implement individual entity loss ratio adjustments based upon recommendations from the Fund actuary. 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 other lines of coverage may be adjusted and the member shall not be eligible for membership in the dropped line of coverage for a three year period.

Loss experience data used by the Fund to determine loss ratio adjustments will be made available twice per year to members at no additional cost. "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 from Fund members will be considered based upon the availability of data, the feasibility of extracting the data, and conditioned upon the member reimbursing the Fund or its vendors for data extraction and formatting costs.

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.

9.) RATING PERIODS

All rating periods for municipal members coincide with the Fund (calendar) year while rating periods for school members can either coincide with their fiscal year (July 1 to June 30) or the Fund year. The Fund offers school entities the option of either Fund year or fiscal year renewals.

10.) 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. Former members of the Fund cannot rejoin the Fund for a period of three (3) years after the date of the termination of their membership in the Fund.

11.) PROVISION FOR PPOs AND ALTERNATIVE PLAN DESIGNS

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.

12.) OPEN ENROLLMENT PROCEDURES

All members have an open enrollment period no later than the first month of their joining the Fund. Participating employees also have an open enrollment period in the fall or at other times designated by the Fund before the beginning of each calendar year during which they may switch between plan options. The changes shall be effective at the beginning of the Fund Year.

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.

13.) 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 or in the event of nonpayment of applicable charges.

14.) DISCLOSURE OF BENEFIT LIMITS

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

15.) 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.

16.) RETIREES

The Fund duplicates coverage for eligible retirees and uses the rates established by the Fund actuary. The Fund's coverage of a retiree shall terminate effective the date the member local unit withdraws from the Fund, or otherwise ceases to be a member of the Fund or in the event of nonpayment of applicable charges.

17.) 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 (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)."

18.) PLAN DOCUMENT

The Fund prepares a plan document and benefit plan booklets 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.

19.) BENEFITS CURRENTLY PROVIDED TO COVERED EMPLOYEES BY EACH MEMBER AND BENEFITS PROPOSED TO BE PROVIDED BY THE FUND.

SEE PLAN DOCUMENT OF EACH MEMBER ENTITY

20.) PROCEDURES FOR THE CLOSURE OF FUND YEARS

Approximately 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. The Fund has determined that maintaining and retaining a surplus equal to two and a half (2.5) months of the current year claim expenses is a benchmark prior to a dividend being declared from surplus generated by claims operations.

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.

- Any member that has withdrawn from the Coastal Fund shall receive its remaining share of the Closed Fund Year/Contingency Account on the following schedule:
 - 3rd year after withdrawal – 25% of balance
 - 4th year after withdrawal – 25% of balance
 - 5th year after withdrawal – 25% of balance
 - 6th year after withdrawal – Remaining balance

21.) MAXIMUM APPROVAL AMOUNT FOR CERTIFYING & APPROVING OFFICER

1. The Fund Treasurer may issue checks or initiate wire transfers in payment of medical claims, as submitted by the third party administrator responsible for handling the Fund's medical claims, as necessary in order to fulfill the Fund's claim funding obligations under the applicable service provider contract between the Fund and the third party administrator. The certifying and approving officer shall prepare a report of all claims approved by him or her since the last report, detailing the nature and amount of the claim, the payee, the reasons supporting payment and any other pertinent information. This report shall be submitted to the Executive Committee of the Fund at their next scheduled meeting. The Executive Committee shall review and approve the actions of the certifying and approving officer. In the event a claim approved and paid by the certifying and approving officer is not approved by the Executive Committee, they shall direct appropriate action to be taken.

2. Delta Dental shall issue checks for the payment of dental claims in the amount of \$.0 to \$5,000 on the adjudication and signature solely of duly authorized Delta Dental personnel.

3. All dental claims, if any, in excess of \$5,000 shall require the approval, at a regularly scheduled meeting, of the Executive Committee of the Fund after obtaining appropriate certifications and making such other inquiries as are reasonable. Checks issued pursuant to any such approval shall be countersigned by a duly authorized representative of the Executive Director.

4. The terms "claims" as herein utilized shall refer to the issuance of any particular check, provided however that no bills shall be split for the purpose of avoiding the requirements hereof.

5. In addition to the claim payment procedure, Delta Dental shall also notify the Executive Committee in writing whenever the cumulative payments to any covered person for a single illness or injury (including related illnesses and injuries) exceeds \$30,000.

22.) "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 prospective 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.

23.) CLAIM AUDIT

The Fund retains a claim auditor experienced in auditing self-insured health plans. The audit will be conducted upon completion of the first Fund Year after the Fund's inception and at least once every three years thereafter. The Fund can conduct this audit on its own, or in a cooperative effort with other Funds through the Municipal Reinsurance Health Insurance Fund.

24.) AUTHORITY OF CLAIM APPEAL COMMITTEE AND INDEPENDENT REVIEW ORGANIZATIONS

The 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 Program Manager, Executive Director and the Fund Attorney with a copy of the memo, which has been prepared concerning the appeal.

The TPA, Program Manager, 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, Program Manager, 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, Program Manager, 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, Program Manager, 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 Program Manager.

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 Program Manager 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 Program Manager 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 meet 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 Program Manager 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 Program Manager 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 Program Manager, 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 Program Manager 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 the 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 after 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 Program Manager 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://www.state.nj.us/dobi/consumer.htm> e-mail address: ombudsman@dobi.state.nj.us/

25.) 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.

26.) 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.

27.) 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.

28.) TERMINATION OF ALL LINES OF COVERAGE

When an entity terminates its membership from the Fund all lines of coverage in the Fund are terminated unless otherwise determined by the Executive Committee.

29.)MEMBER MONTHLY BILLING POLICY

To assure timely billing and preservation of cashflow the Fund has developed the following timeline and protocols as it relates to monthly invoices.

Please note, all changes must be entered in the system by the 15th of the month to reflect on the bill.

16th of the month - PERMA's Operations team will run and review all pre-bill audits.

Upon completion of the pre-bill audits - PERMA's Operations team will generate all invoices and associated billing reports. Review of adjustments are completed within 2 business days of being generated

Bills are sent to accounting for review and approval

Upon receipt of accountings approval, invoices are sent to members within two business days

Bills are due 45 days of receipt. Payments not received within 45 days are subject to a 10% interest penalty. If any of the dates outlined above fall on a weekend or holiday, the due date will be the next business day.

If there is a delay on one client's bill, this will not hold up the distribution of any other of the Fund's bills.

All clients should review their bills immediately and report any discrepancies so they can be addressed before the next invoice is generated.

The Fund's policy is to pay as billed and necessary adjustments will be reflected on a future invoice.

The client will receive a delinquent notice via email if payment is not made within a reasonable amount of time.

28.) **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.

29.) **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: JANUARY 28, 2026

REVISED: MARCH 30, 2026

BY: _____
CHAIRPERSON

ATTEST:

SECRETARY

RESOLUTION NO. 14-26

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
RESOLUTION TO OFFER MEMBERSHIP**

WHEREAS, the Southern Coastal Regional Employee Benefits Fund (hereinafter the Fund) is duly constituted as a joint insurance fund and is subject to certain requirements of the Local Public Contracts Law; and;

WHEREAS, the Fund held a Public Meeting on **March 30, 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 Weymouth Township Board of Education commend offers of membership; and

1. Weymouth Twp BOE – Medical & Prescription – Effective on or around 7/1/2026 contingent upon receipt of Indemnity and Trust Agreement.

BE IT RESOLVED, it has been determined that the admission to membership in the Fund of the above mentioned municipalities 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 Southern Coastal Regional Employee Benefits Fund hereby offers membership to the above mentioned entity’s for medical and prescription coverage, contingent upon receipt acceptance of the conditions stated above.

ADOPTED: March 30, 2026

BY: _____
CHAIRPERSON

ATTEST: _____
SECRETARY

RESOLUTION NO. 15-26

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
APPROVAL OF THE FEBRUARY AND MARCH 2026 BILLS LIST**

WHEREAS, the Southern Coastal Regional Employee Benefits Fund held a Public Meeting on **March 30, 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 months of February and March 2026 for consideration and approval of the Executive Committee; and

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

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

NOW THEREFORE BE IT RESOLVED the Commissioners of the Executive Committee of the Southern Coastal Regional Employee Benefits Fund hereby approve the Bills List for February and March 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 Municipal Health Insurance Funds.

NOW, THEREFORE BE IT FURTHER RESOLVED, the Commissioners of the Executive Committee of the Southern Coastal Regional Employee Benefits Fund hereby approve the Treasurers Report as furnished by the Treasurer of the Fund and concur with actions undertaken by the Treasurer, in accordance with the laws and regulations promulgated by the State of New Jersey for Municipal Health Insurance Funds.

ADOPTED: MARCH 30, 2026

BY: _____
CHAIRPERSON

ATTEST:

SECRETARY

APPENDIX I

**SOUTHERN COASTAL REGIONAL EMPLOYEE BENEFITS FUND
MINUTES OF THE REORGANIZATION MEETING
JANUARY 28, 2026
VIA ZOOM CONFERENCE CALL
12:30 P.M.**

STATEMENT OF COMPLIANCE WITH THE OPEN PUBLIC MEETINGS ACT

CALL TO ORDER – 2025 EXECUTIVE COMMITTEE (SINE DIE)

The Open Public Meetings Act statement was read into the record.

PLEDGE OF ALLEGIANCE

Chairperson Richard Davidson led all attendees in the Pledge of Allegiance.

ROLL CALL – 2025 EXECUTIVE COMMITTEE

Jordyn Robinson conducted the roll call of the 2025 Executive Committee. The following members were present:

Name	Title	Status
Richard Davidson	Chairperson	Present
Pasquale Yacovelli	Secretary	Present
Jerry Velazquez	Executive Committee	Present
Megan Duffield	Executive Committee	Present
Laurie Ryan	Executive Committee	Present
Scott Musterel	Executive Committee	Present
Mark Mallet	Executive Committee	Present
Frank Badessa	EC Alternate	Present
Dennis Zakroff	EC Alternate	Present
Kevin Smaniotto	EC Alternate	Present

FUND PROFESSIONALS PRESENT

The following Fund professionals were in attendance:

Fund Administrator (PERMA Risk Management Services): Emily Koval, Jordyn Robinson, Jim Rhodes

Fund Attorney (Marmero Law, LLC): John Carleton

Program Manager (Shared Health Alliance): Rich Allen, Susan (Allen Associates), Corey Allen

Fund Treasurer (Laracy Associates LLC / Verrill & Verrill): Lorraine Verrill

Network TPA – Aetna: Jason Silverstein

Network TPA – AmeriHealth: Kristina Strain

Prescription Administrator – Express Scripts: Hiteksha Patel

RAMP Health (Wellness Pilot Presenter): Nicole Putnam, Lauren Carson
 Fund Auditor: Absent
 Guardian Nurses: Absent

Others Present:

Adam Siegel	Christopher Eberly	JSnyder
Allen Associates Insurance Services	Chuck Hughes P	Katie Siciliano
Amanda Gresko	Dawn Leary	Kelle - City of Margate
Anthony Coco	Gerald Crow	knight
Bob Dickenson	Jim Ridgway - CAIP	Lauren Carson
Cait Perkins	Joe Madera	Mary Canesi (City of Northfield)

APPROVAL OF MINUTES – OCTOBER 27, 2025 AND NOVEMBER 10, 2025

Chairperson Davidson called for a motion to approve the open minutes of October 27, 2025 and November 10, 2025.

Moved:	Pasquale Yacovelli
Seconded:	Megan Duffield
Vote:	Dennis Zakroff – Yes; Mark Mallet – Yes; Scott Musterel – Yes; Laurie Ryan – Yes; Megan Duffield – Yes; Jerry Velazquez – Yes; Pasquale Yacovelli – Yes; Richard Davidson – Yes. Motion Carried.

ADJOURNMENT SINE DIE – 2025 EXECUTIVE COMMITTEE

Upon completion of the foregoing business, the 2025 Executive Committee adjourned sine die.

– MEETING OF FUND COMMISSIONERS CALLED TO ORDER –

ROLL CALL – ALL FUND COMMISSIONERS

In accordance with the Fund's bylaws, a roll call of all 2026 Fund Commissioners was conducted to determine whether a quorum was present for purposes of the reorganization meeting. Executive Director Koval stated that a minimum of 16 commissioners was required for a quorum. Jordyn Robinson conducted the roll call, and the following commissioners responded as present (20 total):

- Christopher Eberly (Waterford Township BOE)
- Wendy Hughes (Vineland Housing Authority)
- Robert Dickenson (Vineland, City of)
- Scott Musterel (Vineland BOE)
- Laurie Ryan (Upper Township BOE)

Charles Hughes (Pittsgrove Township)
 Timothy Kelly (Ocean City BOE)
 Mary Canesi (Northfield, City of)
 Richard Davidson (Millville BOE)
 Mark Mallet (Lower Cape May Regional BOE)
 Thomas D'Intino (Egg Harbor Township Muni)
 Wayne Knight (Cumberland Regional BOE)
 Megan Duffield (CCTEC)
 Jerry Velazquez (Cumberland County Improvement Authority)
 Dennis Zakroff (Cumberland County Charter School Network)
 Kevin Smaniotto (Cumberland County)
 Dawn Leary (Buena BOE)
 Pasquale Yacovelli (Bridgeton BOE)
 Shannon Brody (Alloway Township BOE)
 Jessica Snyder (Absecon, City of)

A quorum of 20 Fund Commissioners was confirmed, exceeding the required minimum of 16.

**ELECTION OF OFFICERS AND EXECUTIVE COMMITTEE – 2026
 REORGANIZATION**

Executive Director Koval stated that, in accordance with the Fund's bylaws, a reorganization meeting must be held at the January meeting to elect officers and members of the Executive Committee for the upcoming year. She called for a motion to open the floor for nominations.

Motion to Open Floor for Nominations:

Moved:	Pasquale Yacovelli
Seconded:	Megan Duffield
Vote:	Ayes – Unanimous. Motion Carried.

The Nominations Committee presented the following slate of officers and Executive Committee members:

Chair: Richard Davidson
 Secretary: Pasquale Yacovelli
 Executive Committee Members: Jerry Velazquez, Megan Duffield, Laurie Ryan, Scott Musterel, Mark Mallet
 Executive Committee Alternates: Frank Badessa, Dennis Zakroff, Kevin Smaniotto, Thomas D'Intino

Motion to Accept Nominations Committee Slate:

Moved:	Pasquale Yacovelli
Seconded:	Scott Musterel
Vote:	All present Fund Commissioners voted in favor. Motion Carried.

No other nominations were received from the floor. The slate was approved as submitted.

OATH OF OFFICE

Fund Attorney John Carleton administered the Oath of Office to all newly elected Executive Committee members and alternates, who repeated the oath pursuant to N.J.S.A. The officers and committee members each swore to support the Constitution of the United States and the Constitution of the State of New Jersey, to bear true faith and allegiance to the same, and to faithfully, impartially, and justly perform all duties as members of the Executive Committee of the Southern Coastal Regional Employee Benefits Fund. Executive Director Koval noted that the signed oath forms would be circulated for signature via DocuSign and thereafter notarized by Fund Attorney Carleton for the Fund's records.

– MEETING OF 2026 EXECUTIVE COMMITTEE CALLED TO ORDER –

ROLL CALL – 2026 EXECUTIVE COMMITTEE

Jordyn Robinson conducted the final roll call of the newly elected 2026 Executive Committee. The following members were confirmed present:

- Richard Davidson – Chairperson (Present)
- Pasquale Yacovelli – Secretary (Present)
- Jerry Velazquez – Executive Committee (Present)
- Megan Duffield – Executive Committee (Present)
- Laurie Ryan – Executive Committee (Present)
- Scott Musterel – Executive Committee (Present)
- Mark Mallet – Executive Committee (Present)
- Frank Badessa – EC Alternate (Present)
- Dennis Zakroff – EC Alternate (Present)
- Kevin Smaniotto – EC Alternate (Present)
- Thomas D'Intino – EC Alternate (Present)

Chairperson Davidson thanked all Executive Committee members and alternates for their continued service and volunteerism.

CORRESPONDENCE

Executive Director Koval referenced a questionnaire and response from the New Jersey Department of Banking and Insurance, attached as Appendix III to the agenda. The questionnaire was issued to all funds administered by PERMA statewide in connection

with the filing of 2024 audits. Mrs. Koval noted that the majority of PERMA-administered funds experienced a deficit in 2024. Several northern New Jersey funds had already approved or implemented supplemental assessments. For this Fund, a \$2.5 million deficit was reported at year-end 2024, which was characterized as relatively modest given the Fund's approximately \$500 million budget. The 2025 fund year continued to reflect a deficit of approximately \$6.4 million; however, November 2025 showed a surplus of approximately \$529,000, primarily tied to fund year 2025, which was viewed as a stabilizing indicator. Mrs. Koval advised that December 31, 2025 financials would be reviewed by the Finance Committee, anticipated to be scheduled in February or March 2026, and that any further cost-containment strategies would be presented thereafter.

PUBLIC COMMENT – AGENDA ITEMS

Chairperson Davidson opened the floor for public comment on agenda items. No members of the public raised their hand or submitted comment. Public comment was closed.

REPORTS

Executive Director's Report (PERMA)

Executive Director Emily Koval presented her report on behalf of PERMA Risk Management Services. In addition to the financial update noted under Correspondence above, Mrs. Koval reviewed the 2026 Reorganization Resolutions included in the Consent Agenda. She provided a summary of each resolution as follows:

Resolution 1-26 awards the 2026 professional service contracts, all consistent with previously approved RFPs and the adopted budget; Resolution 2-26 designates PERMA as agent for service of process; Resolution 3-26 designates the Fund Secretary as Custodian of Records; Resolution 4-26 designates the Press of Atlantic City as the official newspaper and notes the transition, effective March 1, 2026, whereby public notices will primarily be published on the Fund's website; Resolution 5-26 sets meeting dates for 2026, with adjustments made to March (moved to March 30) and May (moved to June 1) due to scheduling conflicts; Resolution 6-26 addresses the Cash Management Plan, including a billing policy with a 10% late payment interest penalty for chronically delinquent members; Resolution 7-26 designates authorized signatories for Fund bank accounts (unchanged from prior year); Resolution 8-26 adopts the 2026 Risk Management Plan, which includes additions for enrollment audits and a new Quality and Clinical Plan Management section allowing cost-containment measures such as drug utilization management, medical care management, and out-of-network fee schedule authority; Resolution 9-26 appoints MRHIF representatives (addressed below); Resolution 10-26 establishes broker compensation; Resolution 11-26 authorizes the Treasurer to process contracted payments in months when the

Fund does not meet; and Resolutions 12-26 and 13-26 address wellness grants and bills list approval, respectively.

Mrs. Koval noted that the MRHIF had met in early December and adopted its 2026 budget. An audit of Express Scripts claims for fund year 2025, funded by Express Scripts, was expected to commence in the near term, with results anticipated within approximately nine to twelve months. She also provided an update on the new billing invoice process, noting that invoices are now being delivered through a secure OneDrive link. She acknowledged that some members had experienced difficulty accessing invoices and indicated that further instructions would be sent; the Fund would not assess penalties to members who were unable to access invoices due to the transition. Chairperson Davidson noted no questions from the committee.

MRHIF Commissioner Appointments (Resolution 9-26)

Discussion was held regarding the appointment of Fund Commissioner and Alternate Fund Commissioner to the Municipal Reinsurance Health Insurance Fund (MRHIF). Mrs. Koval noted that Laurie Ryan and Megan Duffield had previously served in these roles and indicated the Board's intent to re-appoint them. Both Commissioners Ryan and Duffield confirmed their willingness to continue in these positions.

The following appointments were confirmed by consensus and reflected in Resolution 9-26:

Fund Commissioner: Laurie Ryan

Alternate Fund Commissioner: Megan Duffield

Program Manager Report (Shared Health Alliance)

Rich Allen of Shared Health Alliance / Allen Associates presented the Program Manager report. He reported that the Fund now has 38 member groups, including 6 new groups effective January 1, 2026: Buena Borough MUA, Middle Township Board of Education, Mullica Township, City of Northfield, Somers Point Board of Education, and City of Vineland. Mr. Allen noted that additional groups are currently in underwriting review. He indicated that the Fund remains selective in its underwriting approach.

Susan (Allen Associates) provided an update on WEX coupon books for direct-bill members, noting that distribution had been delayed but was underway. She also highlighted the new OneDrive billing process and advised member groups to communicate the updated invoice delivery method to their accounts payable departments.

Wellness Update – Corey Allen reported that 8 wellness grant applications had been received for the January 1, 2026 cycle, totaling \$96,645, as reflected in Resolution 12-26. He announced that the next application deadline for spring/summer wellness programs is May 15, 2026 (moved up from prior years), with programs approved for a

July 1, 2026 start. He noted that funding is now budgeted to cover all member groups rather than on a first-come, first-served basis.

RAMP Health Wellness Pilot Program Presentation

Nicole Putnam and Lauren Carson of RAMP Health presented an overview of the RAMP Health wellness coaching pilot program, which launched in October 2025 with the Millville Board of Education and the Cumberland County Improvement Authority. Ms. Putnam described the program's model, which places on-site wellness coaches within participating organizations to provide individualized health coaching, group wellness activities, preventative care advocacy, and mental health first aid support. She cited a 86% employee engagement rate across RAMP Health's book of business and noted that, for a comparable New Jersey county client, RAMP Health had generated approximately \$1.7 million in annual claim savings against a \$500,000 investment, representing a 3.5 to 1 return on investment.

Lauren Carson, the wellness coach embedded at the Millville School District and Cumberland County Authority, described her weekly schedule and early program activities, including a Healthy Habit Bingo initiative during the holiday season. Mr. Allen noted that the pilot program was developed in response to Chairperson Davidson's request for value-added, lifestyle-changing wellness services. Discussion of expanding the program to additional Fund members was referenced as a future consideration.

Treasurer's Report

Lorraine Verrill, Deputy Treasurer (Verrill & Verrill), presented the Treasurer's Report. She reported the following bills lists:

November 2025 Bills List: \$1,490,424.93

December 2025 Bills List: \$1,316,206.88

January 2026 Bills List: \$1,829,074.17

The Schedule of Claims Paid for November 2025 totaled \$12,133,068.87. The Summary of Cash Transactions for all fund years combined as of November 30, 2025 reflected total cash of \$21,667,988.72. The Schedule of Cash and Investments as of November 30, 2025 also reflected total cash of \$21,667,988.72. No questions were raised regarding the Treasurer's report.

Fund Attorney's Report (Marmero Law, LLC)

Fund Attorney John Carleton reported that he had no items to present beyond his participation in the oath of office administration.

Network TPA Report – Aetna

Jason Silverstein of Aetna presented the monthly report. For the month of November 2025, paid claims totaled \$8,996,850.57 based on enrollment of 4,835 employees, reflecting a per employee per month claim cost of \$1,861. High-cost claims (above the

\$100,000 threshold) for November numbered 8, totaling \$2,105,962.65. All dashboard performance metrics continued to perform well for the Fund. Mr. Silverstein noted that Aetna is currently in active negotiations with Hackensack Meridian Health, with an anticipated effective date of July 1, 2026; the Fund will be kept informed of progress. No questions were raised.

Network TPA Report – AmeriHealth

Kristina Strain of AmeriHealth presented the monthly report. Medical paid claims for December 2025 totaled \$2,566,800.33 based on enrollment of 1,534 employees, reflecting a per employee per month average of \$1,673.27. One high-cost claimant exceeded the \$100,000 threshold for December, at \$227,345.97. Dashboard metrics for all of 2025 fell within performance guarantees. No questions were raised.

Prescription Administrator Report – Express Scripts

Hiteksha Patel of Express Scripts presented the pharmacy report. For November 2025, total plan cost was \$791,360, with a generic fill rate of 80.2% and a monthly plan cost per member of \$297.39 – representing a 48% increase compared to the prior year. Total specialty medication plan cost was \$357,646, representing 45% of total plan cost. Significant year-over-year increases were noted in cancer drug utilization (prescriptions increased from 79 to 164, with plan costs rising from approximately \$200,000 to \$567,000) and multiple sclerosis medications (plan costs increased approximately 250%). A review of the top 25 drugs utilized from January through November 2025 was included in the agenda. No questions were raised.

CONSENT AGENDA – RESOLUTIONS 1-26 THROUGH 13-26

Chairperson Davidson presented the Consent Agenda, comprising Resolutions 1-26 through 13-26. Mrs. Koval confirmed all resolutions were appropriate for consent. Chairperson Davidson indicated he was comfortable keeping all items on consent.

Prior to the roll call vote, the following abstentions were noted with respect to Resolution 12-26 (Wellness Grant Program) due to apparent conflicts of interest regarding grants to members with which certain commissioners are affiliated:

Chairperson Richard Davidson – Abstained on Resolution 12-26 (grant to Millville Board of Education); voted Yes on all other resolutions.

Thomas D'Intino – Abstained on Resolution 12-26; voted Yes on all other resolutions.

Scott Musterel – Abstained on Resolution 12-26; voted Yes on all other resolutions.

Laurie Ryan – Abstained on Resolution 12-26; voted Yes on all other resolutions.

Fund Attorney Carleton confirmed that abstentions on Resolution 12-26 were appropriate for commissioners whose entities are recipients of wellness grants under that resolution.

Motion to Approve Resolutions 1-26 through 13-26 (Consent Agenda):

Moved:	Laurie Ryan
Seconded:	Pasquale Yacovelli
Vote:	Thomas D'Intino – Abstain 12-26, Yes all others; Kevin Smaniotto – Yes; Dennis Zakroff – Yes; Mark Mallet – Yes; Scott Musterel – Abstain 12-26, Yes all others; Laurie Ryan – Abstain 12-26, Yes all others; Megan Duffield – Yes; Jerry Velazquez – Yes; Pasquale Yacovelli – Yes; Richard Davidson – Abstain 12-26, Yes all others. Motion Carried.

The following Resolutions were adopted:

- Resolution 1-26: Appointing Professionals and Awarding Contracts for Fund Year 2026
- Resolution 2-26: Designation of PERMA Risk Management Services as Agent for Service of Process
- Resolution 3-26: Designation of Secretary as Custodian of Fund Records
- Resolution 4-26: Designation of the Press of Atlantic City as Official Newspaper
- Resolution 5-26: Fixing Public Meeting Dates for 2026
- Resolution 6-26: Designation of Authorized Depositories and Adoption of Cash Management Plan
- Resolution 7-26: Designation of Authorized Signatories for Fund Bank Accounts
- Resolution 8-26: Adoption of 2026 Risk Management Plan
- Resolution 9-26: Appointment of MRHIF Fund Commissioner and Alternate
- Resolution 10-26: Establishing Plan for Compensating Producers
- Resolution 11-26: Authorizing Treasurer to Process Contracted Payments and Expenses
- Resolution 12-26: Adoption of 2026 Wellness Grant Programs (total \$96,645)
- Resolution 13-26: Approval of November 2025, December 2025, and January 2026 Bills List

OLD BUSINESS

There was no old business to come before the Committee.

NEW BUSINESS

There was no new business to come before the Committee.

ADDITIONAL PUBLIC COMMENT

Chairperson Davidson opened the floor for additional public comment. Adam Siegel, attending on behalf of Commissioner Diane Fox (Middle Township Board of Education), submitted a question via the chat regarding what percentage increase should be budgeted for the HIF for the current year. The Program Manager clarified that Middle Township Board of Education joined the Fund effective January 1, 2026 and will not renew until January 2027; accordingly, no budgetary increase is required and

the current rates will remain in effect for the full year. Mr. Siegel confirmed the response addressed his question. No further public comments were received.

RESOLUTION FOR EXECUTIVE SESSION

The Fund Secretary was asked whether executive session was required. The Fund Secretary indicated that executive session was not necessary.

ADJOURNMENT

Chairperson Davidson called for a motion to adjourn the meeting.

Moved:	Pasquale Yacovelli
Seconded:	Megan Duffield
Vote:	All in Favor – Ayes. Motion Carried.

The meeting was adjourned.

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)

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**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

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APPENDIX III

Government Accounting Standards Board (GASB)

GASB 102 – Certain Risk Disclosures

GASB 102 requires disclosure of constraints and concentrations that could impact the organization being audited. Health Insurance Funds (HIFs) are not insurance companies. They are governmental entities organized pursuant NJSA 40A:10 – 36 et seq that receive their income from member assessments (i.e. premium) and interest on funds held to settle outstanding claims. As governmental entities, they are exempt from a wide range of taxes and other charges assessed commercial insurance companies. This gives HIFs a considerable cost advantage as compared to commercial insurers. All profits for any given year are ultimately returned as dividends to members that participated in the HIF during that fund year. The timing of dividends is controlled by state regulation. However, claims are inherently subject to considerable variation. To offset risk, HIFs are indefinitely assessable on a joint and several basis. Under state law and HIF bylaws, HIFs may assess members including former members for any year that incurs a loss, even if that loss is not known for a few years. While this assures that claims will be paid, members must realize that their final ultimate cost cannot be definitively established until all claims are paid.

While the Health Insurance Funds have a concentration from a membership standpoint, as described above, it is not a vulnerability, it actually is a strength of the HIF.

The HIF has strong governance from its governing body and leadership as well as oversight by the State of New Jersey Departments of Community Affairs and Department of Banking and Insurance.

As such, the requirement for disclosure in the December 31, 2025, Annual Audits is not required for the Health Insurance Funds.