Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	December 12, 2025 1:00 p.m.
Physical Meeting Location:	3427 Goni Road, Suite 117, Carson City, Nevada
Video Conferencing:	**This meeting will also be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://www.youtube.com/live/JfE9JE5Xk70**

To submit written public comment, please upload your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov*, no later than two business days prior to the meeting.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Video Conferencing" field above.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Option #1 **Join the webinar as an attendee https://us06web.zoom.us/j/85763116245**
This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Video Conferencing" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 857 6311 6245 then press #. When prompted for a Participant ID, please enter #.**

Participants that call in will be muted until it is time for public comment. A moderator will then unmute callers one at a time for public comment.

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email jcrane@peb.nv.gov

AGENDA

1. Open Meeting; Roll Call.

2. Public Comment.
   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three-minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting in person or by telephone and persons whose comments may extend past the three-minute time limit may submit their public comment in writing by uploading your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov*, no later than two business days prior to the meeting. **If you need ADA accommodation, please let us know by 4:00 pm two days before the board meeting so that we may make appropriate arrangements**. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

4. Approval of Action Minutes from October 24, 2025, PEBP Board Meeting. (Jim Wells, Board Chair) (**For Possible Action)**

5. Discussion and acceptance of Eide Bailey's audited financial statements: Retiree Health and Welfare Trust and Employer allocation reports. (Kurt Shlicker, Eide Bailly) (**For Possible Action**)

6. Discussion and possible action regarding Board Policy and Procedure Appendix A. (Leslie Bittleston, Quality Control Officer, and Jim Wells, Board Chair) (**For Possible Action**)

7. Discussion and possible action on recommended enhancements to the Master Plan Documents for PY 26, PY 27 and PY 28. (Leslie Bittleston, Quality Control Officer) **(For possible Action)**

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of April 1, 2025 – June 30, 2025. (Joni Amato, CTI) (**For Possible Action**)

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for Willis Towers Watson for the period of July 1, 2024, through June 30, 2025. (Joni Amato, CTI) (**For Possible Action**)

10. Q4 Sierra Healthcare Options – Utilization and Large Case Management. (Joan Operario and Kelly Hall, UnitedHealthcare) (Information/Discussion)

11. Q4 Express Scripts – Utilization and Summary Reports. (Amy Donohue and Amy Daily, Express Scripts) (Information/Discussion)

12. SFY 25 Year End Report and SFY 26 Q1 Budget Report. (Monica McJoy, Chief Financial Officer) (Information/Discussion)

13. Presentation and possible action on current PEBP plans and possible revisions to future plan years. (Richard Ward, Segal) (**For Possible Action**)
    - 13.1 Medical Pharmacy Coupon Program
    - 13.2 Prior Authorization
      - 13.2.1 Biopsy Coverage
      - 13.2.2 Board consideration and potential approval for UMR to review PA approval rates for all prior authorizations twice per year, and report to board any services that are above a 95% approval rate for the review period for the board to consider removal of PAs for such services/codes
    - 13.3 Diagnostic breast imaging and colonoscopies to be covered at 100% as preventative services
    - 13.4 Network Lab Access and Education
    - 13.5 Vision
    - 13.6 Pharmacy
      - 13.6.1 Increase non-preferred brand cost from $75 to 30% coinsurance
      - 13.6.2 3 Tier specialty co-pay structure
        - 13.6.2.1 3 Tier Bio similar only
        - 13.6.2.3 3 Tier for Specialty Drugs
    - 13.7 Mountain West Comparison of LDPPO plan

14. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations. (Brandee Mooneyhan, Lead Insurance Counsel) (**For Possible Action**)
    - 14.1 Contract Overview
    - 14.2 New Contracts
    - 14.3 Contract Amendments
      - 14.3.1 Carrum Health – Centers of Excellence
    - 14.4 Status of Current Solicitations

15. Executive Officer Report. (Theresa Carsten, Executive Officer) (Information/Discussion)

16. CY 26 Meeting Dates. (Theresa Carsten, Executive Officer) (**For Possible Action**)

17. Strategic Planning Discussion. (Theresa Carsten, Executive Officer) (**For Possible Action**)
18. Quarter 4 Vendor Reports. (Information/Discussion)
    - 18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
      - 18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
      - 18.1.2 Q4 Doctor on Demand Engagement Report
      - 18.1.3 Q4 CDHP Performance Review
      - 18.1.4 Q4 LD PPO Performance Review
      - 18.1.5 Q4 EPO Performance Review
      - 18.1.6 Q4 HPN Performance Review
      - 18.1.7 Q4 Dental Performance Review
    - 18.2 Questions or discussion related to any reports provided (Board)
19. Public Comment.
    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.
20. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at https://pebp.nv.gov. For additional information, contact Jessica Crane at (775) 684-7020 or (800) 326-5496.

Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at https://pebp.nv.gov, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call.

2.

2. Public Comment.

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

4.

4. Approval of Action Minutes from October 24, 2025 PEBP Board Meeting. **(For Possible Action)**

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
October 24, 2025

MEMBERS PRESENT	Ms. Tarryn Emmerich-Choi, Member
VIA TELECONFERENCE:	Ms. Joy Grimmer, Vice Chair
MEMBERS PRESENT	Mr. Jim Wells, Board Chair
IN PERSON:	Ms. Blaine Harper, Member
	Dr. Jennifer McClendon, Member
	Ms. Janell Woodward, Member
	Mr. Jim Barnes, Member
	Mr. Christopher Viton, Member
	Ms. Keiko Duncan, Member
MEMBERS EXCUSED:	Ms. Laura Rich, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
	Mr. Phil Su, Deputy Attorney General
FOR STAFF:	Ms. Theresa Carsten, Executive Officer
	Mr. Nik Proper, Operations Officer
	Ms. Brandee Mooneyhan, Lead Insurance Counsel
	Ms. Leslie Bittleston, Quality Control Officer
	Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Mr. Richard Ward, Segal
	Ms. Shelley Chun, Segal
	Ms. Rhonda Huckaby, UMR
	Mr. Jesse Stockewell, UMR

1. Open Meeting; Roll Call.

    - Board Chair Wells opened the meeting at 9:00 a.m.

2. Public Comment.

    - Kent Ervin – NV Faculty Alliance
    - Doug Unger – NV Faculty Alliance
    - Terri Laird – RPEN
    - Brooke Maylath – Member
    - Tess Opferman – AFSCME

3. PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4. Approval of Action Minutes from the July 31, 2025, PEBP Board Meeting. (**For Possible Action)**

BOARD ACTION ON ITEM 4
MOTION: Approve meeting minutes.
BY: Member, Jim Barnes
SECOND: Member, Keiko Duncan
VOTE: Unanimous; the motion carried

5. Review of Board Duties and Updates from 83rd Legislative Session. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)

6. Discussion and possible action regarding Board Policy and Procedure. (Leslie Bittleston, Quality Control Officer, and Jim Wells, Board Chair) (**For Possible Action**)
    6.1 Presentation and potential adoption of redlined revisions arising from 81st, 82nd, and 83rd legislative sessions
    6.2 Discussion regarding additional Board-Suggested revisions to be made
    6.3 Discussion on identifying a Board meeting to discuss a revised PEBP Strategic Plan

BOARD ACTION ON ITEM 6
MOTION: Adopt changes and review Appendix A at November board meeting.
BY: Member, Keiko Duncan
SECOND: Vice Chair, Joy Grimmer
VOTE: Unanimous, the motion carried

7. Discussion and possible action on recommended changes and updates to the Master Plan Documents for PY26 (July 1, 2025 – June 30, 2026). (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7
MOTIOM: Amend Master Plan Document for PY26 for sections 1 and 2 as presented.
BY: Member, Janell Woodward
SECOND: Member, Jim Barnes
VOTE: Unanimous; the motion carried

8. Presentation and possible action on Structure and Financial Results (Premiums Collected, Benefits Paid, Actuarial Value) of the Current PEBP Plans. (Richard Ward, Segal) (**For Possible Action**)
    - 8.1 Overview of current PEBP plans and possible revisions for future plan years: Consumer Driven Health Plan (CDHP), Low-Deductible Preferred Provider Organization (LDPPO), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO)
    - 8.2 Incurred but Not Reported (IBNR) for end of FY25
    - 8.3 Other Post Employment Benefits (OPEB/GASB) Measured for FY24 for FY25 Reporting
    - 8.4 Discussion on other models or information Board would like to review in November

Public Comment

- Kent Ervin – NV Faculty Alliance
- Doug Unger – NV Faculty Alliance

BOARD ACTION ON ITEM 8
MOTION: Have Segal bring back additional information on Pharmacy Coupon Program to November board meeting for consideration for PY27.
BY: Member, Chris Viton
SECOND: Member, Jennifer McClendon
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Bring removal of prior authorization for biopsy coverage back to November board meeting with an additional review of other prior authorizations that might be nearing the 100% approval rate.
BY: Member, Keiko Duncan
SECOND: Member, Janell Woodward
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Bring back diagnostic breast imaging and colonoscopies at 100% to the November board meeting.
BY: Member, Blaine Harper
SECOND: Member, Janell Woodward
VOTE: Unanimous, the motioned carried

BOARD ACTION ON ITEM 8
MOTION: Cover non-network lab at cost share first time ever and fist time each plan year.
BY: Member, Christopher Viton
SECOND: Member, Janell Woodward
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Add hardware coverage to CDHP to align with LDPPO, EPO and HMO and increase the current $100 limit to align with market.
BY: Member, Janell Woodward
SECOND: Member, Blaine Harper
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Bring back to November board meeting 30% coinsurance with a min/max and options therein.
BY: Member, Keiko Duncan
SECOND: Vice Chair, Joy Grimmer
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Bring back to November board meeting a two part impact analysis to develop a 3 tier copay structure for Biosimilars only and a 3 tier copay structure for specialty drugs all inclusive.
BY: Member, Keiko Duncan
SECOND: Member, Jennifer McClendon
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Have Segal bring back Mountain West states comparison of our plans for the purpose of looking at the true value of the LDPPO Plan.
BY: Member, Keiko Duncan
SECOND: Member, Jennifer McClendon
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 8
MOTION: Evaluate the cost of adding Long Term Disability back to coverage.
BY: Member, Janell Woodward
SECOND: Member, Blaine Harper
VOTE: Unanimous, the motion carried

9. FY25 Year End Financial/ Budget Report. (Theresa Carsten, Executive Officer) (Information/Discussion)

10. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitation. (Theresa Carsten, Executive Officer,) (**For Possible Action**)
    1. Contract Overview
    2. New Contracts
    3. Contract Amendments
    4. Status of Current Solicitations

BOARD ACTION ON ITEM 10
MOTION: Extend HSA Bank and UnitedHealthcare Basic Life Insurance from June 30, 2026 to June 30, 2028.
BY: Member, Janelle Wood
SECOND: Member, Jim Barnes
VOTE: Unanimous, the motion carried

11. Executive Officer Report. (Theresa Carsten, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 11
MOTION: Change the premium in the PEBP system to reduce the HMO premiums by $79 or correct amount based on enrollment for a one month period within the next three months.
BY: Vice Chair, Joy grimmer
SECOND: Member, Keiko Duncan
VOTE: Unanimous, the motion carried

MOTION: Write checks to non-state employers with a memo to direct them to refund the amount to the participants they have enrolled in the HMO.
BY: Member, Janell Woodward
SECOND: Member, Keiko Duncan
VOTE: Unanimous, the motion carried

12. Quarter 4 Vendor Reports. (Information/Discussion)
    12.1 Receipt of quarterly vendor reports for the period ending July 30, 2025:
        12.1.1 Q4 UMR – Obesity and Diabetes Care Management
        12.1.2 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
        12.1.3 Q4 UnitedHealthcare Basic Life Insurance
        12.1.4 Amplifon Performance Report
    12.2 Questions or discussion related to any reports provided (Board)

13. Public Comment.

- Kent Ervin – NV Faculty Alliance

14. Adjournment.

- Board Chair Wells adjourned the meeting at 1:30pm

BOARD ACTION ON ITEM 14
MOTION: Motion to adjourn.
BY: Member, Keiko Duncan
SECOND: Member, Jennifer McClendon
VOTE: Unanimous, the motion carried

5.

5. Discussion and acceptance of Eide Bailey's audited financial statements: Retiree Health and Welfare Trust and Employer allocation reports.
(Kurt Shlicker, Eide Bailly) (**For Possible Action**)

Financial Statements
For the Years Ended June 30, 2024 and 2023

State Retirees' Health & Welfare Benefits Fund,
Public Employees' Benefits Program,
a fiduciary component unit of the State of Nevada

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Table of Contents
June 30, 2024 and 2023

Independent Auditor's Report

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

Report on the Audit of the Financial Statements

Opinions

We have audited the financial statements of the State Retirees' Health & Welfare Benefits Fund (the Fund), Public Employees' Benefits Program, a fiduciary component unit of the State of Nevada, as of and for the years ended June 30, 2024 and 2023, and the related notes to the financial statements, which collectively comprise the Fund's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of the Fund, as of June 30, 2024 and 2023, and the changes in its financial position for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States (Government Auditing Standards). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

eidebailly.com
5441 Kietzke Ln., Ste. 150 • Reno, NV 89511-2094 • T 775.689.9100 • F 775.689.9299 • EOE

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and Government Auditing Standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the schedule of changes in net OPEB liability and related ratios, the schedule of contributions, and the schedule of investment returns be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with Government Auditing Standards, we have also issued our report dated October 14, 2025, on our consideration of the Fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness the Fund's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the Fund's internal control over financial reporting and compliance.

Eide Bailly LLP

Reno, Nevada
October 14, 2025

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Statements of Fiduciary Net Position
June 30, 2024 and 2023

	2024	2023
Assets		
Cash with State Treasurer	$ 2,803,705	$ 2,199,374
Intergovernmental receivable	29,273	23,940
Due from other State of Nevada funds	148,807	137,891
Due from State of Nevada component units	-	1,526,308
Total assets	2,981,785	3,887,513
Liabilities and Net Position		
Current Liabilities		
Due to State of Nevada Self Insurance Fund	16,813,187	34,414,831
Net Position		
Unrestricted (deficit)	$ (13,831,402)	$ (30,527,318)

See Notes to Financial Statements

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2024 and 2023

	2024	2023
Additions		
Contributions		
Employer contributions	$ 67,278,021	$ 41,136,140
Treasurer's pool income		
Interest and dividends	186,802	102,658
Net appreciation in fair value of treasurer's pool	16,623	37,344
Total net treasurer's pool income	203,425	140,002
Total additions	67,481,446	41,276,142
Deductions		
Benefit payments	50,785,530	51,710,749
Change in Net Position	16,695,916	(10,434,607)
Net Position (Deficit), Beginning of Year	(30,527,318)	(20,092,711)
Net Position (Deficit), End of Year	$ (13,831,402)	$ (30,527,318)

Note 1 - Summary of Significant Accounting Policies

Reporting Entity, Purpose, and Plan Administration

The State Retirees' Health and Welfare Benefits Fund (the Fund), Public Employees Benefits Program (PEBP) of the State of Nevada (the State) was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of the State retirees. The Fund is a multiple employer cost-sharing defined postemployment benefit plan run by the PEBP Board. The Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

The Fund is governed by the PEBP Board of Trustees which consists of eleven members who are appointed by the Governor of the State. Each appointee represents a specific class of public employees and retirees including the Nevada System of Higher Education, retired public employees, State employees, and local government employees. Additionally, two members must have substantial and demonstrated experience in risk management, health care administration, or employee benefits programs. One member must be employed in a managerial capacity for the State Department of Administration. These requirements are all in accordance with Nevada Revised Statute (NRS) 287.041.

The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. GASB standards have set forth certain component unit criteria to consider, in part, as follows:

- If the State of Nevada appoints a voting majority of the PEBP board and either has financial burden (legally or assumed) to make contributions to the Fund or if the State of Nevada may impose its will on the Fund.
- If the State of Nevada does not appoint a voting majority of the PEBP board and has both a financial burden (legally or assumed) to make contributions to the Fund and the Fund is fiscally dependent on the State of Nevada.

The Governor appoints the majority of the PEBP board, and the State of Nevada has the financial burden to make contributions to the Fund. The assets of the Fund belong to the officers, employees, and retirees of the State of Nevada in aggregate. Neither the State of Nevada nor the governing body of any county, school district, municipal corporation, political subdivision, public corporation, or other local governmental agency of the State of Nevada, nor any single officer, employee or retiree of any such entity has any right to the assets in the Fund. Therefore, due to the above factors, the Fund is considered a fiduciary component unit of the State of Nevada.

Basis of Accounting

The financial statements of the Fund have been prepared in conformity with accounting principles accepted in the United States of America (U.S. GAAP) as applied to governmental units. The accompanying financial statements of the Fund have been prepared using the accrual basis of accounting and the economic resources measurement focus.

Cash with State Treasurer

Monies being held by the Fund that are not required to pay current benefits are invested in either the Retirement Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada's general portfolio (Treasurer's Pool) pursuant to NRS 226.110 as approved in the legislatively approved budget. Cash with State Treasurer functions as a demand deposit account.

Contributions and Receivables

For state agencies whose employer contributions are paid through central payroll at the State, the contributions are collected during each pay period and are funded by an assessment based on a percentage of actual payroll incurred. For all other employer participants, the contributions are paid based on an estimated assessment of each month and then trued up at least quarterly.

The receivable balances are reported in three classifications: intergovernmental, other State of Nevada funds, and State of Nevada component units. Intergovernmental receivables are outstanding amounts from state agencies, such as state boards and commissions. Other State of Nevada funds are amounts outstanding from governmental and proprietary funds within the State of Nevada. State of Nevada component unit receivables are outstanding amounts from the Nevada System of Higher Education. The Fund has not established an allowance for uncollectible amounts based on prior experience and known factors with respect to the employers.

The Fund does not receive member contributions.

Benefits and Payables

Benefits and refunds are recognized when due and payable in accordance with the terms of the plan. Benefits are administered by the State of Nevada Self Insurance Fund, an internal service fund of the State of Nevada. Therefore, all benefit liabilities are recognized as due to the Self Insurance Fund.

Net Position

Net position is restricted for postemployment benefits other than pension as described in NRS 287.04362. As more fully described in Note 5 to the financial statements, the Fund has a deficit net position as of June 30, 2024 and 2023, respectively, which requires presentation as an unrestricted (deficit) within the Statements of Fiduciary Net Position to be in accordance with U.S. GAAP.

Use of Estimates

The preparation of financial statements is in conformity with accounting principles accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and notes. Actual results could differ from those estimates.

Note 2 - Plan Description and Contribution and Benefits Provided

The Fund was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of the State retirees. The Fund is a multiple employer cost-sharing defined postemployment benefit plan run by the PEBP Board. The Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

Contributions to the Fund are paid by the participating state agencies through an assessment of actual payroll paid by each State agency through the Retired Employee Group Insurance assessment (REGI). REGI is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. REGI was 3.11% and 2.18% of actual payroll for the years ended June 30, 2024 and 2023, respectively. Benefits are paid to the PEBP Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Administrative costs of the Fund are absorbed by the State of Nevada Self Insurance Trust Fund.

Pursuant to NRS 287.023 and NRS 287.046, the following individuals and their dependents are eligible to receive benefits from the Fund:

Any PEBP covered retiree with state service whose last employer was the State and who:

- Has at least five years of public service and who was initially hired by the State prior to January 1, 2010; or
- Has at least 15 years of public service and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Any PEBP covered retirees with state service whose last employer was not the State or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

State service is defined as employment with any Nevada State agency, the Nevada System of Higher Education and any State Board or Commission.

Pursuant to NRS 287.0425, the Executive Officer reports information regarding the Fund annually to the Governor's Finance Office and the Nevada Legislature. The Fund is governed by NRS 287.0436 through NRS 287.04364.

State active employee and retiree enrollment and inactive members consisted of the following as of the actuarial valuation and measurement date of June 30, 2024 and June 30, 2023:

	2024	2023
Active Plan members*	30,699	28,015
Inactive Plan members or beneficiaries currently receiving benefit**	12,547	12,692
Inactive Plan members entitled to but Not Yet Receiving Benefit Payments	19,730	18,495
Total Plan members	62,976	59,202

*Active counts reflect those hired prior to January 1, 2012
**Inactive counts include terminated vested participants and reflect State retirees only.

State participating employers consisted of the following as of the actuarial valuation date:

	2024	2023
Total participating employers	25	24

Note 3 - Net OPEB Liability

The projections of the net OPEB liability are based on the substantive plan (the plan as understood by the employer and plan members) and includes the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The projection of the net OPEB liability does not explicitly incorporate the potential effects of legal or contractual funding limitations on the pattern of cost-sharing between the employer and plan members in the future. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial estimated liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations. However, the preparation of any estimate of future post-employment costs requires consideration of a broad array of complex social and economic events. Future changes in the healthcare reform, changes in reimbursement methodology, the emergence of new and expensive medical procedures and prescription drug options, changes in the investment rate of return and other matters increase the level of uncertainty of such estimates. As such, the estimate of postemployment program costs contains considerable uncertainty and variability, and actual experience may vary significantly by the current estimated net OPEB liability.

Net OPEB Liability of the State

The components of the net OPEB liability of the State at June 30, 2024 and 2023 were as follows:

	2024	2023
Total OPEB liability	$ 1,344,358,275	$ 1,427,443,647
Plan fiduciary net position	(13,831,402)	(30,527,318)
Net OPEB liability	$ 1,358,189,677	$ 1,457,970,965
Plan fiduciary net position as a percentage of total OPEB liability	-1.03%	-2.14%

Actuarial Assumptions

The total OPEB liability was determined by an actuarial valuation as of June 30, 2024 and 2023, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

	2024
Inflation	2.50%
Salary increases	4.20% to 9.10%, for regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Investment rate of return	2.50%
Healthcare cost trend rates	For medical prescription drug benefits, the current amount is 8.00% graded down 0.25% to ultimate 4.50% over 14 years. For dental benefits 4.00% graded down .25% to ultimate 3.00% over 4 years. For Part B Reimbursement, the trend rate is 27.17% and 7.63%, effective July 1, 2024 and 2025, respectively, then 1.00%.

	2023
Inflation	2.50%
Salary increases	4.20% to 9.10%, for regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Investment rate of return	2.50%
Healthcare cost trend rates	For medical prescription drug benefits, the current amount is 4.80% increase effective July 1, 2023, then 7.25% graded down 0.25% to ultimate 4.50% over eleven years. For dental benefits 4.00%. For Part B Reimbursement, the trend rate is 0.00% and 27.17%, effective July 1, 2023 and 2024, respectively, then 4.50%.

Investment Rate of Return

As more fully described in Note 4, the Fund deposits its funds within the State of Nevada Treasurer's Pool. Therefore, the Fund does not have its own policies which determine the investment portfolio target asset allocation or expected real rate of return. The Treasurer's Office's policy is to invest for a competitive rate of return in relation to prevailing budgetary and economic environments, while considering the State of Nevada's investment risk constraints and cash flow characteristics. In addition, the Fund is funded on a pay-as-you-go basis. Due to these factors, the investment rate of return the same as the inflation rate of 2.50%.

Postretirement Mortality Rates

Healthy: Regular Members – Pub-2010 General Healthy Retiree Headcount-Weighted Above-Median Mortality Table with rates increased by 30% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Healthy Retiree Headcount-Weighted Above-Median Morality Table with rates increased by 30% for males and 5% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Disabled: Regular Members – Pub-2010 Non-Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 20% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 30% for males and 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Beneficiaries: Regular and Police/Fire Current Beneficiaries in Pay Status – Pub-2010 Contingent Survivor Headcount-Weighted Above-Median Mortality Table with rates increased by 15% for males and 30% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

The actuarial assumptions used in the June 30, 2024 and 2023valuations were based on the results of the 2020 actuarial experience study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021.

Preretirement Mortality Rates

Actuarial assumptions remained consistent for the valuation periods of June 30, 2024 and 2023.

Regular Members: Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Police/Fire Members: Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality table, projected with the two-dimensional morality improvement scale MP-2020.

Discount Rate

The discount rate used to measure the total OPEB liability was 3.93% and 3.65% for fiscal years ended June 30, 2024 and 2023, respectively. As the Fund is funded on a pay-as-you-go basis, the discount rate is based on the Bond Buyer 20-Bond General Obligation Index rate.

Significant Changes in Assumptions

- The discount rate changed from 3.54% as of June 30, 2022, to 3.65% as of June 30, 2023, and 3.93% as of June 30, 2024, based on the published change in return for the applicable municipal bond index.
- Healthcare costs trends remained the same from June 30, 2022 to June 30, 2023, using the 2020 Actuarial Experience Study conducted for the Public Employees' Retirement System of the State of Nevada, dated September 10, 2021. The healthcare cost trends were updated for June 30, 2024, to reflect future trend rates on valuation-year per capita health care costs and the plan's Part B reimbursement but were still reported using the 2020 Actuarial Experience Study conducted for the Public Employees' Retirement System of the State of Nevada, dated September 10, 2021.

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate

The following presents the net OPEB liability of the State, as well as what the State's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current discount rate:

	1% Decrease (2.93%)	Discount Rate (3.93%)	1% Increase (4.93%)
Net OPEB liability, June 30, 2024	$ 1,488,951,973	$ 1,358,189,677	$ 1,244,567,477

	1% Decrease (2.65%)	Discount Rate (3.65%)	1% Increase (4.65%)
Net OPEB liability, June 30, 2023	$ 1,599,173,891	$ 1,457,970,965	$ 1,335,498,630

Sensitivity of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates

The following presents the net OPEB liability of the State, as well as what the State's liability would be if it were using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease	Healthcare Cost Trend Rates	1% Increase
Net OPEB liability, June 30, 2024	$ 1,294,283,024	$ 1,358,189,677	$ 1,430,924,725

	1% Decrease	Healthcare Cost Trend Rates	1% Increase
Net OPEB liability, June 30, 2023	$ 1,382,571,885	$ 1,457,970,965	$ 1,544,492,010

Note 4 - Cash and Deposits with the State Treasurer

The NRS directs the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State against loss. The pooled collateral for deposits program maintains a 102% pledge collateral for all public deposits. The Fund is a participant in the investment pool maintained by the Treasurer of the State. The investment pool is not registered with the Securities and Exchange Commission as an investment company. The State has not provided or obtained any legally binding guarantees during the period to support the value of the shares. The Fund receives a pro-rated share of the earnings from its participation in the investment pool based on daily cash balances. Due to the nature of the investment pool, it is not possible to separately identify any specific investment as being that of the Fund. Instead, the Fund owns a proportionate share of each investment, based on the Fund's participating percentage in the investment pool. The cash (due on demand) with State Treasurer balance as of June 30, were as follows (expressed in thousands):

	2024	2023
Cash		
Cash with State Treasurer		
State Treasurer's Investment Pool	$ 2,856	$ 2,268
Unrealized gains and losses	(52)	(69)
Total cash with State Treasurer	$ 2,804	$ 2,199

Rate of Return

For the years ended June 30, 2024 and 2023, the annual money-weighted rate of return on investment, net of investment expenses was 0.99% and 0.63%, respectively. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Note 5 - Net Position

Net position is normally restricted for postemployment benefits other than pension; however, the net position of the Fund is in a deficit position. The deficit balance as of June 30, 2024 and 2023 was $13,831,402 and $30,527,318 respectively. Management of the Fund actively worked on a plan to improve the Fund's net position. A rebalancing of the REGI Assessment was approved during the 2023 legislative session. The REGI assessment is calculated and collected as a percentage of gross salaries. REGI assessments were approved at 3.11% for Fiscal Year 2024 and 3.18% for Fiscal Year 2025. This is an increase from the 2.18% approved for Fiscal Year 2023 and is related to the Governor's recommendation to revise the methodology by which the REGI assessment is determined. This increase of the REGI assessment is expected to gradually decrease the deficit. Management of the Fund is committed to ongoing monitoring of benefit costs, expected payroll, and the REGI assessment rates to better present the Fund's net position and financial health.

Note 6 - Commitment and Contingencies

The State of Nevada, the Fund, its officers or its employees are parties to a number of lawsuits which may indirectly or directly affect the Fund. The litigation potentially affecting the Fund has been evaluated and has either been evaluated as minimal risk of loss due to an unfavorable outcome or due to other various facts and circumstances. No potential losses have been evaluated as probable and thus no liability has been recorded.

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Changes in Net OPEB Liability and Related Ratios (in thousands)
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,								
	2024	2023	2022	2021	2020	2019	2018	2017	2016
Total OPEB Liability									
Service cost	$ 45,431	$ 46,424	$ 52,675	$ 55,710	$ 53,039	$ 51,349	$ 51,882	$ 59,309	$ 49,794
Interest cost	52,521	50,768	33,718	33,853	49,915	52,488	47,795	39,469	45,361
Changes of benefit terms	-	-	38,605	-	-	-	-	-	-
Differences between expected and actual experiences	(9,533)	(7,880)	(19,316)	(2,313)	(72,984)	(31,485)	-	-	-
Changes of assumptions	(102,980)	(14,550)	(159,738)	(938)	124,245	37,971	(36,851)	(102,300)	123,519
Gross benefit payments	(68,524)	(69,433)	(64,012)	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Total OPEB Liability	(83,085)	5,329	(118,068)	42,124	104,246	67,833	23,116	(41,591)	182,742
Total OPEB liability, beginning of year	1,427,444	1,422,115	1,540,183	1,498,059	1,393,813	1,325,980	1,302,864	1,344,455	1,161,713
Total OPEB liability, end of year	1,344,359	1,427,444	1,422,115	1,540,183	1,498,059	1,393,813	1,325,980	1,302,864	1,344,455
Plan Fiduciary Net Position									
Contributions									
Employer	67,278	41,136	39,621	39,564	43,882	40,943	39,669	38,049	32,213
Net investment income	203	140	(93)	308	205	181	162	164	55
Gross benefit payments	(50,785)	(51,711)	(49,653)	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Plan Fiduciary Net Position	16,696	(10,435)	(10,125)	(4,316)	(5,882)	(1,366)	121	144	(3,664)
Plan Fiduciary Net Position, Beginning of Year	(30,527)	(20,092)	(9,967)	(5,651)	231	1,597	144	-	4,996
Plan Fiduciary Net Position, End of Year	(13,831)	(30,527)	(20,092)	(9,967)	(5,651)	231	265	144	1,332
State's Net OPEB Liability	$ 1,358,190	$ 1,457,971	$ 1,442,207	$ 1,550,150	$ 1,503,710	$ 1,393,582	$ 1,325,715	$ 1,302,720	$ 1,343,123
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	-1.03%	-2.14%	-1.41%	-0.65%	-0.38%	0.02%	0.02%	0.01%	0.10%
Covered Payroll	$ 2,176,532	$ 1,886,972	$ 1,825,853	$ 1,676,441	$ 1,875,299	$ 1,749,658	$ 1,688,043	$ 1,612,246	$ 1,627,517
State's Net OPEB Liability as a Percentage of Covered Payroll	62.40%	77.27%	78.99%	92.47%	80.19%	79.65%	78.54%	80.80%	82.53%

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Contributions (in thousands)
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,								
	2024	2023	2022	2021	2020	2019	2018	2017	2016
Actuarially Determined Contributions/ Contractually Required Contribution**	$ 127,290	$ 41,136	$ 39,621	$ 39,564	$ 43,882	$ 40,942	$ 39,669	$ 38,049	$ 32,213
Contributions Made in Relation to the Contractually Required Contribution	67,278	41,136	39,621	39,564	43,882	40,942	39,669	38,049	32,213
Contribution Deficiency (Excess)	$ 60,012	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 2,176,532	$ 1,886,972	$ 1,825,853	$ 1,676,441	$ 1,875,299	$ 1,749,658	$ 1,688,043	$ 1,612,246	$ 1,512,347
Contributions as a Percentage of Covered Payroll	3.09%	2.18%	2.17%	2.36%	2.34%	2.34%	2.35%	2.36%	2.13%

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

**GASB Statement No. 74 requires the Actuarially Determined Contribution (ADC) to be reported if calculated. The ADC is presented for June 30, 2024 but is not available for prior years. The Contractually Required Contribution is presented for 2017-2023.

Notes to Schedules:

	2024	2023	2022	2021	2020	2019	2018	2017	2016
Valuation Date	June 30, 2024	June 30, 2022	June 30, 2022	July 1, 2020	July 1, 2020	June 30, 2018	June 30, 2018	January 1, 2018	January 1, 2018
Actuarial Cost Method	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal
Amortization Method	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay
Amortization Period	25-year	25-year	25-year	25-year	25-year	25-year	25-year	25-year	25-year
Asset Valuation Method	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value
Inflation Rate	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%	2.75%
Discount Rate	3.93%	3.65%	3.54%	2.16%	2.21%	3.51%	3.87%	3.58%	3.58%
Healthcare Cost Trend Rates									
Medical prescription drug	8.00% - 4.50%	7.25% - 4.50%	7.25% - 4.50%	6.25% - 4.50%	6.25% - 4.50%	6.50% - 4.50%	6.50% - 4.50%	6.50% - 5.00%	6.50% - 5.00%
Dental	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Part B Reimbursement	7.63% effective 7/1/2025 then 1.00%	27.17% effective 7/1/2024 then 4.00%	27.17% effective 7/1/2024 then 4.00%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%
Salary Increases									
Regular Members	4.20% - 9.10%	4.20% - 9.10%	4.20% - 9.10%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Police/Fire Members	4.60% - 14.50%	4.60% - 14.50%	4.60% - 14.50%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Investment Rate of Return	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%	2.75%
Retirement Age	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service
Mortality									
Healthy									
Regular Members	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Disabled									
Regular Members	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Beneficiaries	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Mortality Improvement	MP-2020	MP-2020	MP-2020	MP-2019	MP-2019	MP-2016	MP-2016	MP-2016	MP-2016

Plan Changes: No significant plan changes

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Investment Returns
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,								
	2024	2023	2022	2021	2020	2019	2018	2017	2016
Annual money-weighted rate of return, net of investment expense**	0.99%	0.63%	0.17%	0.15%	0.48%	0.55%	***	***	***

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

**The annual money-weighted rate of return includes cash held by the State Treasurer and related earnings.

***Information for 2018 - 2016 is not available.

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements the State Retirees' Health & Welfare Benefits Fund (the Fund), Public Employees' Benefits Program, a fiduciary component unit of the State of Nevada, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise Fund's basic financial statements, and have issued our report thereon dated October 14, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Fund internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control. Accordingly, we do not express an opinion on the effectiveness of the Fund's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. However, as described in the accompanying Schedule of Findings and Responses, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. We consider the deficiency described in the accompanying Schedule of Findings and Responses as item 2024-002 to be a material weakness.

A *significant* deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiency described in the accompanying Schedule of Findings and Responses as item 2024-001 to be a significant deficiency.

eidebailly.com
5441 Kietzke Ln., Ste. 150 • Reno, NV 89511-2094 • T 775.689.9100 • F 775.689.9299 • EOE

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Fund's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Fund's Response to Finding

Government Auditing Standards requires the auditor to perform limited procedures on the Fund's response to the findings identified in our audit and described in the accompanying Schedule of Findings and Responses. The Fund's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Fund's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the Fund's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Reno, Nevada
October 14, 2025

2024-001 Financial Statement Preparation
Significant Deficiency

Criteria: Management is responsible for establishing and maintaining an effective system of internal control over financial reporting. One of the key components of an effective system of internal control over financial reporting is the preparation of full disclosure financial statements in accordance with generally accepted accounting principles.

Condition: Management prepares internal use financial statements. However, management required the assistance of the external audit firm to prepare the audited financial statements and related note disclosures. Although the preparation of financial statements as a part of the audit engagement is not unusual, it may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by the Fund's personnel.

Cause: Accounting personnel do not have the current resources of time and training necessary to prepare the financial statements in accordance with generally accepted accounting principles. As a result, the Fund chose to contract with Eide Bailly, LLP to the prepare its financial statements.

Effect: Internally prepared records upon which the financial statements are prepared do not contain all information required by generally accepted accounting principles.

Recommendation: We recommend the Public Employees' Benefits Program allocate the resources necessary to enable the preparation of the financial statements in accordance with generally accepted accounting principles and enhance internal controls to ensure financial statements are appropriately disclosed and presented.

Views of Responsible Officials: Management agrees with the finding.

2024-002 ***Contributions***
Material Weakness

Criteria: Management is responsible for obtaining and retaining supporting documentation related to revenue receipts for contributions. Additionally, management is responsible for verifying the accuracy of the contribution made. Operating internal controls that ensure revenue is recorded appropriately is a key component of ensuring contributions are recognized accurately and in accordance with U.S. GAAP.

Condition: During our testing of contributions, we selected a sample of 60 individual contributions from across all the participants. A summary of the errors noted are as follows:

- Three contributions were made using the prior year REGI assessment rate.
- The remittance did not include the payroll amount used to calculate the assessment nor the underlying payroll report (remittances were incomplete) for six of the transactions.
- A remittance was not submitted (or retained) for five transactions.
- A remittance was provided but the underlying payroll report or support for the estimate was not included for six transactions.

Ultimately, we requested the underlying support from the plan participants in order to verify the accuracy of the contribution amounts.

In addition, we examined the annual contributions from central payroll of the State and noted the prior year REGI rate was applied to one current year contribution and that the assessment recalculation could not be re-performed accurately for one other pay period.

Cause: The Public Employees' Benefits Program did not have adequate internal controls to ensure plan participants were making contributions to the plan in accordance with plan provisions.

Effect: A passed adjustment for the understatement of $391,647 in contributions was identified.

Recommendation: We recommend the Public Employees' Benefits Program enhance internal controls to ensure plan participants are making contributions to the plan in accordance with plan provisions.

Views of Responsible Officials: Management agrees with the finding.

6.

6. Discussion and possible action regarding Board Policy and Procedure Appendix A. (Leslie Bittleston, Quality Control Officer, and Jim Wells, Board Chair) (**For Possible Action**)

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

November DRAFT

I. INTRODUCTION

Nevada Revised Statutes (NRS) 287.41 creates the Public Employees' Benefits Program (PEBP) Board (Board) to establish and carry out a Program for health, life, and other voluntary insurance benefits.

The Board has adopted the following Duties, Policies and Procedures for general direction, information, and guidance of the Program. The Duties, Policies and Procedures may be amended, varied, or suspended at the discretion of the Board by a motion passed in an open meeting.

A comprehensive fiduciary policy provides the Program with functional guidelines within which to operate. The Program is accountable to the Participants and the Public. Board Members and agency employees must be willing to perform their responsibilities that preclude and inhibit misconduct, eliminate waste of resources, and embrace the concepts of sound cost effective measures.

GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

Service to the participants of the Program is the primary function of the Board and the Agency. Board members are fiduciaries who are to act for the exclusive benefit of the participants. Board members will act with integrity, objectivity, independence, prudence, and due care.

II. APPOINTING AUTHORITY

The "Appointing Authority" is made up of the Governor, the Senate Majority Leader, and the Speaker of the House.

In making appointments, the Appointing Authority shall coordinate to ensure that the membership of the Board is diverse and, to the extent practicable, proportionally and equitably represents the constituencies served by the Program.

III. GOVERNANCE

The policy is designed to enable Board members and agency employees to seek counsel, to remain inquisitive, and to exercise their functions with the prudence demanded of them in the public sector.

Board members are entrusted with the responsibility of exercising their duties in a manner that ensures the efficient and effective administration of the Program in compliance with all applicable Federal and State laws and regulations, including those relating to ethics (NRS 281A), contracting (NRS 333) and the Nevada Open Meeting Law (NRS 241).

FRAMEWORK:

- "Board" means the PEBP Board members
- "Agency" means the PEBP agency and its employees
- "Program" means both the Board and the Agency

A. BOARD RESPONSIBILITIES

Board members are entrusted with the responsibility of ensuring efficient administration of the program in accordance with all applicable laws and regulations, and shall:

1. Be responsible for adopting the Mission Statement, Values, Goals and Objectives (i.e., the Strategic Plan) of the Program.
2. Provide health care, life insurance, and other voluntary benefits in a responsible manner balancing the needs of the State, Plan participants and the taxpaying community. Benefit changes may be considered by the Board based upon recommendations from individual Board members, the Agency or from the public.
3. Adopt sound actuarial and accounting standards and appropriate internal controls.
4. Review and revise Duties, Policies and Procedures regarding matters that are not specifically enumerated in statute or regulation as needed.
5. Take a position on any proposed legislative matters affecting the Program and direct Agency employees to make that position known to the Legislature. During the legislative session, the Board authorizes the Executive Officer to take a position of "neutral" on any new bill affecting the Program by default. This allows for rapid response to legislative committee meetings scheduled prior to a Board vote. The Board can revise the default position at the next Board meeting.
6. Prior to the commencement of each biennial legislative session, review and approve the framework for the biennial budget to be submitted to the Governor's office.
7. Be responsible for PEBP's contracting activities in accordance with NRS 287.04345.
8. Interview qualified candidates for the position of Executive Officer and make recommendations to the Director and the Governor concerning the appointment, to oversee the day-to-day operations of the Program in accordance with NRS 287.0424.
9. Delegate to the Executive Officer the authority to manage the Program within the parameters defined by the Board.
10. Evaluate the Executive Officer as needed in a public forum adhering to all

applicable open meeting law requirements.

11. To the extent money and resources are available, compile a report on or before August 31st of each even number year comparing benefits under Medicare to those under the Program for retirees, and submit the report to the Director of the Legislative Counsel Bureau in accordance with Senate Bill 494 (2025).
    a. The Board may use the resources of the Nevada Health Authority to prepare the report.
12. The Director of the Department of Administration appoints the Quality Control Officer for the Program. The Director shall define the duties of the Quality Control Officer with the concurrence of the Board. The Quality Control Officer serves at the pleasure of the Director.

B. BOARD MEMBER CONDUCT

Individual Board members shall:

1. Prepare for and attend Board meetings.
2. Refrain from making commitments to any individual or entity regarding any matter that is scheduled for consideration by the Board.
3. Not communicating with the press or plan participants on behalf of the Board.
4. Be encouraged to obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
5. Conduct their affairs in such a manner that they always represent the best interest of the Board. To fulfill these functions satisfactorily, individual Board members must exercise utmost judgment, discretion, and tact to ensure good public relations, and to avoid any possible misunderstanding regarding actions as an individual as opposed to actions as a Board member.
6. Not acting in any official capacity on behalf of the Board except as directed by Board action.
7. Refrain from performing any function delegated or normally assigned to Agency employees.
8. Not obligate expenses on behalf of the Agency without following state law, regulations, policy, and Agency procedures.
9. Direct their inquiries and requests for information which may occur outside of a Board meeting to the Agency through the Executive Officer. A request that requires significant Agency resources, as determined by the Executive Officer, must be approved by the Board Chair before the staff shall be required to act upon the request.

C. BOARD MEETINGS

Board meetings shall be held in accordance with NRS 287.0415. The Board shall conduct business in accordance with Nevada Administrative Code NAC 287.170-176 the Nevada Open Meeting Law pursuant to NRS 241, federal and state statutory and regulatory provisions and current Duties, Policies and Procedures, as applicable.

1. The board shall meet no less than once every calendar quarter. The Chair may call additional meetings as necessary.
2. Any Board member may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program, a request for a matter to be placed on the agenda.
3. At the first meeting of each calendar year, the Board will elect a Chair. The Governor will designate a Vice Chair. The Vice Chair shall serve as the Board Chair in the absence of the Board Chair.
4. Meetings may be transcribed by a court reporter who is certified pursuant to NRS Chapter 656. A transcription shall be posted no later than 30 days from the date of the board meeting.
5. The board may meet in closed session for any of the following reasons.
    a. To discuss matters relating to personnel.
    b. With investment counsel to plan future investments or establish investment objectives and policies.
    c. With legal counsel to receive advice upon claims or suits by or against the Program.
    d. To prepare a request for a proposal or other solicitation for bids to be released by the Board for competitive bidding; or (e) As otherwise provided pursuant to NRS 241.
6. The Board may appoint advisory committees as necessary.

D. EXECUTIVE OFFICER AND AGENCY ADMINISTRATION

The Executive Officer serves at the pleasure of the Governor, is appointed by the Director of NVHA, but is interviewed by the Board who makes recommendations to the Director of NVHA and Governor. The Executive Officer is delegated the responsibility to implement the plan of benefits, decisions, directions, internal controls, and policies approved by the Board. Except as may otherwise be specified in plan documents approved by the Board, the Executive Officer executes the authority of Plan Administrator as described in such documents.

1. The Board authorizes the Executive Officer or his/her designee to provide official press releases and to answer questions from the press and other news media.
2. The Board authorizes the Executive Officer or his/her designee to carry out

administrative functions of the Agency, including but not limited to:

a. Financial management of contribution/rate billing, accounts receivable, accounts payable and budgetary compliance.
b. Management of Agency personnel, day-to-day operations and vendor performance matters.
c. Interpretation of NRS and NAC in performing functions of the Agency.
d. Approval of subrogation settlements and other financial settlements relating to claims processing.
e. Representation of the Agency to other pertinent governmental bodies.

3. Consistent with Board policies and directions, the Agency shall work with the Governor's Finance Office (GFO) and the Legislative Counsel Bureau (LCB) to ensure that the Program is funded on an actuarially sound basis. The Agency shall ensure the use of funds and resources directly related to the purpose of the agency and the statutory intent for the use of those resources.
4. Ensure the Agency notifies participants of health care benefit changes as approved by the Board.
5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:
   a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.
   b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures. A review of recent Board actions and precedents and current issues being considered by the Board.
   c. An overview of the funding and rate setting process.
   d. The continuing education opportunities for the members pending available funding.
6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt and understanding by signing the "Acknowledgment Form for Employees."

7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
8. The Executive Officer will provide Agency employees with relevanteducation and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee attending a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.
9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

- Avoid the perception of misuse ofinfluence.
- Be willing to adopt and abide by Duties, Policies and Procedures thatpreclude and inhibit misconduct.
- Eliminate the wasteful use of resources; and
- Embrace the concepts of sound cost effectivemeasures.

Each Board Member and each member of the Executive Staff will read the most current Ethics Manual and sign an acknowledgement of their understanding of the ethics requirements upon appointment or hire and receive annual Ethics Training provided by the staff of the Commission on
Ethics every subsequent year. The most current Ethics Manual may befound at: ethics-manuals.

In addition to the Ethics Manual and annual Ethics Training, Board members and agency employees will not:

1. Disclose information regarding business developments of a confidential nature received in the course of their duties except in the authorized performance of those duties.

2. Attempt to take advantage of confidential information received in the course of their duties for themselves or any third party.
3. Accept meals, travel, lodging or any other gift from any contractor or vendor in accordance with NRS 281A.

Business meetings, such as employee benefits orientations, open enrollment meetings, staff meetings, planning meetings, etc., may, in the interest of efficiency, be conducted at a contracted vendor's facility at no cost to the Agency if the expenses are customary and not intended to improperly influence a reasonable person.

If the Chair, Executive Officer, Director of the Nevada Health Authority, or assigned Deputy Attorney General cannot resolve an ethical question, the question should be referred to the Commission on Ethics:

Commission on Ethics
704 W. Nye Lane, Suite 204Carson City, Nevada 89703Telephone: 775-687-5469
Fax: 775-687-1279
Email: ncoe@ethics.nv.gov Website: www.ethics.nv.gov

Nothing herein precludes a Board member from directly contacting the Commission on Ethics with a question about his or her ethical obligations as a Board member.

F. SEXUAL HARASSMENT

The State of Nevada has a sexual harassment policy that prohibits unwelcome sexual conduct that creates a hostile work environment or affects employment. The policy requires state employees to receive training, and employees have a process for reporting harassment through their supervisor or the agency's Equal Employment Opportunity (EEO) officer.

The policy applies to all executive branch employees and is enforced through state law and federal Title VII of the Civil Rights Act.

The Board hereby adopts and authorizes the Executive Officer to enforce the most current State Policy Against Sexual Harassment and Discrimination approved by the Office of the Governor. Information regarding sexual harassment is located within the Division of Human Resource Management.

G. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITYACT (HIPAA)

Each Board member and agency employee must complete annual training regarding the privacy, protection, and disclosure requirements of HIPAA and sign an acknowledge form for PEBPs Executive Assistant and Quality Control Officer.

Information regarding HIPAA is located within the United States Department of Health and Human Services.

H. CONFIDENTIALITY

Each Board member and agency employee shall sign a Confidentiality andSecurity Statement of Understanding upon appointment/hire.

This form shall be provided to PEBPs Executive Assistant and Quality Control Officer.

I. TRAVEL POLICY

1. If a member of the Board must travel, they must adhere to the State of Nevada's travel policy which may be found the State Administrative Manual in sections 0200 (Travel) and 1400 (Fleet Services)
2. Board members are subject to the same travel requirements as Agency employees and will receive a copy of the Travel Policy and Procedures during their orientation. The Travel Policy and Procedures outline the requirements for submitting travel requests, travel reimbursements and necessary supporting documentation to the Agency.

IV. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for new contracts and contract extensions which will be in accordance with NRS 333, SAM 1500, and the Nevada Health Authority (NVHA).
2. There shall be a standing item on the Board meeting agenda to review the status of current contracts and active RFPs.

B. PROCUREMENT PROCESS

1. The Board shall act as the chief of the using agency pursuant to NRS 333.335 (1) (a).
    a. The Board delegates the role as chief of the using agency to the Executive Officer for routine administrative contracts under $100,000 pursuant to NRS 333.162, e.g., auditors, leases, PEBP

web site management, etc.

b. The Executive Officer shall solicit the participation of Board members to participate in the development of a solicitation as well as serve on the committee as an evaluator.

c. For all other contracts including any that involve the procurement of services to PEBP members or actuarial services, the Board delegates ministerial and administrative duties as chief of the "using agency" to the Executive Officer. The Executive Officer should ensure that accurate and detailed information and supporting documentation, within the bounds of statute and regulation, is provided to the Board and other governing bodies when seeking to bid new contracts and amend existing contracts.

d. The Board retains the power and duty as chief of the usingagency to appoint members of the Board to evaluation committees pursuant to NRS 333.335.

e. The duty of negotiating and administering the contracts isdelegated to the Executive Officer.

2. If a committee to evaluate proposals for a contract for the Program is established pursuant to NRS 333.335, any number of members of the Board may be appointed to the evaluation committee. If one or more members of the Board are appointed to an evaluation committee:

   a. No action or deliberation regarding any business of theBoard other than the confidential review of the proposals pursuant to NRS 333.335 may be taken or conducted by theevaluation committee.

   b. Except as otherwise provided above, a meeting of the evaluation committee is not subject to NRS 241.

3. If the Board determines to review the results of any evaluation of proposals for a contract for the Program, it shall conduct such review in a closed meeting pursuant to NRS 333.335.

   a. The Executive Officer will provide an appropriate check list to assist the Board in their review of the RFP.

4. The Board shall take the following actions only in an open meeting:

   a. Award the contract pursuant to NRS 333.335;

   b. Cancel the request for proposals; or

   c. Modify and reissue the request for proposals.

5. The Board shall review sufficient documentation to ensure justification for the recommended action(s) and validation of recommendations by PEBP management.

6. Service performance standards and Financial Guarantees and/or Penalties

will be included in all contracts. Specific standards, guarantees and penalties will depend upon the type of service(s) provided by vendor.

7. Contracts which are subject to an audit pursuant to the scope of work: the contracted auditor will conduct the audit in accordance with the schedule in the scope of work and provide the results to the Board at the next meeting after the conclusion of the audit and response from the vendor have been rendered.
8. The Board shall oversee significant scope of modifications and ensure a competitive bid process is followed for (but not limited to):
   a. Changes in the scope of the competition or vendor status.
   b. Changes which were not within the contemplation of the parties when the original contract was entered.
   c. Changes that materially alter the contract.
   d. Changes in the quantity of major items or portions of work;or
   e. Historically provided services under a separate contract.

C. Amendments

1. The Board shall review and discuss all contract extensions and ensure extensions receive all required approvals, i.e., solicitation waivers, appropriate justification, and documentation.
2. The Executive Officer shall provide appropriate check lists to the Board to assist the Board in their evaluation of the amendment.

V. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

PEBP sponsors both self-insured and fully insured plans of benefits.

For benefit plans that are self-insured, the Board will annually establish plan contributions based on the recommendation of PEBP's contracted actuarieswhich fund the plan(s) for the forthcoming plan year on an actuarially sound basis. Rates so established will be sufficient to fund anticipated paidclaims as well as reserves. These reserves include Incurred but Not Reported (IBNR) claims, Health Reimbursement Arrangement (HRA) fund balances and a Catastrophic reserve.

For benefit plans that are fully insured, the Program will negotiate rates with insurance underwriters for the provision of benefits based on equity to both the underwriters and to the Public Employees' Benefits Self-Insured Plan.

The Authority of the Board to establish rates are contained in NRS 287.043 (1) and (2).

B. RESERVE POLICY

PEBP will maintain fully funded IBNR and Catastrophic Reserves as determined by plan actuaries using the confidence intervals and margins described herein and a fully funded HRA Reserve based on 80% of the total balance remaining in all HRA accounts. Should the Catastrophic Reserve become underfunded or be forecast to be underfunded, the Executive Officer shall notify the Board at the next Board meeting.

The IBNR Reserves will be funded at a 95% confidence level to pay all known claims incurred. The Catastrophic Reserves will be funded at a level of 45 days on hand to meet unknown expenses which do not include IBNR. Both IBNR and Catastrophic Reserve levels will be recommended by PEBP's actuaries. The HRA Reserve will be funded to cover 80% of available balances.

Any cash-on-hand in addition to required reserves (IBNR, Catastrophic, and HRA) when the Program closes a fiscal will be identified as "Excess Reserves." Per section 20(2) of Senate Bill 501 (2025) (the Authorizations Act), "the Public Employees' Benefits Program, including, without limitation, the Board of the Public Employees' Benefits Program, shall not expend or otherwise obligate any reserves, either realized or projected, in excess of the amounts authorized in section 1 of this act for purposes of changing the health benefits, including, without limitation, reducing or off-setting participant premiums, available to state and nonstate active employees, retirees and covered dependents over the ~~2019~~25-2027~~1~~ biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

C. DEFINITIONS

As used herein the following terms mean:

1. **Open Enrollment** – The period during which participants in the Program may select among all health benefit programs that are offered by PEBP or eligible individuals not currently enrolled in the Program may enroll for coverage.
2. **Participant Contribution** – The portion of the rate paid by participants.
3. **Plan Design** – The benefits provided to participants of the plan. This includes provider access, out-of-pocket expenses (deductibles, co-payments, and coinsurance), and lines of coverage (medical, dental, vision, life insurance, etc.). Plan design does not refer to the methodology used to determine rates.
4. **Plan Year** – The PEBP benefit plan year as approved by the Board.
5. **Premium** – The cost paid for fully-insured benefits (e.g., health

maintenance organization membership, life insurance, etc.) as determined by insurance companies contracted with by PEBP. Premiums are passed through PEBP to the participants and employers.

6. **Rate** – The total monthly cost of coverage for a participant in each plan option and tier.
7. **Rating Methodology** – The basis for allocating costs between plan options and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.
8. **Subsidy (Contribution)** – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:
    a. Base Subsidy – For state employees, the portion of the rate paid by the employer pursuant to NRS 287.044. For retirees not on the Medicare Exchange, the portion of the rate paid by a retiree's previous employer(s) at 15 years of service pursuant to NRS 287.046.
    b. Years of Service (YOS) Subsidy – The adjustment to the Base Subsidy, for participants who retired on or after January 1, 1994, based on a retiree's YOS, paid by a retiree's previous employer(s) pursuant to NRS 287.046 and NRS 287.023(4)(b).
9. **Differential Cash** – The difference between revenue and expenditures.

D. OVERVIEW OF THE BIENNIAL PROCESSES

1. **Rate Setting** – Prior to the commencement of each plan year, the Board will establish rates based upon the recommendation of the Agency and PEBP's contracted actuaries based upon a variety of factors, including, but not limited to:
    a. Established plan designs
    b. Forecast claims costs for self-insured plan(s)
    c. Forecast premium costs for fully insured plan(s)
    d. Forecast fixed expenses from plan administrative vendors
    e. Forecast PEBP internal administrative expenses
    f. Forecast required adjustments to reserves
    g. Consideration of material demographic changes
2. **Plan Design** – The Board will identify the priorities for plan design (i.e., options for changes in the plan design). These priorities may include scope of benefits offered by the plan and/or cost-sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can

Take into consideration all information provided by Program staff and consultants during the year, along with any other sources available to individual Board members.

The Board makes its initial determination regarding plan design changes approximately four to five months prior to Open Enrollment. Composite trend developed by the Plan actuaries is presented to the Board based on the final plan design changes. Final plan design is approved at the rate setting Board meeting to allow for flexibility and an opportunity to adjust rates at that meeting.

PEBP uses the approved plan design changes and rating methodologies to finalize the rates, subsidies, and participant contribution amounts. The final rates are then reviewed and approved by the Board approximately four to eight weeks prior to open enrollment.

3. **Strategic Planning** – The Board will review, revise, and approve the program's Strategic Plan on an annual basis. The Strategic Plan will be the guiding document designed to assist the Board and the Agency to develop and maintain a high-quality program of benefits at affordable prices. Every effort will be made to review and approve the Strategic Plan prior to the initial annual plan benefit design approval meeting.
4. **Establishing the Legislative Agenda** – Using the strategic plan as a basis, any revisions required to the Nevada Revised Statutes (NRS) to implement the strategic plan will be identified. The Agency will present Bill Draft Request (BDR) recommendations to the Board every even numbered year and develop approved summaries and BDRs in accordance with State mandated schedules. Administrative departments are required to submit non-budgetary Legislative Summaries to the Governor's office by early April of each even numbered year. Upon approval of the Legislative Summary by the Governor's office, completed BDRs are due by June 1st of each even numbered year. Legislative Summaries and final non-budgetary BDRs will be approved by the Board prior to submission.
5. **Preparing the Biennial Budget Request** – Departments are required to submit their biennial budget requests no later than September 1st of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the spring of each even numbered year. A framework for the budget request will be presented to the Board in late

spring or early summer, with final approval required at the July or August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1st.

6. **Program Reporting** – Per NRS 287.0425, the Executive Officer shall submit a report regarding the administration and operation of the Program to the Board, the Director of NVHA, the Director of the Office of Finance, and the Director of the Legislative Counsel Bureau for transmittal to the appropriate committees of the Legislature or, if the Legislature is not in regular session, to the Legislative Commission and the Interim Retirement and Benefits Committee of the Legislature created by NRS 218E.420. Additionally, the Board receives reports on a prescribed schedule to assist in strategic planning, decision-making, and program design. Below is a list of the sources of information that will be considered by the Board when making all plan design and rate decisions, along with the timeframe of availability for each item. It is important to note that the information is provided to the Board throughout the year and is not limited to the Board meetings when rates are approved.
    a. Quarterly Vendor Reports – The reports provide utilization activity, participant contacts, provider updates, and other information applicable to each vendor's relationship with PEBP.
    b. Self-Insured Plan Utilization Reports – PEBP's Third Party Administrator provides a utilization report for the self- funded plan on a quarterly basis. In addition, an annual utilization report is provided within 90 days following each plan year. The utilization report provides the following data for the entire plan:
        - Executive summary and trend analysis
        - Plan demographics
        - Paid claims by benefit
        - Medical claims paid for inpatient/outpatient services
        - Surplus and loss summaries broken down by state and non-state groups and active employees, non-Medicare retirees and Medicare retirees
        - Costs by tier and age by medical, dental, prescription
        - Network utilization and cost sharing
        - Analysis of medical paid claims by major diagnostic
            - category, large claims, and prevalence
        - Chronic conditions and wellness
        - Analysis of prescription drug utilization
    c. Disease management and wellness reports are made available to

the Board in vendor quarterly reports. In addition, as each of these programs "mature", they will be analyzed by PEBP and PEBP's consultant/actuary on a cost
/ Benefit basis and the results reported to the Board.

d. The results of any participant questionnaire will be reported to the Board as soon as practical upon compilation of the results.

e. Differential cash will be reported in September to provide the most sound and consistent figures.

7. **Projected Expenses and Rate Calculations** – Any change in methodology for projecting expenses (such as changing from claimstrends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP using the approved framework and rating methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the medical, prescription drug, and dental cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these Duties, Policies and Procedures (see Appendix A).

Appendix A - Plan Year Rating Methodology

Rates are developed first by establishing plan design. The second step is to project claims costs or premiums for each plan option (e.g., PPO self-funded, HMO, etc.) and participant tier (e.g., single, family, etc.). Finally, PEBP operating costs, administrative costs and reserve adjustments are applied to the various plan options to derive the final rates. Subsidies are applied to the appropriate rate resulting in the participant's contribution. Unless otherwise approved by the Board, rates are to be calculated by staff using the following methods.

Plan Design

- Plan Selection Options (medical, prescription, ~~and~~ vision, dental, and basic life):
  - ✓ Preferred Provider Organization (PPO) Consumer Driven Health Plan (CDHP) (Base Plan) – self-funded with a

    Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if there is no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.

    OR

    Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP isequal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryoverlimit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.
  - ✓ Exclusive Provider Organization (EPO) Premier Plan – self-insured
  - ~~✓ Low-Deductible Copay plan (LD) – self-insured~~
  - ✓ Health Maintenance Organization (HMO) Plans – fully insured
  - ✓ Individual Market Medicare Exchange (IMME) – fully insured; only for retirees and their dependents who are eligible for premium free Medicare Part A; Medicare retirees who qualify for the exchange are not eligible for any other PEBP coverage (other than dental) unless they cover a dependent who is not eligible for the IMME. Includes a Health Reimbursement Arrangement (HRA) for those hired before January 1, 2012.

- Self-Funded Plan Designs: See Master Plan Documents for details.
- Benefits other than medical, prescription, and vision: See Master Plan Documents fordetails.
  - ✓ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
  - ✓ Basic Life Insurance - fully insured

- ~~Long Term Disability Insurance (LTD) – fully insured~~
- ~~Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if there is no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.~~
- ~~Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP isequal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryoverlimit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.~~

- Voluntary Benefits Option/s:
  - ✓ Flexible Spending Account (FSA) – IRS section 125 voluntary plan guaranteed by PEBP. For active employees only, employees with an HSA arenot eligible for a Medical FSA.
  - ✓ Additional Life Insurance – voluntary; fully insured
  - ✓ Long Term Care – voluntary; fully insured
  - ✓ Long Term Disability – voluntary; fully insured
  - ✓ Short Term Disability – voluntary; fully insured
  - ✓ Homeowners and Automobile Insurance – voluntary; fully insured
  - ✓ Accident/Indemnity – voluntary; fully insured
  - ✓ Legal Support – voluntary, fully insured
  - ✓ Identify Theft Protection – voluntary, fully insured
  - ✓ Buy-Up Vision Insurance – voluntary; fully insured
  - ✓ Pet Insurance – voluntary; fully insured

Cost Projections

- Commingling: Pursuant to NRS 287.043(2) and NRS 287.0434(3)(b), claims experience will be commingled for participants for whom the Program provides primary health insurance coverage in a single risk pool of low and high.

- Cost Projection Methodology: Predictive Modeling
  - ✓ In addition to taking traditional rating methodologies into consideration, such as demographics and claims experience, predictive modeling considers PEBP's actual disease states and medical conditions to add precision to actuarial projections
  - ✓ Medical diagnosis data is reviewed by certified clinicians, such as PEBP's Actuary's Medical Director and nursing staff.
  - ✓ PEBP's actuaries will develop rate cards so that there is 50% probability that the developed rates will cover plan costs.

- Secondary Insurance Coordination: Standard Coordination of Benefits

- ✓ PEBP plan pays the difference between the allowable cost of the health care services and supplies provided to the plan participants less whatever the primary plan paid for them.
- ✓ The participant is still responsible for the annual PEBP plan deductible.

- Rate Structure: Separate rates are developed for each of the following groups (NRS 287.043(2)(a) and (b)):
  - ✓ State active employees and non-IMME retirees
  - ✓ Non-State active employees and non-IMME retirees

- Participant Tiers of Coverage: Four
  - ✓ Single
  - ✓ Single + Spouse
  - ✓ Single + Child(ren)
  - ✓ Single + Family (Spouse and one or more children)

Rate Development

- PEBP's actuaries and HMO vendors will develop costs in accordance with the plan design approved by the Board and in accordance with the methodologies found in the Cost Projections section above.

- Enrollment projections are based on the average change in enrollment over the past 4 years and assumptions approved by the Executive Officer.

- The following costs, revenues and reserve adjustments will be allocated equally to all active employees and non-IMME retirees:
  - ✓ Life insurance (per $1,000 of coverage)
  - ~~✓ Long Term Disability (active employees only)~~
  - ✓ PEBP operating costs
  - ✓ Contracted dental network and claims payment administrative fees
  - ✓ Miscellaneous Revenues (RGL 4254)
  - ✓ Treasurer's Interest (RGL 4326)
  - ✓ Cost of Medicare Part B premium credit (reduction to excess reserves, Category 86)
  - ✓ Projected credit due to NRS 287.046(4) (increase to excess reserves, Category 86)
  - ✓ IMME administrative costs for Health Reimbursement Arrangement
  - ✓ Life Insurance for IMME retirees

- The following costs, revenues and reserve adjustments will be allocated only to ~~CDHP~~ self-funded participants:
  - ✓ Contracted CDHP administrative fees
  - ✓ HSA/HRA plan contributions
  - ✓ ~~CDHP~~ Rx Rebates (RGL 4218)

- ✓ Adjustments to Catastrophic Reserves (Category 85) in accordance withreserve policies.

- IMME retirees will not be charged PEBP operating costs, life insurance costs or HRA administration costs. The following costs will be allocated only to IMME retirees who choose PEBP dental coverage:
  - ✓ Contracted dental network and claims payment administrative fees

- Reserves
  - ✓ Catastrophic Reserves will be established at a level necessary to ensure plansolvency over the long term to a set ~~50~~ 45 days on hand.
  - ✓ IBNR Reserves will be established at a level to achieve a 95% probability that all claims incurred can be paid.

Participant contributions for HMO/EPO rates are blended between the northern EPO and southern HMO after all the above adjustments are applied. The blended HMO/EPO rate is based on the average cost of coverage by tier and projected enrollment.

Subsidy Allocation and Participant Contribution

- Base subsidy allocation
  - ✓ The employer subsidy percentages will be recommended by the Board to the Governor during the Agency Request phase of the Biennial Budget. The Legislature, through the Senate Finance Committee and Assembly Ways and Means Committee, will approve the final employer contribution percentages for each biennium when approving PEBP's biennial budget.
  - ✓ Non-State Active Employee: Determined by employer
  - ✓ Non-State Retiree: Determined by State Retiree amount (NRS 287.023(4)(b)) as set in session law and is based only upon years of service, regardless of plan selection or participant tier.
  - ~~✓ A single contribution strategy (flat dollar amount) will be applied equally across PEBP plans CHDP, EPO, LD, and HMO).~~

Include a table here: EE Share (Pending percentages from Segal)

Base Plan:	State Actives Employees %	Dependents %
Base Plan:	State Retirees %	Dependents %

All Other Plans:	State Actives Employees %	Dependents %
All Other Plans:	State Retirees %	Dependents %

- Retiree Years of Service (YOS) subsidy adjustment to the base subsidy (NRS287.046):
  - ✓ Retirees who retired prior to January 1, 1994: No adjustment.
  - ✓ Retirees who retired on or after January 1, 1994:

- For each YOS less than 15, subtract 7.5% of the amount set in session law from the base subsidy.
- For each YOS greater than 15, add 7.5% of the amount set in session law to the base subsidy (maximum, 20 YOS).

✓ Retirees who were hired by their last employer on or after January 1, 2010, and who have less than 15 YOS do not receive a YOS or base subsidy.

✓ Retirees who were hired by their last employer on or after January 1, 2012, do not receive a YOS or base subsidy.

- Medicare Part B premium credit – Retired primary participants enrolled in the Consumer Driven Health Plan, EPO, LD or HMO plan with Medicare Part B coverage will receive a CDHP, EPO or HMO premium reduction as approved by the Board. In no case shall the premium contribution for an individual be less than zero.

7.

7. Discussion and possible action on recommended enhancements to the Master Plan Documents for PY 26, PY 27 and PY 28. (Leslie Bittleston, Quality Control Officer) **(For possible Action)**

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 12, 2025

Item Number: 7

Title: Plan Year 2026, 2027, and 2028 Changes for Approval

Plan Design Changes: Implementation of clarification and legislative changes; language for approval.

I. The following clarification will be effective July 1, 2025 (Current Plan Year)

#	Change Type	Proposed Change	Justification	Document/s
1	Outpatient Observation & Outpatient Care	Clarification of when an outpatient observation & care becomes and inpatient state	UMR Staff Request and Clarification	Master Plan Documents for the EPO, CDHP, and the LDPPO
There is conflicting language for outpatient observation. Outpatient observation lasting more than 23 hours will be considered and paid as an inpatient confinement under this Plan. (This language will be used) If a hospital intends to keep someone in observation status from more than 48 hours, observation status will become an inpatient admission. (This language will be deleted)				

II. The following enhancement will be effective July 1, 2026 (Next Plan Year)

Enhancement: Genetic Counseling & Fertility /Family Planning

#	Change Type	Proposed Change	Justification	Document/s
1	Genetic Counseling *&* *Screening*	Noninvasive prenatal screening	SB 344 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO

#	Change Type	Proposed Change	Justification	Document/s

Genetics is the study of how genes and how traits are passed down from one generation to the next.

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.
Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:
  - The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
  - The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

The Plan covers noninvasive prenatal screening, that is, drawing blood from a pregnant person to perform laboratory analysis on the DNA circulating in the maternal blood stream for the purpose of detecting chromosomal abnormalities in the fetus, at any time during pregnancy. Prior authorization is not required for such noninvasive prenatal screening.

The Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, case management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

#	Change Type	Proposed Change	Justification	Document/s
Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law. Benefits include amniocentesis, ~~non-invasive pre-natal testing for fetal aneuploidy,~~ chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E. This list is not all-inclusive for what genetic tests may be covered. Contact the UM company for coverage details and prior authorization requirements for covered genetic testing.				

III. The following enhancement will be effective July 1, 2027. (Due to fiscal note)

Enhancement: Genetic Counseling & Fertility /Family Planning

#	Change Type	Proposed Change	Justification	Document/s
1	Fertility/Family Planning	Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception	AB 428 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO
The Plan covers procedures and services for the preservation of fertility that are medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and (a) the cancer may, in a health care provider's judgment, directly or indirectly cause infertility; or (2) the insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility. A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology (ASCO) or the American Society for Reproductive Medicine (ASRM), or their successor organizations. The procedures and services covered under this provision are those that are consistent with established medical practice or any guidelines published by the ASCO or the ASRM, or their successor organizations. *Other than procedures for the preservation of fertility for insureds diagnosed with breast or ovarian cancer as set forth above, only* ~~Only~~ diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner. Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible. *Other than the procedures and services for the preservation of fertility for insureds diagnosed with breast or ovarian cancer as set forth above, the* ~~The~~ Plan does not cover the treatment of fertility or infertility.				

#	Change Type	Proposed Change	Justification	Document/s
Please see the Benefit Limitations and Exclusions section, and in particular, the subsections for drugs, medicines, and nutrition; fertility and infertility; *and* maternity services~~; and sexual dysfunction services~~, for more details.				

Clarification with enhancement: Genetic Counseling & Fertility /Family Planning

#	Change Type	Proposed Clarification	Justification	Document/s
1	Maternity/Family Planning:	Benefit Limitations and Exclusions section	AB 428 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO
Maternity/Family Planning: *Except as otherwise specified in the Schedule of Benefits section, the* ~~The~~ following are not covered under the Plan. • Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy. • Expenses related to cryo-storage of umbilical cord blood or other tissue or organs. • For nondurable supplies. Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.				

Recommendation from PEBP Staff:

- Approve PEBP Staff's proposed changes, as presented.
- Allow for technical adjustment as necessary.

8.

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of April 1, 2025 – June 30, 2025. (Joni Amato, CTI) (**For Possible Action**)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT
and Annual Operational Review

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR

Audit Period: April 1, 2025 – June 30, 2025
Audit Number 1.FY25.Q4

Presented to

State of Nevada Public Employees' Benefits Program

November 20, 2025

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of UMR's (UMR's) administration of the State of Nevada Public Employees' Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of April 1, 2025 through June 30, 2025 (quarter 4 (Q4) for Fiscal Year (FY) 2025). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$73,400,268
Total Number of Claims Paid/Denied/Adjusted	244,958

The audit included the following components which are described in more detail in the following pages.

- Operational Review
- Quarterly Performance Guarantees Validation and Review of Self-Reported Results
- 100% Electronic Screening with 50 Targeted Samples
- Random Sample Audit of 200 Claims

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR met all 34 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective, and a penalty is owed (breakdown in summary below).
3. CTI recommends UMR:
   - Review errors identified in our Random Sample audit as well as the additional observations and determine if procedures, system changes, or claim processor training could help reduce or eliminate errors of a similar nature in the future.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining have occurred because most errors were manually processed.

Random Sample Audit Performance Guarantee Summary

Based on CTI's Random Sample Audit results, UMR did not meet the claim processing measurements for PEBP in Q4 FY2025 and owes a penalty. Reported administrative fees for the quarter totaled $1,404,474.33.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.40%	Not Met – 99.20%	1.5%	$21,067.12
Overall Accuracy	98.00%	Not Met – 97.00%	1%	$14,040.74
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Met – 92.60% Not Met – 98.10%	NA 1%	$0.00 $14,040.74
		Total Penalty	3.5%	$49,149.60

The following table presents a summary of UMR's historical performance against the quarterly metrics based on CTI's random sample audit results for the last four quarters. Results shown in red represent where UMR missed the agreed upon metric.

Measure	Guarantee	FY 2025			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Accuracy	**99.40%**	98.68%	99.99%	99.56%	99.20%
Overall Accuracy	**98.00%**	98.00%	99.00%	99.00%	97.00%
Claim Turnaround Time	**92% in 14 Days**	94.20%	95.60%	93.10%	92.60%
	99% in 30 Days	99.00%	99.30%	97.50%	98.10%

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR's administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and UMR. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between UMR and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by UMR was incurred.

ANNUAL OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates UMR's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed UMR's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

Findings

We observed the following from UMR's response to the operational review questionnaire:

- UMR was audited by Baker Tilly for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2024 to December 31, 2024. A bridge letter dated July 7, 2025 was also provided noting no material changes were made to internal controls.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- UMR stated it did not require an additional review and approval before issuing large claim checks over a pre-determined amount.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR used ClearHealth grouper software to perform prepayment Diagnostic Related Grouping (DRG) verification. It also used Optum Credit Balance Recovery for post-payment DRG validation.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than the total allowable amount. UMR did not provide a report on COB savings for the PEBP plans for FY2025.
- UMR reported 94.4% of claims were received electronically during the audit period and 75.05% of claims received were auto adjudicated.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. UMR reported it used vendors to perform overpayment recovery. No fee was charged back to PEBP for recoveries from Optum Payment Recovery Services. Optum also pursued credit balance recoveries and a 20% fee was charged back to PEBP for those recoveries. An overpayment adjustment report was provided to CTI for FY2025 showed $1,032,929 overpayments identified for adjustment.
- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR provided a member appeal tracking report to CTI for FY2025. It showed 260 appeals received; 175 appeals had the original determination upheld, 81 were overturned, one was partially overturned, and five were pending at the time of reporting. Twenty-two appeals took more than 20 days to resolve.
- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations.

- We screened 100% of non-facility claims against the Office of the Inspector General's List of Excluded Individuals and Entities (OIG's LEIE) and identified the following sanctioned provider who received payment from the UMR during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1669412243	20181120	20250416	1128a1	CONNER,BYRON,MD	1	$5,014	$4,764	$4,458
				Totals	**1**	**$5,014**	**$4,764**	**$4,458**

- UMR reported it received 99.1% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Cancer Resource Programs and Centers of Excellence.
- PEBP's members under age 65 had utilization of network or secondary network providers at 96.6% of all allowed charges and 95.6% of all claims.

Total of All Claims for Members Under Age 65		
Claim Type	**Provider Discount**	
Ancillary	$2,742,783.09	46.9%
Non-Facility	$48,534,647.12	55.9%
Facility Inpatient	$38,174,447.36	69.6%
Facility Outpatient	$63,445,601.17	67.5%
Total	**$152,897,478.74**	**63.3%**

- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 25 appeals, and 12 inquiries received for allowances made for out-of-network services. Twelve appeals were overturned and 13 were upheld.
- All new employees were required to complete HIPAA training, and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q4 FY2025 as well as annual metrics follow.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	96.2%	Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	91.6%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.6%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	96.8%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.7% 99.6%	Met Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	98.1%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	96.55%	Met
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	4.375	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			

	Metric	Service Objective	Actual	Met/ Not Met
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representatives will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	3.50		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of receipt of eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution – within 10 Business Days**	100%	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No new subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not stored on a designated server.	100% 30 Business Days	No issues	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.5%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	98.48%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within 10 business days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No new subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No Issues	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	99.99%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within 10 calendar days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	100%	Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	99.96%	Met
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to provider using approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	99.92%	Met
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	97.09%	Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	100%	Met
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	100%	Met
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No issues	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and UMR should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review
- Case and disease management

Methodology

We used ESAS to analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched UMR's administration.

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following pages were copied directly from UMR's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

For each potential error, we sent an ESAS Questionnaire with an identification number (QID) to UMR for written response. After reviewing the response and any additional information provided, CTI confirmed the potential for process improvement.

Manually adjudicated claims were processed by an individual claim processor. Auto-adjudicated claims were paid by the system with no manual intervention.

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
1	$23,609.66	Agree. Sample claim xxxxxxx6917 is a duplicate to xxxxxxx0552. This claim will be adjusted at the completion of the audit.	Procedural deficiencies and overpayments remain. UMR paid a duplicate charge.	☐ M ☒ S
2	$66.11	Agree. sample claim xxxxxxx0003 is a duplicate to xxxxxxx3414. This claim will be adjusted at the completion of the audit.		☒ M ☐ S
3	$1,125.71	Agree. Sample claim xxxxxxx1591 is a duplicate to xxxxxxx0842. This claim will be adjusted at the completion of the audit.		☒ M ☐ S
4	$48.00	Agree. Sample claim xxxxxxxx3592 is a duplicate to xxxxxxx1483. Claim xxxxxxxx3592 was adjusted and reimbursement was received from the provider on 7-2-2025.		☒ M ☐ S
5	$98.25	Agree. Sample claim xxxxxxxx9945 is a duplicate to xxxxxxxx9962. This claim will be adjusted at the completion of the audit.		☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
7	$95.00	Agree. There was a second payment made in error. This claim will be adjusted at the completion of the audit and results in a $95.00 overpayment.		☒ M ☐ S
Preventive Services				
Deductible Applied				
14	($146.55)	Agree. These services are allowed at 100% per the plan benefit.	Procedural deficiency and underpayment remain. The preventive service was applied to the deductible in error.	☒ M ☐ S
Service Not Medically Necessary				
42	$1,169.28	Agree. Medical records were reviewed but did not support the medical necessity of this claim.	Procedural deficiency and underpayment remain. Services were reviewed and determined to be not medically necessary by UMR's clinical coordinator. The claim should have been denied as not medically necessary.	☒ M ☐ S
Plan Exclusions				
Experimental/Investigational				
46	$494.00	Agree. There is no authorization on file. The claims will be adjusted at the completion of the audit.	Procedural deficiencies and overpayments remain. Experimental services require prior authorization to be eligible for coverage.	☒ M ☐ S
47	$653.12			☒ M ☐ S
Dental Paid Under Medical				
44	$79.50	Agree. Services should have been processed under member's dental plan, not medical plan. This results in a $79.50 overpayment. Claim has now processed under dental benefit on 7/22/25.	Procedural deficiency and overpayment remain. This is a three-surface resin (D2332) and should have been covered under the dental plan but was paid under medical.	☒ M ☐ S
Biofeedback				
48	$60.00	Agree. Code 90901 is not a covered service and was allowed in error. An adjustment will be done at the completion of the audit.	Procedural deficiency and overpayment remain. Biofeedback is excluded by the plan.	☒ M ☐ S
Incorrect Preferred Provider Discount Applied				
30	$8,919.60	Agree. Incorrect allowed amount was applied to this claim. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Provider discount was not applied to the claim in error.	☒ M ☐ S
34	$257.11	Agree. Original manual pricing by MRU was ASP $2.68 – 20% = $2.144 x 6 units = $12.86. UMR received a corrected claim with additional units and adjusted without updated pricing. Due to the error on no updated repricing this claim is overpaid $257.11. The claim was adjusted on 7/31/2025.	Procedural deficiency and overpayment remain. Correct provider discount pricing was not used on the claim.	☒ M ☐ S
35	$6,088.00	Agree. An incorrect allowable was used to process J0585. This claim was adjusted on 9/2/25 and resulted in a $6,088.00 overpayment.	Procedural deficiency and overpayment remain. Correct provider discount pricing was not applied to the claim.	☒ M ☐ S
40	14,006.61	Agree. Medicare pricing should have applied to claim. An incorrect allowable	Procedural deficiency and overpayment remain. The claim should have been priced at Medicare allowable and was paid at billed	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		was used to process. An adjustment will be done at the completion of this audit.	charges in error. The allowable of $235.93 should have paid 80% = $188.74.	
Copay Application				
Office Visit				
25	$30.00	Agree. Claim should have applied a copay. Claim adjusted on 9/22/25 and resulted in a $30.00 overpayment.	Procedural deficiency and overpayment remain. The copay was not applied in error.	☐ M ☒ S

Annual Eligibility Verification

CTI electronically compared dates of service for FY2025 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for its review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$161,329
Payments Prior to Effective Date	$285
Payments During Gaps in Coverage	$4,368
After Termination Date of Employee's Coverage	$51,774
Subtotal	$217,757
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$572,448
Payments Prior to Effective Date	$1,768,000
Payments During Gaps in Coverage	$2,705
After Termination Date of Employee's Coverage	$29,912
Subtotal	$2,373,064
COMBINED TOTAL*	**$2,590,821**

**CTI notes that 0.93% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are above normal compared to the less than 0.5% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information UMR had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $1,385,347.37. The claims sampled and reviewed revealed $651.13 in underpayments and $18,349.27 in overpayments. This reflects a weighted Financial Accuracy rate of 99.20% over the stratified sample. This is a decrease in performance from the prior period. Details are provided on the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q4 FY2025 of 99.40% for this measure. The penalty owed for this Performance Guarantee is 1.5% of the administrative fees of $1,404,474.33 or $21,067.12.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 6 incorrectly paid claim and 194 correctly paid claims. This is a decrease in performance from the prior period. Detail is provided on the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	3	3	97.00%

Overall Accuracy

CTI defines Overall Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Performance declined from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q4 FY2025 of 98.0% for this measure and a penalty is owed. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,404,474.33 or $14,040.74. Detail is provided on the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
194	0	6	97.00%

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount				
1040	$145.50	Agree. This claim was manually priced and J7030 was priced incorrectly. Allowed billed charges and should be $2.50. This results in a $145.50 overpayment.	Procedural error and overpayment remain. Procedure code J7030 was priced incorrectly.	☒ M ☐ S
1045	$6,366.77	Agree. Claim manually priced incorrectly. This results in a $6366.77 overpayment.	Procedural error and overpayment remain. Incorrect provider discount applied.	☒ M ☐ S
1046	($43.50)	Agree. Incorrect pricing was used resulting in a payment error. Lessor of 125% 2024 NV Medicare or 60% billed charges.	Procedural error and underpayment remain. Incorrect provider discount applied.	☒ M ☐ S
1095	($431.99)	Agree. Incorrect allowable used to process claim. Results in $431.99 underpayment. The claim was adjusted on 8/26/25.	Procedural error and underpayment remain. An incorrect provider discount applied.	☒ M ☐ S
Paid Ineligible Procedure				
1092	$11,837.00	Agree. Prior authorization is not on file for this service and should have been denied. This results in a $11,837.00 overpayment and the claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. Claim was not eligible for benefits, procedure code 0211U was not authorized and should have been denied.	☒ M ☐ S
Coinsurance Error				
1096	($175.64)	Agree. The coinsurance should be $0.00 for the outpatient surgery related services. This results in $175.64 underpayment. An adjustment will be done at the completion	Procedural error and underpayment remain. The coinsurance applied should have been $0.00 for outpatient surgery related services and it was $175.64.	☒ M ☐ S

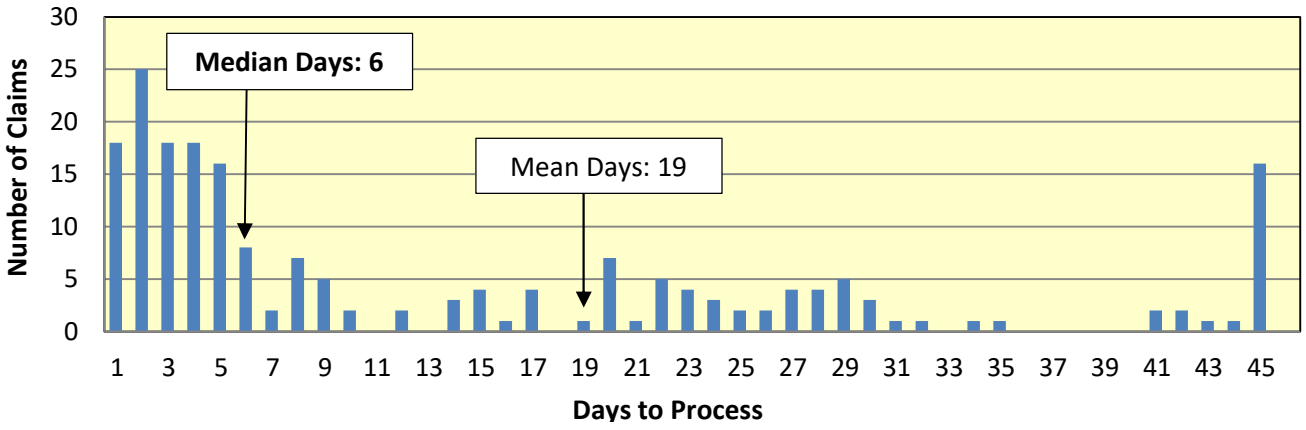
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		of this audit.		

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR did meet the Performance Guarantee for PEBP in Q4 FY2025 of 92% processed within 14 days but did not meet 99% processed within 30 days. This performance decreased from the prior period. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,404,474.33 or $14,040.74.

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Audit Number	Observation
2041	Page 14 of the dental MPD states *If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance*. UMR states its system logic does not support combining a temporary and permanent appliance and allows these codes individually. PEBP should ensure this procedure meets the intent of the plan, and if so, consider updating the plan language.

FY2025 REVIEW AND RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY2025 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2025 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.

CONCLUSION

UMR did not meet the performance metrics for financial accuracy, overall accuracy and claim turnaround in the fourth quarter of FY2025. A penalty of $49,149.60, or 3.5% of the administration fees for the quarter, is owed.

We consider it a privilege to have worked for, and with, the PEBP staff and its administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report appears on the following page.

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES INCORPORATED
100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

September 24, 2025

[redacted]

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y25 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 1 – Medical claim [redacted]6917 is a duplicate to claim [redacted]0552. This claim will be adjusted at the completion of the audit and results in a $23,609.66.

QID 2 – Medical claim [redacted]0003 is a duplicate to claim [redacted]3414. This claim will be adjusted at the completion of the audit and results in a $66.11 overpayment.

QID 3 – Medical claim [redacted]1591 is a duplicate to claim [redacted]0842. This claim will be adjusted at the completion of the audit and results in a $1125.71 overpayment.

QID 4 – Dental claim UMR agrees sample claim [redacted]3592 is a duplicate to claim [redacted]1483. Claim [redacted]3592 was adjusted and reimbursement was received from the provider on 7-2-2025.

QID 5 – Medical claim [redacted]9945 is a duplicate claim to [redacted]9962. This claim will be adjusted at the completion of the audit and results in a $98.25 overpayment.

QID 7 – After further review, UMR agrees there was a second payment made in error. This claim will be adjusted at the completion fo the audit and results in a $95.00 overpayment.

Preventive Services – Deductible Applied

QID 14 – UMR agrees with this finding. These services should be allowed at 100% per the plan benefit. This claim will be adjusted at the completion of the audit and results in a $146.55 overpayment.

Service Not Medically Necessary

QID 42 - UMR agrees with this finding. The review of medical records did not support these services, and payment should not have been made. This claim will be adjusted at the completion of the audit and results in a $1169.28 overpayment.

Plan Exclusions – Experimental/Investigational

QID 46 – UMR agrees with this finding. Authorization for services is not on file. The Customer First Representative should have denied this claim. This claim will be adjusted at the completion of the audit and results in a $494.00 overpayment.

715-841-7262 www.UMR.com [redacted]@UMR.com

QID 47 – UMR agrees with this finding. This claim was allowed in error and should have denied as excluded on the plan – Experimental/Investigational. The claim will be adjusted at the completion of the audit and results in a $653.12 overpayment.

Plan Exclusions – Dental paid Under Medical

QID 44 – After further review, UMR agrees with this finding. These services should have been processed under the members' dental plan, not the medical plan. This results in a $79.50 overpayment. This claim has now been processed under the dental benefit on 7-22-225.

Plan Exclusions – Biofeedback

QID 48 – UMR agrees with this finding. Biofeedback is excluded by this plan. The services should have been denied. This claim will be adjusted at the completion of the audit and results in a $60.00 overpayment.

Incorrect Preferred Provider Discount Applied

QID 30 – UMR agrees with this finding. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $8919.60 overpayment.
QID 34 – UMR agrees with this finding. An incorrect allowable amount applied to this corrected claim. This claim was adjusted on 7-31-2025 and resulted in a $257.11 overpayment.
QID 35 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim was adjusted on 9-2-2025 and resulted in a $6,088.00 overpayment.
QID 40 - UMR agrees with this error. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $14,006.61 overpayment.

Copay Application - Office Visit

QID 25 – UMR agrees with this finding. Office visit copay should apply to this claim. This claim was adjusted on 9-22-2025 and resulted in a $30.00 overpayment.

Random Sample Findings

PPO Discount

Sample 1033 – UMR disagrees with this finding. There was no change in the contracted rate and no additional payment made on 1/30/2025. This claim is processed correctly.
Sample 1040 - UMR agrees with this finding. An incorrect allowable amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $145.50 overpayment.
Sample 1044 – UMR disagrees with this finding. This claim is repriced correctly per the contract. Additional pricing breakdown of the allowed and payment were provided to CTI. The allowed amount of $13,529.90 is correct for this claim.
Sample 1045 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $6366.77 overpayment.
Sample 1046 – UMR agrees with this error. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $43.50 underpayment.
Sample 1072 – UMR disagrees with this finding. Both sample 1072 and 1073 allowable amount are correct. Sample 1072 pricing is based on a percentage of billed charges as outlined in the Other Medical Services Rate. Sample 1073 pricing is based on a percentage of billed charges as outlined in the Transplant Period Case Rate.
Sample 1095 – UMR agrees with this finding. An incorrect allowed amount applied to this claim. This claim will be adjusted at the completion of the audit and results in a $431.99 underpayment.

Paid Ineligible Procedure

Sample 1092 – UMR agrees with this finding. Authorization for services is not on file. The Customer First Representative should have denied this claim. This claim will be adjusted at the completion of the audit and results in a $11,837.00 overpayment.

Coinsurance Error

Sample 1096 – UMR agrees with this finding. Incorrect coinsurance applied to this outpatient surgery claim. This claim will be adjusted at the completion of the audit and results in a 4175.64 underpayment.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.
If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

[redacted]
Sr. UMR External Audit Coordinator

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

9.

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for Willis Towers Watson for the period of July 1, 2024, through June 30, 2025. (Joni Amato, CTI) (**For Possible Action**)

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan

Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2024 through June 30, 2025
Plan Year 2025

Presented to

State of Nevada Public Employees' Benefits Program

November 20, 2025

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of Via Benefits from Willis Towers Watson's administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2024 through June 30, 2025 (plan year 2025). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$19,357,954
Total Number of Claims Paid/Denied/Adjusted	180,185

The audit included the following components which are described in more detail in the following pages.

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in CTI's opinion:

1. Via Benefits provided good service to PEBP members by exceeding its performance guarantee for all four quarters for the Customer Satisfaction Quarterly Review goal, despite missing the annual Customer Service Abandonment Rate and Average Speed of Answer performance goals for FY 2025 Q2 and Q4.
2. Based on the random sample findings, CTI recommends the following areas for improvement:
    - Provide claim processors with coaching on the errors identified during the audit, with focus on verification of claim amounts, claimant, and service dates.
    - Clarification and consistent application of the banking procedures for claim payments.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met two of three annual metrics for PEBP in plan year 2025. The metric for Claim Processing Payment Precision was not met, and a penalty is owed.

FY 2024 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Met – 99.09%	$0
Claim Processing Payment Precision	98%	Not Met – 97.50%	$10,000
Claim Processing Turnaround Time	Average 2 business days	Met – 0.44 days	$0
		Total Penalty	$10,000

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of Via Benefits' administration of the PEBP's Medicare HRA plan. We provide this report to PEBP, the plan sponsor, and Via Benefits, the claim administrator. A copy of Via Benefits' response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and Via Benefits. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between Via Benefits and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Via Benefits used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of Via Benefits' claim administration were to determine whether:

- Via Benefits followed the terms of its contract with PEBP;
- Via Benefits paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible for PEBP's benefits at the time a service paid by Via Benefits was incurred.

OPERATIONAL REVIEW

Objectives

CTI's Operational Review evaluated Via Benefits' claim system, staffing, and procedures related to administration including enrollment, customer service, and overpayment recovery. It was also used to verify compliance with contract terms and in support of our Random Sample Audit activities.

Scope

The scope of our review included:

1. Claim administrator information:
    - Insurance and bonding
    - Conflicts of interest
    - Performance standards
    - Business continuity planning
    - System software
    - Offsite claim administration
2. Claim funding:
    - Claim funding mechanism
    - Check processing and security
3. Claim adjudication, customer service, and eligibility maintenance procedures:
    - Contributions and rollovers
    - Claim processing
    - Customer service call and inquiry handling
    - Overpayment and adjustments
    - System security
4. Privacy and security compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Via Benefits. We reviewed Via Benefits' responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the PEBP's HRA plan. This allowed us to conduct the audit more effectively.

Findings

We observed the following from Via Benefits' response to the operational review questionnaire:

- Via Benefits indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- Willis Towers Watson (WTW), parent company of Via Benefits, reported it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report.

- The business continuity plan provided by Via Benefits included two approaches to data protection: 1) continuous offsite replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions, member services, or provider services were outsourced. All claim processing was handled by a dedicated team of claim processors.
- Refunds and returned checks were forwarded to PEBP for deposit into PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount for which participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits indicated loss of HRA eligibility was the biggest reason for a claim overpayment; and the biggest reason for loss of eligibility was a late notification of death status.
- Via Benefits provided an overpayment report for FY2025 showing $240,047.64 in overpayments on 1,020 transactions. Via Benefits recovered $1,368.54 of the overpaid amounts.
- Customer service operations were available via phone Monday through Friday from 8:00 AM to 7:00 PM EST, excluding holidays.
- The online portal allowed members to submit claims, check claim status, check participant balance, support documents submittal, and view historical information.
- Via Benefits communicated with account holders via mail or email. It provided digital newsletters approximately every two months, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties for system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' Acclaim System Controls document provided a thorough overview including detail on data entry logic, duplicate logic, processing thresholds for processor levels and overpayment logic as examples.
- Web-based security and compliance training was provided to Via Benefits staff within 90 days after hire and then annually thereafter.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

Performance Guarantee Validation

As part of CTI's audit of PEBP, we reviewed the Performance Guarantees included in its contract with Via Benefits. The self-reported results for plan year 2025 follow.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	All reports delivered within 15 days	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.72%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	6.43%	Not Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to:		
Ninety seconds in Q1 PY 2025	Q1 PY 2025 – 1:28	Met
Five minutes in Q2 PY 2025	Q2 PY 2025 – 11:41	Not Met
Two minutes in Q3 PY 2025	Q3 PY 2025 – 1:35	Met
Ninety seconds in Q4 PY 2025	Q4 PY 2025 – 0:06	Met
Customer Satisfaction Quarterly Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2025 – 88.21% Q2 PY 2025 – 81.32% Q3 PY 2025 – 91.70% Q4 PY 2025 – 90.91%	Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	100%	Met
Unauthorize Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 day notification.	100%	Met

RANDOM SAMPLE AUDIT

Objective

The objective of the Random Sample Audit was to identify any administrative process deficiencies in PEBP's health reimbursement arrangement claims.

Scope

The Random Sample Audit included a random sample of 200 HRA claims paid or denied during the audit period. Via Benefits' performance was measured for the following key performance categories:

- Claim Financial Precision
- Claim Processing Payment Precision

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

The Random Sample Audit was conducted remotely at CTI's Des Moines, Iowa office. A CTI auditor reviewed each sample claim selected to determine if it was paid or processed correctly based on member eligibility or plan provisions as defined in the plan documents or amendments.

CTI cited errors when a sampled claim was determined to have been paid or processed incorrectly. Payment errors were observed based on how the selected claim was paid and the information Via Benefits had at the time the transaction was processed.

Findings

CTI defines claim financial precision as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample. Claim processing payment precision is defined as the total number of payments made correctly without a payment or nonpayment error compared to the total number of payments issued. The sampled claims were selected from the PEBP HRA claims processed during the 2025 plan year.

Via Benefits met the performance guarantees for claim financial precision and claim turnaround time, they did not meet the guarantee for claim processing payment precision.

Note: A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$23,044.12	5	$209.96	99.09%
Claim Processing Payment Precision	200		5		97.50%
Claim Turnaround Time	Average 2 business days				0.44 days

Random Sample Findings Detail Report			
Audit Number	**Over/ (Under) Paid**	**Via Benefits Response**	**CTI's Conclusion**
Incorrect Claim Amount			
1123	$3.32	Agree.	Procedural errors and overpayments remain. Incorrect premium amounts were entered.
1189	$4.00		
Unknown Claimant Paid			
1178	$202.64	Disagree. The processor inferred the participant's name with the indications provided including *Participant Only* and *PEBP dental* and *Spouse Not Coverage*. Spouse and dependent coverage are not covered. Although the name is not explicitly mentioned, we were able to later confirm claim was approved appropriately based on previous claim submissions. Reference Claim number XXXXX8265.	Procedural error and overpayment remain. The original claim submission did not include information needed to identify the claimant and should have been pended or denied until the claimant was verified.
Procedural Errors – Incorrect Date of Service			
1074	NA	Agree.	Procedural errors remain. The incorrect dates were used on the reimbursement.
1079			

Additional Observations

During the Random Sample Audit, CTI's auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Audit Number	Observation
1021	The sampled claim was paid via check and was handled correctly. CTI noted other claims processed before and after the sample claim in the member's history were suspended stating *Bank Account Required*. Via Benefits stated PEBP required ACH only beginning 9/1/25; this procedure caused claim submissions prior to 9/1/25 that were pended for funds to continue to pend for bank account information once funds became available.
1175, 1185	Via Benefits' protocol was to process claims as one payment for multiple receipts. Best practice would be to separate individual claims to allow for identification and prevention of potential duplicate payments. In the samples cited, multiple receipts were combined into one claim.

ELIGIBILITY VERIFICATION

CTI electronically compared dates of service to PEBP's electronic eligibility file received from TELUS Health. CTI's screening revealed some services were paid during the audit period for potentially ineligible claimants. The results were provided to TELUS Health for its review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Claim Lines	Members	Paid Amount*
Member Not on File	372	34	$51,994
Incurred After Member Benefit End Date	178	62	$24,595
Incurred Prior to Member Benefit Begin Date	18	6	1,999
TOTALS	**568**	**102**	**$78,588**

**CTI notes that 0.41% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 0.5% CTI generally reports.*

PLAN YEAR 2025 RECOMMENDATIONS

Based on the findings of the Plan year 2025 audit, CTI recommends:

1. Via Benefits coach its claims processors on errors and additional observations identified during the audit including:
    - Incorrect claim amounts entered creating overpayments
    - Verification of claimant prior to issuing payment
    - Verification of claim dates of service
    - Clarification and consistent application of the ACH banking requirements
2. PEBP ensures receipt of penalty payments for missed performance guarantees for:
    - Claim Processing Payment Precision
    - Customer Service Abandonment Rate
    - Customer Service Average Speed of Answer
3. PEBP and TELUS review eligibility screening results for potential workflow improvements to reduce payments made for ineligible members.

CONCLUSION

Via Benefits met the performance metrics for claim financial precision and claim turnaround time for FY2025 and did not meet the metric for claim processing payment precision and a $10,000 penalty is owed.

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO INITIAL REPORT

Additional information submitted to CTI from the administrator in response to the initial report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the initial report.

wtw

October 23, 2025

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2024-June 2025 please see our response to the report and the auditors recommendations below:

Observation:

Audit Number 1021:

Effective September 1st, 2025, Nevada PEBP implemented a direct deposit account requirement for participants to receive reimbursements from their HRA. Due to this update any existing claims in a pended or held status indicate a direct deposit account is required to issue the reimbursement.

Audit Number 1175 & 1185:

Below is our logic and rules on why we combined the claim into one claim line instead of multiple lines:

The term, "Clubbing," refers to combining multiple expense amounts and/or dates of service found on supporting documentation and entering them into one claim line instead of several individual claim lines in CPI.

Required Information:

In order to "Club," expenses, the requirements below must be met. Eligible Health Care Expenses that are on the same document (EOB, receipt, statement, or invoice) and meet the criteria below, must be clubbed into one claim line entry if applicable.

Expenses must be for the same person (participant or dependent)

- Expenses must be on the same document (Please note that multiple individual strips or receipts that are put on one piece of paper should not be clubbed)
- Expenses must be for the same provider
- Expenses must be for same Category/Claim Type
- Expenses must be for the same calendar year

Guidance:

Common documentation that can be used to club expenses:

- Prescriptions

- Cash register receipts (Meaning all eligible items contained in one receipt should be clubbed including tax on those items if applicable)
- Ledgers from the pharmacy

- Dental Expenses
  - Invoice
  - Statement
  - Ledger
  - EOB
- Medical Expenses
  - EOB
  - Invoice
  - Statement
  - Ledger

Claim Entry Instructions:

- If there are multiple years on the same document, do not enter a line that crosses plan years when clubbing.
  - Processor must enter a clubbed line for expenses within the same year.
    - For example, if the ledger has dates from 2023 and 2024 – processor would club all expenses for 2023 and enter into one claim line and then enter a second line for expenses from 2024.
- If the required information listed above is not met, do not club the lines. Enter the Health Care Expenses on individual claim lines per claim processing guidelines.

Recommendations:

Based on the findings of the Plan year 2025 audit, CTI recommends:

1. Via Benefits coach its claims processors on errors and additional observations identified during
the audit including:
   - Incorrect claim amounts entered creating overpayments
   - Verification of claimant prior to issuing payment
   - Verification of claim dates of service
   - Clarification and consistent application of the ACH banking requirements
2. PEBP ensures receipt of penalty payments for missed performance guarantees for:
   - Claim Processing Payment Precision
   - Customer Service Abandonment Rate
   - Customer Service Average Speed of Answer
3. PEBP and TELUS review eligibility screening results for potential workflow improvements to reduce payments made for ineligible members.

WTW Response:

1. WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.
2. WTW will pay Nevada PEBP for the following missed performance guarantees as soon as administratively possible once the report is provided to the Nevada PEBP Board of Directors.

Performance Guarantee	Metric	Result	Penalty
Claim Processing Payment Precision	98% or Greater	97.5%	$10,000
Customer Service Abandonment Rate	5% or Less	6.43%	$7,500
Customer Service Average Speed of Answer	Ninety seconds in Q1 PY 2025 Five minutes in Q2 PY 2025 Two minutes in Q3 PY 2025 Ninety seconds in Q4 PY 2025	Q1 PY 2025 – 1:28 Q2 PY 2025 – 11:41 Q3 PY 2025 – 1:35 Q4 PY 2025 – 0:06	$2,000 Per Missed Quarter. Note: Only Q2 PY 2025 was missed.
Total:			**$19,500**

3. WTW is currently working with TELUS Health to identify participants who had incorrect data loaded to their accounts, which cause participants to lose their HRA qualification and place their account into overpayment. Nevada PEBP is aware of the incorrect data that was sent to WTW and that WTW and TELUS are working together to identify impacted participants and ensure correct data is received to update the accounts. WTW will continue to work with TELUS and Nevada PEBP on identifying solutions for data corrections.

In conclusion this audit has provided valuable insights. We are confident the recommendations outlined in this report will contribute to the continued success of service to the participants. We appreciate the cooperation demonstrated by Claim Technologies Incorporated on behalf of the State of Nevada Public Employees' Benefits Program. We look forward to our continued partnership.

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

10.

10. Q4 Sierra Healthcare Options – Utilization and Large Case Management. (Joan Operario and Kelly Hall, UnitedHealthcare) (Information/Discussion)

Executive Summary

Metrics	Apr-25	May-25	Jun-25	Average
Enrollment	52,395	52,407	52,288	**52,363**

Inpatient All - LTACH, AIR, SNF, and OOA

Month	Apr-25	May-25	Jun-25	Total	Average
Total Discharges	188	204	161	**553**	**184**
Total Discharges LOS	844	841	845	**2,530**	**843**
Average LOS	4.5	4.1	5.2	**4.6**	**4.6**

Out of Area, Hopital Rehabilitation and Skilled Nursing are excluded from this calculation.

Inpatient Hospital Acute Only

Month	Apr-25	May-25	Jun-25	Total	Average
Total Discharges	145	153	115	**413**	**138**
Total Discharges LOS	650	532	596	**1,778**	**593**
Average LOS	4.5	3.5	5.2	**4.3**	**4.3**

Beddays by Facility Type

Metrics				Beddays	
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	652	567	632	**1,851**	**617**
Hospital Rehabilitation	0	0	10	**10**	**10**
Skilled Nursing	0	39	14	**53**	**27**
Out of Area	195	270	270	**735**	**245**

Metrics				Beddays per K
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**
Hospital	149.3	129.8	145.0	**141.4**
Hospital Rehabilitation	0.0	0.0	2.3	**0.8**
Skilled Nursing	0.0	8.9	3.2	**4.0**
Out of Area	44.7	61.8	62.0	**56.1**

Admits by Facility Type

Metrics				Admits	
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	155	146	118	**419**	**140**
Hospital Rehabilitation	0	0	1	**1**	**1**
Skilled Nursing	0	1	1	**2**	**1**
Out of Area	43	47	44	**134**	**45**

Metrics				Admits per K
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**
Hospital	35.5	33.4	27.1	**32.0**
Hospital Rehabilitation	0.0	0.0	0.2	**0.1**

Executive Summary

Metrics	Admits per K			
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**
Skilled Nursing	0.0	0.2	0.2	**0.2**
Out of Area	9.8	10.8	10.1	**10.2**

Readmits by Facility Type

Metrics	Readmits				
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	16	17	6	**39**	**13**
Hospital Rehabilitation	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	**0**	**0**
All Other	3	2	2	**7**	**2**

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	**Apr-25**	**May-25**	**Jun-25**	**Total**
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0.0	0.0	9.0	**9.0**
	CARSON TAHOE REGIONAL MEDICAL CENTER	2.4	3.9	3.9	**3.3**
	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	2.2	3.6	6.1	**4.0**
	HENDERSON HOSPITAL	4.7	3.0	0.0	**3.8**
	LAS VEGAS VAMC	0.0	2.0	0.0	**2.0**
	MOUNTAIN VIEW HOSPITAL	2.4	2.3	2.5	**2.4**
	NORTH VISTA HOSPITAL	1.0	0.0	0.0	**1.0**
	RENOWN REGIONAL MEDICAL CENTER	5.2	3.2	5.0	**4.5**
	SOUTHERN HILLS HOSPITAL	5.3	1.6	2.5	**2.6**
	SPRING VALLEY HOSPITAL	0.0	0.0	0.0	**0.0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	6.0	0.0	7.0	**4.3**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	4.8	3.2	6.9	**4.8**
	SUMMERLIN HOSPITAL MEDICAL CTR	3.9	4.7	2.9	**3.9**
	SUNRISE HOSPITAL	13.0	6.0	8.9	**9.0**
	UNIVERSITY MEDICAL CENTER SO NV	4.7	3.3	2.9	**3.5**
	VALLEY HOSPITAL MEDICAL CTR	3.0	4.5	3.0	**3.6**
	Total	**4.5**	**3.5**	**5.2**	**4.3**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0.0	0.0	10.0	**10.0**
	KINDRED HOSPITAL W SAHARA	0.0	0.0	0.0	**0.0**
	Total	**0.0**	**0.0**	**5.0**	**5.0**
Skilled Nursing	HARMON HOSPITAL	0.0	0.0	14.0	**14.0**
	SANDSTONE SPRING VALLEY LLC	0.0	0.0	0.0	**0.0**
	WELBROOK CENTENNIAL HILLS	0.0	0.0	0.0	**39.0**
	Total	**0.0**	**39.0**	**7.0**	**17.7**

Executive Summary

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	Apr-25	May-25	Jun-25	Total
Out of Area	Out of Area	4.5	5.4	5.4	**5.1**
	Total	**4.5**	**5.4**	**5.4**	**5.1**

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0	0	27	**27**	**27**
	CARSON TAHOE REGIONAL MEDICAL CENTER	73	95	106	**274**	**91**
	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	13	40	43	**96**	**32**
	HENDERSON HOSPITAL	14	15	1	**30**	**10**
	LAS VEGAS VAMC	0	2	0	**2**	**2**
	MOUNTAIN VIEW HOSPITAL	12	18	9	**39**	**13**
	NORTH VISTA HOSPITAL	1	0	0	**1**	**1**
	RENOWN REGIONAL MEDICAL CENTER	307	185	161	**653**	**218**
	SOUTHERN HILLS HOSPITAL	21	16	15	**52**	**17**
	SPRING VALLEY HOSPITAL	0	0	38	**38**	**38**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	6	0	7	**13**	**7**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	54	45	76	**175**	**58**
	SUMMERLIN HOSPITAL MEDICAL CTR	39	61	32	**132**	**44**
	SUNRISE HOSPITAL	78	48	94	**220**	**73**
	UNIVERSITY MEDICAL CENTER SO NV	28	33	20	**81**	**27**
	VALLEY HOSPITAL MEDICAL CTR	6	9	3	**18**	**6**
	Total	**652**	**567**	**632**	**1,851**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	10	**10**	**10**
	KINDRED HOSPITAL W SAHARA	0	0	0	**0**	**0**
	Total	**0**	**0**	**10**	**10**	**0**
Skilled Nursing	HARMON HOSPITAL	0	0	14	**14**	**14**
	SANDSTONE SPRING VALLEY LLC	0	0	0	**0**	**0**
	WELBROOK CENTENNIAL HILLS	0	39	0	**39**	**39**
	Total	**0**	**39**	**14**	**53**	**0**
Out of Area	Out of Area	195	270	270	**735**	**245**
	Total	**195**	**270**	**270**	**735**	**0**

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0	0	4	**4**	**4**

Executive Summary

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	26	29	25	**80**	**27**
	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	6	12	6	**24**	**8**
	HENDERSON HOSPITAL	3	5	1	**9**	**3**
	LAS VEGAS VAMC	0	1	0	**1**	**1**
	MOUNTAIN VIEW HOSPITAL	5	6	3	**14**	**5**
	NORTH VISTA HOSPITAL	1	0	0	**1**	**1**
	RENOWN REGIONAL MEDICAL CENTER	63	42	33	**138**	**46**
	SOUTHERN HILLS HOSPITAL	8	6	6	**20**	**7**
	SPRING VALLEY HOSPITAL	0	0	2	**2**	**2**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2	0	2	**4**	**1**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	13	12	13	**38**	**13**
	SUMMERLIN HOSPITAL MEDICAL CTR	11	13	9	**33**	**11**
	SUNRISE HOSPITAL	9	8	7	**24**	**8**
	UNIVERSITY MEDICAL CENTER SO NV	6	10	6	**22**	**7**
	VALLEY HOSPITAL MEDICAL CTR	2	2	1	**5**	**2**
	Total	**155**	**146**	**118**	**419**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	1	**1**	**1**
	KINDRED HOSPITAL W SAHARA	0	0	0	**0**	**0**
	Total	**0**	**0**	**1**	**1**	**0**
Skilled Nursing	HARMON HOSPITAL	0	0	1	**1**	**1**
	SANDSTONE SPRING VALLEY LLC	0	0	0	**0**	**0**
	WELBROOK CENTENNIAL HILLS	0	1	0	**1**	**1**
	Total	**0**	**1**	**1**	**2**	**0**
Out of Area	Out of Area	43	47	44	**134**	**45**
	Total	**43**	**47**	**44**	**134**	**0**

Readmits by Facility

Facility Type	Metrics	Readmits				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0	0	0	**0**	**0**
	CARSON TAHOE REGIONAL MEDICAL CENTER	2	5	1	**8**	**3**
	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0	0	0	**0**	**0**
	HENDERSON HOSPITAL	0	0	0	**0**	**0**
	LAS VEGAS VAMC	0	0	0	**0**	**0**
	MOUNTAIN VIEW HOSPITAL	0	0	0	**0**	**0**
	NORTH VISTA HOSPITAL	0	0	0	**0**	**0**

Executive Summary

Facility Type	Readmits by Facility					
	Metrics	Readmits				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	RENOWN REGIONAL MEDICAL CENTER	9	5	1	**15**	**5**
	SOUTHERN HILLS HOSPITAL	1	1	0	**2**	**1**
	SPRING VALLEY HOSPITAL	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	2	3	3	**8**	**3**
	SUMMERLIN HOSPITAL MEDICAL CTR	2	3	0	**5**	**2**
	SUNRISE HOSPITAL	0	0	0	**0**	**0**
	UNIVERSITY MEDICAL CENTER SO NV	0	0	1	**1**	**0**
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	**0**	**0**
	Total	**16**	**17**	**6**	**39**	**0**
Out of Area	Out of Area	3	2	2	**7**	**2**
	Total	**3**	**2**	**2**	**7**	**0**

Facility Type	Readmits by Facility					
	Metrics	Readmit Rate				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	CARSON TAHOE REGIONAL MEDICAL CENTER	7.7%	17.2%	4.0%	**10.0%**	**10.0%**
	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	HENDERSON HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	LAS VEGAS VAMC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	MOUNTAIN VIEW HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	14.3%	11.9%	3.0%	**10.9%**	**10.9%**
	SOUTHERN HILLS HOSPITAL	12.5%	16.7%	0.0%	**10.0%**	**10.0%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	15.4%	25.0%	23.1%	**21.1%**	**21.1%**
	SUMMERLIN HOSPITAL MEDICAL CTR	18.2%	23.1%	0.0%	**15.2%**	**15.2%**
	SUNRISE HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	UNIVERSITY MEDICAL CENTER SO NV	0.0%	0.0%	16.7%	**4.5%**	**4.5%**
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	Total	**10.3%**	**11.6%**	**5.1%**	**9.3%**	**0.0%**
Out of Area	Out of Area	7.0%	4.3%	4.5%	**5.2%**	**5.2%**
	Total	**7.0%**	**4.3%**	**4.5%**	**5.2%**	**0.0%**

Utilization Summary

Outpatient Case Management					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
New Cases	295	349	278	**922**	**307**
Accepted	197	212	172	**581**	**194**
Acceptance Rate	66.8%	60.7%	61.9%	**63.0%**	**63.0%**
Average Duration (closed only)	6.7	6.5	4.7	**6.0**	**6.0**

Inpatient Case Management					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Open End of Month	42	29	28	**99**	**33**
Cases opened in the month	198	194	164	**556**	**185**
Cases closed in the month	188	204	161	**553**	**184**
Denied Days	2	5	9	**16**	**5**
Average LOS	4.5	4.1	5.2	**4.6**	**4.6**
NICU Open at End of Month	5	1	0	**6**	**2**
NICU Cases opened in the month	10	7	7	**24**	**8**
NICU Cases closed in the month	7	9	7	**23**	**8**
NICU Average Legth of Stay	26.1	6.3	12.4	**14.2**	**14.2**

Authorizations					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Total services reviewed	4,557	4,397	4,101	**13,055**	**4,352**
Services Approved	4,413	4,273	4,001	**12,687**	**4,229**
Approval Rate	96.8%	97.2%	97.6%	**97.2%**	**97.2%**
Services Denied	144	124	100	**368**	**123**
Denied Charges	$7,450,641	$112,240	$77,800	**$7,640,681**	**$2,546,894**
Denial Rate	3%	3%	2%	**3%**	**3%**

Denial Reason					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Denial Reason	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**
Not A Mental Illness	1	0	0	**1**	**1**
Not medically necessary	143	124	100	**367**	**122**

Utilization Summary

Turn Around Time					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
2 or fewer days	906	1,131	1,065	**3,102**	**1,034**
2 or fewer Pct	51.9%	64.3%	65.3%	**60.4%**	**60.4%**
5 or fewer days	1,216	1,228	1,148	**3,592**	**1,197**
5 or fewer Pct	69.7%	69.8%	70.4%	**70.0%**	**70.0%**
15 or fewer Days	1,713	1,740	1,616	**5,069**	**1,690**
15 or fewer Pct	98.2%	98.9%	99.1%	**98.7%**	**98.7%**
Over 15 days	32	19	15	**66**	**22**
Over 15 days Pct	1.8%	1.1%	0.9%	**1.3%**	**1.3%**

Turn around time is the number of days between the case open date and case close date.

Stat					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Stat Request	1,232	1,167	1,035	**3,434**	**1,145**

Appeals					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Appeals 1st Level	3	4	7	**14.00**	**4.67**
Appeals 2nd Level	0	0	0	**0.00**	**0.00**
Appeals 3rd Level	0	0	0	**0.00**	**0.00**
Appeals Overturned	1	0	0	**1.00**	**0.33**
Appeals Upheld	2	3	8	**13.00**	**4.33**

Utilization Summary

Retro Reviews					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Retros	8	8	7	**23**	**8**

Telephone Advise Nurse					
Metrics					
Outcome description	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Call 911	1	2	0	**3**	**2**
ER	4	10	6	**20**	**7**
Information or Advice Only	0	2	2	**4**	**2**
Other	12	20	14	**46**	**15**
PCP	13	10	13	**36**	**12**
Poison Center	0	1	1	**2**	**1**
Self-Care/Home Care	2	3	2	**7**	**2**
Urgent Care	11	9	13	**33**	**11**

Bedday Summary

Acute only

*NOTE: Per K formula: Actual number / membership * 12,000*

Month	Apr-25	May-25	Jun-25	YTD
Membership	52,395	52,407	52,288	**52,363**
Beddays per K	194.0	163.9	187.3	**181.7**
Admits per K	45.3	43.3	36.7	**41.8**
Average LOS	4.6	3.4	4.7	**4.1**
Readmits per K	4.4	4.4	1.8	**3.5**
Readmit Rate	9.6%	10.1%	5.0%	**8.4%**

SHO

Month	Apr-25	May-25	Jun-25	YTD
Beddays per K	200.4	197.2	180.5	**192.7**
Admits per K	40.9	41.3	37.1	**39.8**
Average LOS	5.0	4.4	4.6	**4.7**
Readmits per K	3.8	3.3	1.8	**2.9**
Readmit Rate	9.3%	7.9%	4.7%	**7.4%**

SHL PPO

Month	Apr-25	May-25	Jun-25	YTD
Beddays per K	132.9	167.5	127.5	**142.6**
Admits per K	37.2	41.3	35.9	**38.2**
Average LOS	5.1	5.2	4.8	**5.1**
Reamits per K	4.8	3.6	2.7	**3.7**
Readmit Rate	12.9%	8.8%	7.4%	**9.7%**

This report includes: Place of service 21 Acute only with a status of "to be discharged" or discharged.

Executive Summary (Behavioral Health)

Metrics	Apr-25	May-25	Jun-25	Average
Enrollment	52,395	52,407	52,288	**52,363**

Inpatient All - Acute, RTC, and OOA

Month	Apr-25	May-25	Jun-25	Total	Average
Total Discharges	22	36	25	**83**	**28**
Total Discharges LOS	321	305	174	**800**	**267**
Average LOS	14.6	8.5	7.0	**9.6**	**9.6**

Beddays by Facility Type

Metrics				Beddays	
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	79	84	52	**215**	**72**
RTC	0	76	15	**91**	**46**
Out of Area	242	235	112	**589**	**196**

Metrics				Beddays per K
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**
Hospital	18.1	19.2	11.9	**16.4**
RTC	0.0	17.4	3.4	**7.0**
Out of Area	55.4	53.8	25.7	**45.0**

Admits by Facility Type

Metrics				Admits	
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	16	16	12	**44**	**15**
RTC	0	3	3	**6**	**3**
Out of Area	14	11	9	**34**	**11**

Metrics				Admits per K
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**
Hospital	3.7	3.7	2.8	**3.4**
RTC	0.0	0.7	0.7	**0.5**
Out of Area	3.2	2.5	2.1	**2.6**

Readmits by Facility Type

Metrics				Readmits	
Facility Type	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	2	0	0	**2**	**1**
RTC	0	0	0	**0**	**0**
Out of Area	1	1	1	**3**	**1**

Executive Summary (Behavioral Health)

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	Apr-25	May-25	Jun-25	Total
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	4.0	6.0	1.3	**3.0**
	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0.0	0.0	5.5	**5.5**
	DESERT HOPE CENTER	0.0	0.0	0.0	**6.0**
	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	0.0	4.0	3.0	**4.5**
	DESERT WINDS HOSPITAL	3.7	4.0	0.0	**3.8**
	LAS VEGAS VAMC	0.0	0.0	2.0	**2.0**
	RENO BEHAVIORAL HEALTHCARE HOSPITAL LLC	2.0	6.5	4.0	**5.1**
	SEVEN HILLS HOSPITAL INC	9.3	3.3	2.0	**4.8**
	SOUTHERN HILLS HOSPITAL	0.0	0.0	8.5	**8.5**
	SPRING MOUNTAIN SAHARA	3.0	0.0	0.0	**3.0**
	SPRING MOUNTAIN TREATMENT CENTER	4.0	0.0	0.0	**4.0**
	VIRTUE RECOVERY LAS VEGAS LLC	0.0	0.0	0.0	**8.0**
	Total	**6.1**	**4.2**	**3.9**	**4.7**
RTC	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0.0	0.0	5.0	**5.0**
	RECOVERY WAYS DENALI LLC	0.0	0.0	5.0	**5.0**
	VIRTUE RECOVERY LAS VEGAS LLC	0.0	20.0	0.0	**20.0**
	WILLOW SPRINGS LLC	0.0	0.0	0.0	**28.0**
	Total	**0.0**	**76.0**	**3.0**	**15.2**
Out of Area	Out of Area	26.9	9.7	14.0	**15.6**
	Total	**26.9**	**9.7**	**14.0**	**15.6**

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	8	6	4	**18**	**6**
	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	11	**11**	**11**
	DESERT HOPE CENTER	6	0	0	**6**	**6**
	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	3	12	3	**18**	**6**
	DESERT WINDS HOSPITAL	11	4	0	**15**	**8**
	LAS VEGAS VAMC	0	0	2	**2**	**2**
	RENO BEHAVIORAL HEALTHCARE HOSPITAL LLC	4	39	13	**56**	**19**
	SEVEN HILLS HOSPITAL INC	28	23	2	**53**	**18**
	SOUTHERN HILLS HOSPITAL	0	0	17	**17**	**17**
	SPRING MOUNTAIN SAHARA	3	0	0	**3**	**3**
	SPRING MOUNTAIN TREATMENT CENTER	8	0	0	**8**	**8**

Executive Summary (Behavioral Health)

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	VIRTUE RECOVERY LAS VEGAS LLC	8	0	0	**8**	**8**
	Total	**79**	**84**	**52**	**215**	**0**
RTC	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	10	**10**	**10**
	RECOVERY WAYS DENALI LLC	0	0	5	**5**	**5**
	VIRTUE RECOVERY LAS VEGAS LLC	0	20	0	**20**	**20**
	WILLOW SPRINGS LLC	0	56	0	**56**	**56**
	Total	**0**	**76**	**15**	**91**	**0**
Out of Area	Out of Area	242	235	112	**589**	**196**
	Total	**242**	**235**	**112**	**589**	**0**

Admits by Facility

Facility Type BHO	Metrics	Admits				
	Facility Name	Apr-25	May-25	Jun-25	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	2	2	2	**6**	**2**
	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	2	**2**	**2**
	DESERT HOPE CENTER	1	0	0	**1**	**1**
	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	1	2	1	**4**	**1**
	DESERT WINDS HOSPITAL	2	1	0	**3**	**2**
	LAS VEGAS VAMC	0	0	1	**1**	**1**
	RENO BEHAVIORAL HEALTHCARE HOSPITAL LLC	1	6	3	**10**	**3**
	SEVEN HILLS HOSPITAL INC	5	5	1	**11**	**4**
	SOUTHERN HILLS HOSPITAL	0	0	2	**2**	**2**
	SPRING MOUNTAIN SAHARA	1	0	0	**1**	**1**
	SPRING MOUNTAIN TREATMENT CENTER	2	0	0	**2**	**2**
	VIRTUE RECOVERY LAS VEGAS LLC	1	0	0	**1**	**1**
	Total	**16**	**16**	**12**	**44**	**0**
RTC	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	2	**2**	**2**
	RECOVERY WAYS DENALI LLC	0	0	1	**1**	**1**
	VIRTUE RECOVERY LAS VEGAS LLC	0	1	0	**1**	**1**
	WILLOW SPRINGS LLC	0	2	0	**2**	**1**
	Total	**0**	**3**	**3**	**6**	**0**
Out of Area	Out of Area	14	11	9	**34**	**11**
	Total	**14**	**11**	**9**	**34**	**0**

Executive Summary (Behavioral Health)

Readmits by Facility

Facility Type BHO	Metrics	Readmits				
	Facility Name	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	0	0	0	**0**	**0**
	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	0	**0**	**0**
	DESERT HOPE CENTER	0	0	0	**0**	**0**
	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	0	0	0	**0**	**0**
	DESERT WINDS HOSPITAL	1	0	0	**1**	**1**
	LAS VEGAS VAMC	0	0	0	**0**	**0**
	RENO BEHAVIORAL HEALTHCARE HOSPITAL LLC	0	0	0	**0**	**0**
	SEVEN HILLS HOSPITAL INC	0	0	0	**0**	**0**
	SOUTHERN HILLS HOSPITAL	0	0	0	**0**	**0**
	SPRING MOUNTAIN SAHARA	0	0	0	**0**	**0**
	SPRING MOUNTAIN TREATMENT CENTER	1	0	0	**1**	**1**
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	0	**0**	**0**
	Total	**2**	**0**	**0**	**2**	**0**
RTC	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0	0	0	**0**	**0**
	RECOVERY WAYS DENALI LLC	0	0	0	**0**	**0**
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	0	**0**	**0**
	WILLOW SPRINGS LLC	0	0	0	**0**	**0**
	Total	**0**	**0**	**0**	**0**	**0**
Out of Area	Out of Area	1	1	1	**3**	**1**
	Total	**1**	**1**	**1**	**3**	**0**

Readmits by Facility

Facility Type BHO	Metrics	Readmit Rate				
	Facility Name	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DESERT HOPE CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DESERT WINDS HOSPITAL	50.0%	0.0%	0.0%	**33.3%**	**33.3%**
	LAS VEGAS VAMC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENO BEHAVIORAL HEALTHCARE HOSPITAL LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SEVEN HILLS HOSPITAL INC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SPRING MOUNTAIN SAHARA	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SPRING MOUNTAIN TREATMENT CENTER	50.0%	0.0%	0.0%	**50.0%**	**50.0%**

Executive Summary (Behavioral Health)

Readmits by Facility

Facility Type BHO	Metrics	Readmit Rate				
	Facility Name	**Apr-25**	**May-25**	**Jun-25**	**Total**	**Average**
Hospital	VIRTUE RECOVERY LAS VEGAS LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	Total	**12.5%**	**0.0%**	**0.0%**	**4.5%**	**0.0%**
RTC	CMJ RECOVERY NV LLC DBA VOGUE RECOVERY CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RECOVERY WAYS DENALI LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	VIRTUE RECOVERY LAS VEGAS LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	WILLOW SPRINGS LLC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Out of Area	Out of Area	7.1%	9.1%	11.1%	**8.8%**	**8.8%**
	Total	**7.1%**	**9.1%**	**11.1%**	**8.8%**	**0.0%**

Utilization Summary (Behavioral Health)

Inpatient Case Management

Month	Apr-25	May-25	Jun-25	YTD	Average
Open End of Month	13	7	4	**24**	**8**
Cases opened in the month	30	30	24	**84**	**28**
Cases closed in the month	22	36	25	**83**	**28**
Denied Days	8	4	4	**16**	**5**
Average LOS	14.6	8.5	7.0	**9.6**	**9.6**

Authorizations

Month	Apr-25	May-25	Jun-25	YTD	Average
Total services reviewed	45	50	35	**130**	**43**
Services Approved	40	45	35	**120**	**40**
Approval Rate	88.9%	90.0%	100.0%	**92.3%**	**92.3%**
Services Denied	5	5	0	**10**	**3**
Denied Charges	$366	$10,259	$0	**$10,625**	**$3,542**
Denial Rate	11%	10%	0%	**8%**	**8%**

Denial Reason

Month	Apr-25	May-25	YTD	Average
Denial Reason	**Denied**	**Denied**	**Denied**	**Denied**
Not medically necessary	5	5	**10**	**5**

Utilization Summary (Behavioral Health)

Stat					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Stat Request	0	0	0	**0**	**0**

Appeals					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Appeals 1st Level	3	4	7	**14.00**	**4.67**
Appeals 2nd Level	0	0	0	**0.00**	**0.00**
Appeals 3rd Level	0	0	0	**0.00**	**0.00**
Appeals Overturned	1	0	0	**1.00**	**0.33**
Appeals Upheld	2	3	8	**13.00**	**4.33**

Utilization Summary (Behavioral Health)

Retro Reviews					
Month	**Apr-25**	**May-25**	**Jun-25**	**YTD**	**Average**
Retros	0	0	0	**0**	**0**

Bedday Summary (Behavioral Health)

Acute only

*NOTE: Per K formula: Actual number / membership * 12,000*

Month	Apr-25	May-25	Jun-25	YTD
Membership	52,395	52,407	52,288	**52,363**
Beddays per K	21.1	24.3	17.4	**20.9**
Admits per K	4.6	5.0	3.9	**4.5**
Average LOS	5.4	3.9	4.4	**4.5**
Readmits per K	0.7	0.2	0.2	**0.4**
Readmit Rate	15.0%	4.5%	5.9%	**8.5%**

SHO

Month	Apr-25	May-25	Jun-25	YTD
Beddays per K	18.3	17.7	14.1	**16.7**
Admits per K	4.0	3.6	2.9	**3.5**
Average LOS	5.1	4.3	4.7	**4.7**
Readmits per K	0.5	0.5	0.2	**0.4**
Readmit Rate	11.4%	12.5%	5.3%	**10.1%**

This report excludes: Place of service 55 & 56 (RTCs)

11.

11. Q4 Express Scripts – Utilization and Summary Reports. (Amy Donohue and Amy Daily, Express Scripts) (Information/Discussion)

Nevada PEBP FY25 Q3 Report

7/1/2024 – 6/30/2025

Report Includes:

- CDHP Comparison Data from Q4 FY25 to Q4 FY24
- EPO Comparison Data from Q4 FY25 to Q4 FY24
- PPO Comparison Data from Q4 FY25 to Q4 FY24
- CDHP, EPO, PPO Breakout Data from Q4 FY25
- Summary Comparison Data from FY25
- Key Metric Breakout Data from FY25

The data contained herein is pulled from a specific point-in-time and is subject to change at any time without notice due to a variety of factors, including but not limited to changes related to Member behavior, population demographics, system updates, and product availability. The data does not represent a guarantee and should not be used for audit purposes.

PREPARED BY CLIENT ANALYTICS
Cynthia Eaton (Cynthia.eaton@express-scripts.com)
8/31/2025

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q4 FY25 vs Q4 FY24

Membership Summary	FY 2025	FY 2024	Change
Member Count (Membership)	51,616	49,065	5.2%
Utilizing Member Count (Patients)	39,423	37,728	4.5%
Percent Utilizing (Utilization)	76.4%	76.9%	-0.5

Claim Summary	FY 2025	FY 2024	Change
Net Claims (Total Adjusted Rx's)	814,774	747,744	9.0%
Claims per Elig Member per Month (Claims PMPM)	1.32	1.27	3.6%
Total Claims for Generic (Generic ARx)	709,970	650,403	9.2%
Total Claims for Brand (Brand ARx)	104,804	97,341	7.7%
Total Claims for Multisource Brand Claims (MSB ARx)	1,963	3,170	-38.1%
Total Non-Specialty Claims	803,981	738,695	8.8%
Total Specialty Claims	10,793	9,049	19.3%
Generic % of Total Claims (GFR)	**87.1%**	**87.0%**	**0.2**
Generic Effective Rate (GCR)	99.7%	99.5%	0.2
Mail Order Claims	211,585	209,792	0.9%
Mail Penetration Rate*	29.3%	31.6%	-2.3

Claims Cost Summary	FY 2025	FY 2024	Change
Total Prescription Cost (Total Gross Cost)	**$123,028,261**	**$107,088,718**	**14.9%**
Total Generic Gross Cost	$12,436,194	$11,213,167	10.9%
Total Brand Gross Cost	$110,592,068	$95,875,550	15.3%
Total MSB Gross Cost	$1,324,197	$1,833,206	-27.8%
Total Ingredient Cost	$119,631,474	$104,000,937	15.0%
Total Dispensing Fee	$3,342,387	$3,007,226	11.1%
Total Other (e.g. tax)	$54,401	$80,555	-32.5%
Avg Total Cost per Claim (Gross Cost/ARx)	**$151.00**	**$143.22**	**5.4%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.52	$17.24	1.6%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,055.23	$984.95	7.1%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$674.58	$578.30	16.6%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q4 FY25 vs Q4 FY24

Member Cost Summary	FY 2025	FY 2024	Change
Total Member Cost Share	**$20,991,756**	**$18,889,112**	**11.1%**
Generic Cost Share	$4,689,977	$4,297,314	9.1%
Brand Cost Share	$16,301,780	$14,591,798	11.7%
MSB Cost Share	$232,635	$238,250	-2.4%
Total Copay	$19,171,278	$17,275,071	11.0%
Total Deductible	$1,820,478	$1,614,041	12.8%
Avg Copay per Claim (Member Cost Share/ARx)	**$25.76**	**$25.26**	**2.0%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.61	$6.61	0.0%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$155.55	$149.90	3.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$118.51	$75.16	57.7%
Copay % of Total Prescription Cost (Member Cost Share %)	**17.1%**	**17.6%**	**-0.6**

Plan Cost Summary	FY 2025	FY 2024	Change
Total Plan Cost (Plan Cost)	**$102,036,505**	**$88,199,606**	**15.7%**
Generic Plan Cost	$7,746,217	$6,915,853	12.0%
Brand Plan Cost	$94,290,288	$81,283,752	16.0%
MSB Plan Cost	$1,091,562	$1,594,956	-31.6%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$49,977,533	$41,840,210	19.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$52,058,972	$46,359,396	12.3%
Avg Plan Cost per Claim (Plan Cost/ARx)	$125.23	$117.95	6.2%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.91	$10.63	2.6%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$899.68	$835.04	7.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$556.07	$503.14	10.5%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$62.16	$56.64	9.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,823.40	$5,123.15	-5.9%
Plan Cost PMPM	**$164.74**	**$149.80**	**10.0%**
Non-Specialty Plan Cost PMPM	$80.69	$71.06	13.5%
Specialty Plan Cost PMPM	$84.05	$78.74	6.7%
Specialty % of Plan Cost	51.0%	52.6%	-1.5
Net Plan Cost PMPM (factoring Rebates)	**$102.15**	**$93.05**	**9.8%**
Non-Specialty Plan Cost PMPM	$44.58	$39.89	11.8%
Specialty Plan Cost PMPM	$57.57	$53.17	8.3%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q4 FY25 vs Q4 FY24

Membership Summary	FY 2025	FY 2024	Change
Member Count (Membership)	23,015	24,149	-4.7%
Utilizing Member Count (Patients)	16,603	17,627	-5.8%
Percent Utilizing (Utilization)	72.1%	73.0%	-0.9

Claim Summary	FY 2025	FY 2024	Change
Net Claims (Total Adjusted Rx's)	336,128	340,981	-1.4%
Claims per Elig Member per Month (Claims PMPM)	1.22	1.18	3.4%
Total Claims for Generic (Generic ARx)	296,521	299,849	-1.1%
Total Claims for Brand (Brand ARx)	39,607	41,132	-3.7%
Total Claims for Multisource Brand Claims (MSB ARx)	534	1,118	-52.2%
Total Non-Specialty Claims	331,860	336,994	-1.5%
Total Specialty Claims	4,268	3,987	7.0%
Generic % of Total Claims (GFR)	**88.2%**	**87.9%**	**0.3**
Generic Effective Rate (GCR)	99.8%	99.6%	0.2
Mail Order Claims	84,972	92,626	-8.3%
Mail Penetration Rate*	28.5%	30.7%	-2.2

Claims Cost Summary	FY 2025	FY 2024	Change
Total Prescription Cost (Total Gross Cost)	**$46,306,406**	**$44,034,083**	**5.2%**
Total Generic Gross Cost	$4,639,175	$4,537,020	2.3%
Total Brand Gross Cost	$41,667,231	$39,497,062	5.5%
Total MSB Gross Cost	$415,739	$523,976	-20.7%
Total Ingredient Cost	$44,893,804	$42,623,341	5.3%
Total Dispensing Fee	$1,392,358	$1,381,664	0.8%
Total Other (e.g. tax)	$20,244	$29,077	-30.4%
Avg Total Cost per Claim (Gross Cost/ARx)	**$137.76**	**$129.14**	**6.7%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$15.65	$15.13	3.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,052.02	$960.25	9.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$778.54	$468.67	66.1%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q4 FY25 vs Q4 FY24

Member Cost Summary	FY 2025	FY 2024	Change
Total Member Cost Share	**$9,829,957**	**$9,467,569**	**3.8%**
Generic Cost Share	$1,938,196	$1,932,573	0.3%
Brand Cost Share	$7,891,760	$7,534,996	4.7%
MSB Cost Share	$171,803	$134,550	27.7%
Total Copay	$8,012,774	$7,855,498	2.0%
Total Deductible	$1,817,182	$1,612,070	12.7%
Avg Copay per Claim (Member Cost Share/ARx)	**$29.24**	**$27.77**	**5.3%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.54	$6.45	1.4%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$199.25	$183.19	8.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$321.73	$120.35	167.3%
Copay % of Total Prescription Cost (Member Cost Share %)	**21.2%**	**21.5%**	**-0.3**

Plan Cost Summary	FY 2025	FY 2024	Change
Total Plan Cost (Plan Cost)	**$36,476,450**	**$34,566,514**	**5.5%**
Generic Plan Cost	$2,700,979	$2,604,448	3.7%
Brand Plan Cost	$33,775,470	$31,962,066	5.7%
MSB Plan Cost	$243,936	$389,426	-37.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$15,322,767	$14,723,970	4.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$21,153,682	$19,842,544	6.6%
Avg Plan Cost per Claim (Plan Cost/ARx)	$108.52	$101.37	7.0%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$9.11	$8.69	4.9%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$852.77	$777.06	9.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$456.81	$348.32	31.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$46.17	$43.69	5.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,956.35	$4,976.81	-0.4%
Plan Cost PMPM	**$132.07**	**$119.28**	**10.7%**
Non-Specialty Plan Cost PMPM	$55.48	$50.81	9.2%
Specialty Plan Cost PMPM	$76.59	$68.47	11.9%
Specialty % of Plan Cost	58.0%	57.4%	0.6
Net Plan Cost PMPM (factoring Rebates)	**$81.09**	**$73.85**	**9.8%**
Non-Specialty Plan Cost PMPM	$28.58	$27.02	5.8%
Specialty Plan Cost PMPM	$52.51	$46.83	12.1%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q4 FY25 vs Q4 FY24

Membership Summary	FY 2025	FY 2024	Change
Member Count (Membership)	5,178	5,730	-9.6%
Utilizing Member Count (Patients)	4,369	4,737	-7.8%
Percent Utilizing (Utilization)	84.4%	82.7%	1.7

Claim Summary	FY 2025	FY 2024	Change
Net Claims (Total Adjusted Rx's)	120,795	126,336	-4.4%
Claims per Elig Member per Month (Claims PMPM)	1.94	1.84	5.8%
Total Claims for Generic (Generic ARx)	104,416	108,983	-4.2%
Total Claims for Brand (Brand ARx)	16,379	17,353	-5.6%
Total Claims for Multisource Brand Claims (MSB ARx)	393	644	-39.0%
Total Non-Specialty Claims	119,000	124,737	-4.6%
Total Specialty Claims	1,795	1,599	12.3%
Generic % of Total Claims (GFR)	**86.4%**	**86.3%**	**0.2**
Generic Effective Rate (GCR)	99.6%	99.4%	0.2
Mail Order Claims	33,844	37,164	-8.9%
Mail Penetration Rate*	30.8%	32.3%	-1.5

Claims Cost Summary	FY 2025	FY 2024	Change
Total Prescription Cost (Total Gross Cost)	**$20,908,722**	**$21,119,723**	**-1.0%**
Total Generic Gross Cost	$1,827,418	$1,922,634	-5.0%
Total Brand Gross Cost	$19,081,303	$19,197,089	-0.6%
Total MSB Gross Cost	$424,956	$473,029	-10.2%
Total Ingredient Cost	$20,397,771	$20,596,344	-1.0%
Total Dispensing Fee	$502,689	$505,922	-0.6%
Total Other (e.g. tax)	$8,261	$17,458	-52.7%
Avg Total Cost per Claim (Gross Cost/ARx)	**$173.09**	**$167.17**	**3.5%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.50	$17.64	-0.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,164.99	$1,106.27	5.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$1,081.31	$734.52	47.2%

Express Scripts

By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q4 FY25 vs Q4 FY24

Member Cost Summary	FY 2025	FY 2024	Change
Total Member Cost Share	**$3,116,254**	**$3,111,997**	**0.1%**
Generic Cost Share	$699,103	$749,049	-6.7%
Brand Cost Share	$2,417,151	$2,362,948	2.3%
MSB Cost Share	$26,941	$50,090	-46.2%
Total Copay	$3,112,958	$3,110,026	0.1%
Total Deductible	$3,296	$1,971	67.3%
Avg Copay per Claim (Member Cost Share/ARx)	**$25.80**	**$24.63**	**4.7%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.70	$6.87	-2.6%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$147.58	$136.17	8.4%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$68.55	$77.78	-11.9%
Copay % of Total Prescription Cost (Member Cost Share %)	**14.9%**	**14.7%**	**0.2**

Plan Cost Summary	FY 2025	FY 2024	Change
Total Plan Cost (Plan Cost)	**$17,792,468**	**$18,007,727**	**-1.2%**
Generic Plan Cost	$1,128,316	$1,173,585	-3.9%
Brand Plan Cost	$16,664,152	$16,834,141	-1.0%
MSB Plan Cost	$398,015	$422,939	-5.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,630,230	$8,481,219	1.8%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,162,238	$9,526,508	-3.8%
Avg Plan Cost per Claim (Plan Cost/ARx)	$147.29	$142.54	3.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.81	$10.77	0.3%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$1,017.41	$970.10	4.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$1,012.76	$656.74	54.2%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$72.52	$67.99	6.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,104.31	$5,957.79	-14.3%
Plan Cost PMPM	**$286.35**	**$261.89**	**9.3%**
Non-Specialty Plan Cost PMPM	$138.89	$123.35	12.6%
Specialty Plan Cost PMPM	$147.45	$138.55	6.4%
Specialty % of Plan Cost	51.5%	52.9%	-1.4
Net Plan Cost PMPM (factoring Rebates)	**$178.52**	**$161.86**	**10.3%**
Non-Specialty Plan Cost PMPM	$75.99	$69.02	10.1%
Specialty Plan Cost PMPM	$102.52	$92.84	10.4%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q4 FY25 vs Q4 FY24

Membership Summary	FY 2025	FY 2024	Change
Member Count (Membership)	23,427	19,192	22.1%
Utilizing Member Count (Patients)	18,539	15,451	20.0%
Percent Utilizing (Utilization)	79.1%	80.5%	-1.4

Claim Summary	FY 2025	FY 2024	Change
Net Claims (Total Adjusted Rx's)	357,851	280,427	27.6%
Claims per Elig Member per Month (Claims PMPM)	1.27	1.22	4.5%
Total Claims for Generic (Generic ARx)	309,033	241,571	27.9%
Total Claims for Brand (Brand ARx)	48,818	38,856	25.6%
Total Claims for Multisource Brand Claims (MSB ARx)	1,036	1,408	-26.4%
Total Non-Specialty Claims	353,121	276,964	27.5%
Total Specialty Claims	4,730	3,463	36.6%
Generic % of Total Claims (GFR)	**86.4%**	**86.1%**	**0.2**
Generic Effective Rate (GCR)	99.7%	99.4%	0.2
Mail Order Claims	92,769	80,002	16.0%
Mail Penetration Rate*	29.4%	32.4%	-3.0

Claims Cost Summary	FY 2025	FY 2024	Change
Total Prescription Cost (Total Gross Cost)	**$55,813,134**	**$41,934,912**	**33.1%**
Total Generic Gross Cost	$5,969,600	$4,753,513	25.6%
Total Brand Gross Cost	$49,843,534	$37,181,399	34.1%
Total MSB Gross Cost	$483,502	$836,201	-42.2%
Total Ingredient Cost	$54,339,899	$40,781,251	33.2%
Total Dispensing Fee	$1,447,339	$1,119,640	29.3%
Total Other (e.g. tax)	$25,895	$34,020	-23.9%
Avg Total Cost per Claim (Gross Cost/ARx)	**$155.97**	**$149.54**	**4.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$19.32	$19.68	-1.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,021.01	$956.90	6.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$466.70	$593.89	-21.4%

Express Scripts
By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ Q4 FY25 vs Q4 FY24

Member Cost Summary	FY 2025	FY 2024	Change
Total Member Cost Share	**$8,045,546**	**$6,309,546**	**27.5%**
Generic Cost Share	$2,052,678	$1,615,692	27.0%
Brand Cost Share	$5,992,868	$4,693,854	27.7%
MSB Cost Share	$33,891	$53,610	-36.8%
Total Copay	$8,045,546	$6,309,546	27.5%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$22.48**	**$22.50**	**-0.1%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.64	$6.69	-0.7%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$122.76	$120.80	1.6%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$32.71	$38.07	-14.1%
Copay % of Total Prescription Cost (Member Cost Share %)	**14.4%**	**15.0%**	**-0.6**

Plan Cost Summary	FY 2025	FY 2024	Change
Total Plan Cost (Plan Cost)	**$47,767,588**	**$35,625,365**	**34.1%**
Generic Plan Cost	$3,916,922	$3,137,820	24.8%
Brand Plan Cost	$43,850,666	$32,487,545	35.0%
MSB Plan Cost	$449,611	$782,591	-42.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$26,024,536	$18,635,021	39.7%
Total Specialty Drug Cost (Specialty Plan Cost)	$21,743,052	$16,990,344	28.0%
Avg Plan Cost per Claim (Plan Cost/ARx)	$133.48	$127.04	5.1%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$12.67	$12.99	-2.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$898.25	$836.10	7.4%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$433.99	$555.82	-21.9%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$73.70	$67.28	9.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,596.84	$4,906.25	-6.3%
Plan Cost PMPM	**$169.92**	**$154.69**	**9.8%**
Non-Specialty Plan Cost PMPM	$92.57	$80.91	14.4%
Specialty Plan Cost PMPM	$77.34	$73.77	4.8%
Specialty % of Plan Cost	45.5%	47.7%	-2.2
Net Plan Cost PMPM (factoring Rebates)	**$105.94**	**$96.65**	**9.6%**
Non-Specialty Plan Cost PMPM	$53.34	$47.37	12.6%
Specialty Plan Cost PMPM	$52.60	$49.28	6.7%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q4 FY25

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	51,616	5,178	23,015	23,427
Utilizing Member Count (Patients)	39,423	4,369	16,603	18,539
Percent Utilizing (Utilization)	76.4%	84.4%	72.1%	79.1%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	814,774	120,795	336,128	357,851
Claims per Elig Member per Month (Claims PMPM)	1.32	1.94	1.22	1.27
Total Claims for Generic (Generic Rx)	709,970	104,416	296,521	309,033
Total Claims for Brand (Brand Rx)	104,804	16,379	39,607	48,818
Total Claims for Multisource Brand Claims (MSB Rx)	1,963	393	534	1,036
Total Non-Specialty Claims	803,981	119,000	331,860	353,121
Total Specialty Claims	10,793	1,795	4,268	4,730
Generic % of Total Claims (GFR)	**87.1%**	**86.4%**	**88.2%**	**86.4%**
Generic Effective Rate (GCR)	99.7%	99.6%	99.8%	99.7%
Mail Order Claims	211,585	33,844	84,972	92,769
Mail Penetration Rate*	29.3%	30.8%	28.5%	29.4%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$123,028,261**	**$20,908,722**	**$46,306,406**	**$55,813,134**
Total Generic Gross Cost	$12,436,194	$1,827,418	$4,639,175	$5,969,600
Total Brand Gross Cost	$110,592,068	$19,081,303	$41,667,231	$49,843,534
Total MSB Gross Cost	$1,324,197	$424,956	$415,739	$483,502
Total Ingredient Cost	$119,631,474	$20,397,771	$44,893,804	$54,339,899
Total Dispensing Fee	$1,895,047	$502,689	$1,392,358	$1,447,339
Total Other (e.g. tax)	$54,401	$8,261	$20,244	$25,895
Avg Total Cost per Claim (Gross Cost/Rx)	**$151.00**	**$173.09**	**$137.76**	**$155.97**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$17.52	$17.50	$15.65	$19.32
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$1,055.23	$1,164.99	$1,052.02	$1,021.01
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$674.58	$1,081.31	$778.54	$466.70

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN
+ Q4 FY25

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$20,991,756**	**$3,116,254**	**$9,829,957**	**$8,045,546**
Generic Cost Share	$4,689,977	$699,103	$1,938,196	$2,052,678
Brand Cost Share	$16,301,780	$2,417,151	$7,891,760	$5,992,868
MSB Cost Share	$232,635	$26,941	$171,803	$33,891
Total Copay	$19,171,278	$3,112,958	$8,012,774	$8,045,546
Total Deductible	$1,820,478	$3,296	$1,817,182	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$25.76**	**$25.80**	**$29.24**	**$22.48**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$6.61	$6.70	$6.54	$6.64
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$155.55	$147.58	$199.25	$122.76
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$118.51	$68.55	$321.73	$32.71
Copay % of Total Prescription Cost (Member Cost Share %)	**17.1%**	**14.9%**	**21.2%**	**14.4%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$102,036,505**	**$17,792,468**	**$36,476,450**	**$47,767,588**
Generic Plan Cost	$7,746,217	$1,128,316	$2,700,979	$3,916,922
Brand Plan Cost	$94,290,288	$16,664,152	$33,775,470	$43,850,666
MSB Plan Cost	$1,091,562	$398,015	$243,936	$449,611
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$49,977,533	$8,630,230	$15,322,767	$26,024,536
Total Specialty Drug Cost (Specialty Plan Cost)	$52,058,972	$9,162,238	$21,153,682	$21,743,052
Avg Plan Cost per Claim (Plan Cost/Rx)	$125.23	$147.29	$108.52	$133.48
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$10.91	$10.81	$9.11	$12.67
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$899.68	$1,017.41	$852.77	$898.25
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$556.07	$1,012.76	$456.81	$433.99
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$62.16	$72.52	$46.17	$73.70
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$4,823.40	$5,104.31	$4,956.35	$4,596.84
Plan Cost PMPM	**$164.74**	**$286.35**	**$132.07**	**$169.92**
Non-Specialty Plan Cost PMPM	$80.69	$138.89	$55.48	$92.57
Specialty Plan Cost PMPM	$84.05	$147.45	$76.59	$77.34
Specialty % of Plan Cost	51.0%	51.5%	58.0%	45.5%
Net Plan Cost PMPM (factoring Rebates)	**$102.15**	**$178.52**	**$81.09**	**$105.94**
Non-Specialty Net Plan Cost PMPM	$44.58	$75.99	$28.58	$53.34
Specialty Net Plan Cost PMPM	$57.57	$102.52	$52.51	$52.60

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q4 FY25

State of Nevada PEBP FY2025 Q4				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	51,616	5,178	23,015	23,427
Pct Members Utilizing Benefit	76.4%	84.4%	72.1%	79.1%
Total Plan Cost	$ 102,036,505	$ 17,792,468	$ 36,476,450	$ 47,767,588
Total Days	21,476,400	3,259,867	8,865,047	9,351,486
Total Adjusted Rxs	814,774	120,795	336,128	357,851
Plan Cost PMPM	$ 164.74	$ 286.35	$ 132.07	$ 169.92
Plan Cost Net PMPM	$ 102.15	$ 178.52	$ 81.09	$ 105.94
Plan Cost/Day	$ 4.75	$ 5.46	$ 4.11	$ 5.11
Plan Cost per Adjusted Rx	$ 125.23	$ 147.29	$ 108.52	$ 133.48
Nbr Rxs PMPM	1.32	1.94	1.22	1.27
Generic Fill Rate	87.1%	86.4%	88.2%	86.4%
Home Delivery Utilization	29.3%	30.8%	28.5%	29.4%
Member Cost %	17.1%	14.9%	21.2%	14.4%
Specialty Percent of Plan Cost	51.0%	51.5%	58.0%	45.5%
Specialty Plan Cost PMPM	$ 84.05	$ 147.45	$ 76.59	$ 77.34
Formulary Compliance Rate	99.5%	99.4%	99.8%	99.4%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q4 FY25

State of Nevada PEBP FY2025 Q4 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	51,616	45,692	5,488	13	426
Pct Members Utilizing Benefit	76.4%	75.2%	89.3%	84.6%	96.9%
Total Plan Cost	$ 102,036,505	$ 80,754,666	$ 19,629,010	$ 49,412	$ 1,603,417
Total Days	21,476,400	16,522,237	4,363,932	6,856	583,375
Total Adjusted Rxs	814,774	634,599	158,832	250	21,093
Plan Cost PMPM	$ 164.74	$ 147.28	$ 298.06	$ 316.74	$ 313.66
Plan Cost Net PMPM	$ 102.15	$ 91.18	$ 188.38	$ 189.62	$ 164.51
Plan Cost/Day	$ 4.75	$ 4.89	$ 4.50	$ 7.21	$ 2.75
Plan Cost per Adjusted Rx	$ 125.23	$ 127.25	$ 123.58	$ 197.65	$ 76.02
Nbr Rxs PMPM	1.32	1.16	2.41	1.60	4.13
Generic Fill Rate	87.1%	86.9%	87.8%	83.6%	88.1%
Home Delivery Utilization	29.3%	27.1%	36.5%	85.7%	35.7%
Member Cost %	17.1%	17.0%	17.5%	20.2%	16.7%
Specialty Percent of Plan Cost	51.0%	50.3%	55.8%	46.0%	28.0%
Specialty Plan Cost PMPM	$ 84.05	$ 74.12	$ 166.20	$ 145.77	$ 87.74
Formulary Compliance Rate	99.5%	99.5%	99.7%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q4 FY25

State of Nevada PEBP FY2025 Q4 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	5,178	4,447	669	2	60
Pct Members Utilizing Benefit	84.4%	83.5%	95.2%	50.0%	93.3%
Total Plan Cost	$ 17,792,468	$ 13,173,301	$ 4,468,838	$ 18,026	$ 132,302
Total Days	3,259,867	2,490,964	702,820	2,859	63,224
Total Adjusted Rxs	120,795	92,937	25,501	99	2,258
Plan Cost PMPM	$ 286.35	$ 246.86	$ 556.66	$ 751.09	$ 183.75
Plan Cost Net PMPM	$ 178.52	$ 148.14	$ 385.92	$ 255.14	$ 114.77
Plan Cost/Day	$ 5.46	$ 5.29	$ 6.36	$ 6.31	$ 2.09
Plan Cost per Adjusted Rx	$ 147.29	$ 141.74	$ 175.24	$ 182.08	$ 58.59
Nbr Rxs PMPM	1.94	1.74	3.18	4.13	4.13
Generic Fill Rate	86.4%	86.4%	86.3%	72.7%	91.1%
Home Delivery Utilization	30.8%	29.6%	34.0%	99.9%	37.8%
Member Cost %	14.9%	15.0%	14.8%	5.4%	11.8%
Specialty Percent of Plan Cost	51.5%	49.6%	58.3%	0.0%	17.5%
Specialty Plan Cost PMPM	$ 147.45	$ 122.41	$ 324.74	$ -	$ 32.17
Formulary Compliance Rate	99.4%	99.4%	99.5%	100.0%	99.2%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q4 FY25

State of Nevada PEBP FY2025 Q4 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	23,015	19,417	3,260	14	331
Pct Members Utilizing Benefit	72.1%	69.8%	86.6%	42.9%	95.8%
Total Plan Cost	$ 36,476,450	$ 25,279,296	$ 10,016,197	$ 55	$ 1,180,901
Total Days	8,865,047	5,981,170	2,420,502	503	462,872
Total Adjusted Rxs	336,128	231,395	87,923	21	16,789
Plan Cost PMPM	$ 132.07	$ 108.49	$ 256.04	$ 0.66	$ 297.31
Plan Cost Net PMPM	$ 81.09	$ 65.75	$ 165.41	$ 0.66	$ 152.03
Plan Cost/Day	$ 4.11	$ 4.23	$ 4.14	$ 0.11	$ 2.55
Plan Cost per Adjusted Rx	$ 108.52	$ 109.25	$ 113.92	$ -	$ 70.34
Nbr Rxs PMPM	1.22	0.99	2.25	0.13	4.23
Generic Fill Rate	88.2%	88.0%	89.0%	100.0%	87.6%
Home Delivery Utilization	28.5%	24.9%	36.0%	0.0%	35.4%
Member Cost %	21.2%	21.9%	19.7%	89.9%	19.0%
Specialty Percent of Plan Cost	58.0%	57.3%	63.3%	0.0%	28.2%
Specialty Plan Cost PMPM	$ 76.59	$ 62.15	$ 162.09	$ -	$ 83.69
Formulary Compliance Rate	99.8%	99.8%	99.8%	100.0%	99.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ Q4 FY25

State of Nevada PEBP FY2025 Q4 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	23,427	21,828	1,559	4	36
Pct Members Utilizing Benefit	79.1%	78.6%	93.0%	100.0%	111.1%
Total Plan Cost	$ 47,767,588	$ 42,302,069	$ 5,143,974	$ 31,330	$ 290,214
Total Days	9,351,486	8,050,103	1,240,610	3,494	57,279
Total Adjusted Rxs	357,851	310,267	45,408	130	2,046
Plan Cost PMPM	$ 169.92	$ 161.50	$ 274.96	$ 712.05	$ 671.79
Plan Cost Net PMPM	$ 105.94	$ 102.19	$ 151.64	$ 531.87	$ 357.57
Plan Cost/Day	$ 5.11	$ 5.25	$ 4.15	$ 8.97	$ 5.07
Plan Cost per Adjusted Rx	$ 133.48	$ 136.34	$ 113.28	$ 241.00	$ 141.84
Nbr Rxs PMPM	1.27	1.18	2.43	2.71	4.74
Generic Fill Rate	86.4%	86.3%	86.3%	89.2%	89.0%
Home Delivery Utilization	29.4%	27.9%	38.7%	86.4%	35.5%
Member Cost %	14.4%	14.3%	15.2%	25.9%	8.5%
Specialty Percent of Plan Cost	45.5%	46.4%	38.8%	72.6%	32.0%
Specialty Plan Cost PMPM	$ 77.34	$ 74.94	$ 106.76	$ 516.83	$ 215.07
Formulary Compliance Rate	99.4%	99.3%	99.5%	100.0%	99.9%

Nevada PEBP

Q4 FY2025

Prepared by Client Analytics

Cynthia Eaton (cynthia.eaton@express-scripts.com)

8/31/2025

**The data contained herein is pulled from a specific point-in-time and is subject to change at any time without notice due to a variety of factors, including but not limited to changes related to Member behavior, population demographics, system updates, and product availability. The data does not represent a guarantee and should not be used for audit purposes.*

Hello PEBP Team,

This is the Q4 FY25 Summary File for the three State of Nevada PEBP plans (CDHP, EPO, and PPO). The summary contains Trend breakouts for each plan (Utilization, Unit Cost, and Cost Share). Along with the most notable changes of drugs within the top moving indications. Each plan breakout has a peer comparison of Trend. The file concludes with several Key Statistics of the three plans in aggregate.

CDHP Overall Trend Summaries:

CDHP Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$81.09**	
Utilization	$2.82	3.8%
Unit Cost	$4.23	5.7%
Member Share	$0.20	0.3%
Total Change in Plan Cost Net PMPM	**$7.24**	**9.8%**
Previous Period - Plan Cost Net PMPM	**$73.85**	

Top moving indications and most notable drug changes within the indications are as follows:

- **HIV:** Previously ranked 4th, currently ranked 3rd by Plan Cost Net.
  - Plan Cost Net: ↑ $261.9k (16.4%) to current $1.86M
  - Plan Cost Net PMPM: ↑ $1.22 (22.2%), current $6.72
  - Patient Count: ↑ 8 to current count of 123
  - Adjusted RXs: ↑ 130 to current count of 1,094

- **Notable Drug Changes within Indication:**

  - **BIKTARVY**: Previously ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: ↑ $128.0k (25.97%) to current $620k
    - Plan Cost Net PMPM: ↑ $0.55 (32.2%), current $2.25
    - Patient Count: ↑ 1 to current count of 21
    - Adjusted RXs: ↑ 32 to current count of 191

  - **DESCOVY**: Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: ↑ $122.6k (29.6%) to current $540k
    - Plan Cost Net PMPM: ↑ $0.51 (36.0%), current $1.95
    - Patient Count: ↑ 6 to current count of 43
    - Adjusted RXs: ↑ 85 to current count of 359

- **GOUT**: Previously ranked 70th, currently ranked 10th by Plan Cost Net.
  - Plan Cost Net: ↑ $525k (6872.7%) to current $532k
  - Plan Cost Net PMPM: ↑ $1.99 (7215.2%), current $1.93
  - Patient Count: ↓ 20 to current count of 342
  - Adjusted RXs: ↓ 117 to current count of 2,687

- **Notable Drug Changes within Indication:**

    - **KRYSTEXXA**: New, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $520k
        - Plan Cost Net PMPM: New, current $1.89
        - Patient Count: New, current count of 2
        - Adjusted Rxs: New, current count of 12

    - **Other drug changes in this indication were not notable.**

- **BLOOD CELL DEFICIENCY**: Previously ranked 58th, currently ranked 13th by Plan Cost Net.
    - Plan Cost Net: ↑ $328k (1500.4%) to current $350k
    - Plan Cost Net PMPM: ↑ $1.19 (1579.2%), current $1.27
    - Patient Count: ↑ 2 to current count of 6
    - Adjusted Rxs: Remains at 21

- **Notable Drug Changes within Indication:**

    - **PROMACTA**: New, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $320k
        - Plan Cost Net PMPM: New, current $1.16
        - Patient Count: New, current count of 1
        - Adjusted Rxs: New, current count of 10

    - **Other drug changes in this indication were not notable.**

- **Ophthalmic Conditions**: Previously ranked 9th currently ranked 24th by Plan Cost Net.
    - Plan Cost Net ↓ $532k (-73.2%) to current $195k.
    - Plan Cost Net PMPM ↓ $1.80 (-71.9%) to current $.71.
    - Patient Count ↑ 11 to current count of 378.
    - Adjusted Rxs ↑ 55 to current count of 1,002.

- **Notable Drug Changes within Indication:**

    - **TEPEZZA**: Previously ranked 15th by Plan Cost Net, no current utilization.
        - Plan Cost Net ↓ $453k (-100%) to current $0.
        - Plan Cost Net PMPM ↓ $1.64 (-100%) to current $0.
        - Patient Count ↓ 1 to current count of 0.
        - Adjusted Rxs ↓ 8 to current count of 0.

    - **Other drug changes in this indication were not notable.**

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $94.74 compared to CDHP PEBP of $81.09.
- Peer experienced Trend of 18.3%, compared to CDHP PEBP Trend of 9.8%

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$178.52**	
Utilization	$9.31	5.8%
Unit Cost	$7.53	4.7%
Member Share	($0.19)	(0.1%)
Total Change in Plan Cost Net PMPM	**$16.65**	**10.3%**
Previous Period - Plan Cost Net PMPM	**$161.86**	

Top moving indications and most notable drug changes within the indications are as follows:

- **CANCER:** Previously ranked 4th, currently ranked 3rd by Plan Cost Net.
  - Plan Cost Net: ↑ $276k (28.9%) to current $1.2M
  - Plan Cost Net PMPM: ↑ $5.93 (42.6%), current $19.84
  - Patient Count: ↓ 11 to current count of 69
  - Adjusted RXs: ↓ 78 to current count of 539

- **Notable Drug Changes within Indication:**

  - **VENCLEXTA**: Previously ranked 5th, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: ↑ $167k (162.2%) to current $271k
    - Plan Cost Net PMPM: ↑ $2.85 (190.1%), current $4.36
    - Patient Count: ↑ 1 to current count of 2
    - Adjusted RXs: ↑ 9 to current count of 19

  - **LENVIMA**: New utilization currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $191k
    - Plan Cost Net PMPM: New, current $3.07
    - Patient Count: New, current count of 1
    - Adjusted Rxs: New, current count of 8

  - **MEKINIST:** Previously ranked 13th, currently ranked 7th by Plan Cost Net.
    - Plan Cost Net: ↑ $60k (966.2%) to current $66k
    - Plan Cost Net PMPM: ↑ $0.98 (1079.8%), current $1.07
    - Patient Count: Remains at count of 1
    - Adjusted RXs: ↑ 5 to current count of 6

- **ATOPIC DERMATITIS**: Previously ranked 14th, currently ranked 7th by Plan Cost Net.
  - Plan Cost Net: ↑ $130k (52.1%) to current $384k
  - Plan Cost Net PMPM: ↑ $2.49 (67.3%), current $6.18
  - Patient Count: ↑ 4 to current count of 440
  - Adjusted RXs: ↑ 154 to current count of 978

- **Notable Drug Changes within Indication:**

- **DUPIXENT PEN:** Previously ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net: ↑ $52k (26.0%) to current $250k
  - Plan Cost Net PMPM: ↑ $1.14 (39.5%), current $4.02
  - Patient Count: ↑ 2 to current count of 15
  - Adjusted RXs: ↑ 18 to current count of 118

- **CIBINQO:** New, currently ranked 3rd by Plan Cost Net.
  - Plan Cost Net: New, current $39k.
  - Plan Cost Net PMPM: New, current $.64.
  - Patient Count: New, current count of 2.
  - Adjusted Rxs: New, current count of 20.

- **BLOOD CELL DEFICIENCY**: Previously ranked 79th, currently ranked 8th by Plan Cost Net.
  - Plan Cost Net: ↑ $371k (89848.7%) to current $371k
  - Plan Cost Net PMPM: ↑ $5.97 (99437.7%) to current $5.97
  - Patient Count: ↑ 3 to current count of 4
  - Adjusted RXs: ↑ 14 to current count of 18

- **Notable Drug Changes within Indication:**

  - **CABLIVI:** New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $359k.
    - Plan Cost Net PMPM: New, current $5.77.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 2.

  - **Other drug changes in this indication were not notable.**

- **ENDOCRINE DISORDERS**: Previously ranked 2nd, currently ranked 13th by Plan Cost Net.
  - Plan Cost Net: ↓ $1,2m (-83.0%) to current $245k
  - Plan Cost Net PMPM: ↓ $16.96 (-81.1%), current $3.94
  - Patient Count: ↑ 3 to current count of 34
  - Adjusted RXs: ↓ 3 to current count of 231

- **Notable Drug Changes within Indication:**

  - **KORLYM:** Previously ranked 1st, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: ↓ $1,2m (-94.0%) to current $80k
    - Plan Cost Net PMPM: ↓ $18.06 (-93.3%), current $1.29
    - Patient Count: Remains at count of 2
    - Adjusted RXs: ↓ 21 to current count of 2

  - **Other drug changes in this indication were not notable.**

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP EPO plan)
- The peer is outperforming PEBP EPO in Plan Cost Net PMPM. However, the Peer has a greater Trend.
- Peer experienced Plan Cost Net PMPM of $131.13 compared to PEBP EPO of $178.52
- Peer experienced Trend of 23.4%, compared to PEBP EPO of 10.3%.

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$105.94**	
Utilization	$4.78	4.9%
Unit Cost	$3.41	3.5%
Member Share	$1.10	1.1%
Total Change in Plan Cost Net PMPM	**$9.30**	**9.6%**
Previous Period - Plan Cost Net PMPM	**$96.65**	

Top moving indications and most notable drug changes within the indications are as follows:

- **INFLAMMATORY CONDITIONS**: Previously ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net: ↑ $851k (25.6%) to current $4.2M
  - Plan Cost Net PMPM: ↑ $0.42 (2.9%), current $14.85
  - Patient Count: ↑ 89 to current count of 362
  - Adjusted RXs: ↑ 712 to current count of 3,263

- **Notable Drug Changes within Indication:**

  - **RINVOQ**: Previously ranked 4th, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: ↑ $249k (75.6%) to current $580k
    - Plan Cost Net PMPM: ↑ $0.63 (43.9%), current $2.06
    - Patient Count: ↑ 5 to current count of 21
    - Adjusted RXs: ↑ 59 to current count of 174

  - **SKYRIZI PEN**: Previously ranked 3rd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: ↑ $149k (45.3%) to current $480k
    - Plan Cost Net PMPM: ↑ $0.27 (19.0%), current $1.71
    - Patient Count: ↑ 1 to current count of 14
    - Adjusted RXs: ↑ 33 to current count of 143

- **ADALIMUMAB-RYVK(CF)** (Biosimilar for Humira CF): Previously ranked 52nd, currently ranked 5th by Plan Cost Net.
    - Plan Cost Net: ↑ $204k (28359.9%) to current $205k
    - Plan Cost Net PMPM: ↑ $0.72 (23215.1%), current $0.73
    - Patient Count: ↑ 28 to current count of 29
    - Adjusted RXs: ↑ 202 to current count of 203

- **DIABETES**: Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: ↑ $1.1M (40.1%) to current $3.9M
    - Plan Cost Net PMPM: ↑ $1.78 (14.8%), current $13.82
    - Patient Count: ↑ 461 to current count of 2,044
    - Adjusted RXs: ↑ 7,114 to current count of 30,989

- **Notable Drug Changes within Indication:**

    - **MOUNJARO**: Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: ↑ $717k (112.8%) to current $1.4M
        - Plan Cost Net PMPM: ↑ $2.05 (74.4%), current $4.81
        - Patient Count: ↑ 226 to current count of 462
        - Adjusted RXs: ↑ 2,298 to current count of 4,082

    - **OZEMPIC**: Previously ranked 1st, currently ranked 2nd by Plan Cost Net.
        - Plan Cost Net: ↑ $204k (25.3%) to current $1M
        - Plan Cost Net PMPM: ↑ $0.09 (2.6%), current $3.60
        - Patient Count: ↑ 55 to current count of 411
        - Adjusted RXs: ↑ 808 to current count of 3,304

    - **TRULICITY**: Previously ranked 3rd, currently ranked 4th by Plan Cost Net.
        - Plan Cost Net: ↓ $92k (-34.2%) to current $178k
        - Plan Cost Net PMPM: ↓ $0.54 (-46.1%), current $0.63
        - Patient Count: ↓ 33 to current count of 70
        - Adjusted RXs: ↓ 279 to current count of 565

- **HIV**: Previously ranked 5th, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net: ↑ $663k (48.3%) to current $2M
    - Plan Cost Net PMPM: ↑ $1.28 (21.5%), current $7.25
    - Patient Count: ↑ 52 to current count of 145
    - Adjusted RXs: ↑ 373 to current count of 1,081

- **Notable Drug Changes within Indication:**

    - **BIKTARVY**: Previously ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: ↑ $225k (39.9%) to current $789k
        - Plan Cost Net PMPM: ↑ $0.36 (14.7%), current $2.81
        - Patient Count: ↑ 7 to current count of 28
        - Adjusted RXs: ↑ 58 to current count of 224

- **DESCOVY**: Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net: ↑ $283k (101.6%) to current $562k
  - Plan Cost Net PMPM: ↑ $0.79 (65.2%), current $2.00
  - Patient Count: ↑ 27 to current count of 54
  - Adjusted RXs: ↑ 181 to current count of 354

- **APRETUDE**: Previously ranked 11th, currently ranked 7th by Plan Cost Net.
  - Plan Cost Net: ↑ $56k (285.7%) to current $76k
  - Plan Cost Net PMPM: ↑ $0.18 (215.9%), current $0.27
  - Patient Count: ↑ 1 to current count of 4
  - Adjusted RXs: ↑ 25 to current count of 36

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP PPO plan)
- PEBP PPO is outperforming the peer.
- PEBP PPO experienced Plan Cost Net PMPM of $105.94 compared to peer of $131.13.
- PEBP PPO experienced Trend of 9.6%, compared to Peer of 23.4%.

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$102.15**	
Utilization	$3.52	3.8%
Unit Cost	$4.59	4.9%
Member Share	$0.99	1.1%
Total Change in Plan Cost Net PMPM	**$9.10**	**9.8%**
Previous Period - Plan Cost Net PMPM	**$93.05**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 19.9% in Specialty patients. This resulted in a 19.6% increase in Specialty Days of Therapy.

Trend was mitigated by increased rebates of 16.0%. This produced a negative Unit Cost Trend of (-6.8%) on Specialty drugs and reduced NonSpecialty Unit Cost Trend to 7.3%, combined is 4.9%.

Member Cost contributed to Trend on both Specialty and NonSpecialty drugs. This is due to increased Utilization on Specialty drugs and Drug Mix on NonSpecialty drugs. Primary driven by utilization of more expensive brand drugs.

Key Statistics:

Nevada PEBP Total			
Description	Q4 FY25	Q4 FY24	Change
Average Members per Month	51,616	49,065	5.2%
Number of Unique patients	39,423	37,728	4.5%
Members Utilizing the Benefit	76.4%	76.9%	-0.5
Gross Cost/Adjusted Rx	$151.00	$143.22	5.4%
Plan Spend	$102,036,505	$88,199,606	15.7%
Rebates (estimated)	$38,766,166	$33,411,415	16.0%
Plan Cost Net	$63,270,339	$54,788,191	15.5%
Plan Cost Net PMPM	$102.15	$93.05	9.8%
Non-Specialty Plan Cost Net PMPM	$44.58	$39.89	11.8%
Specialty Plan Cost Net PMPM	$57.57	$53.17	8.3%
Generic Fill Rate	87.1%	87.0%	0.2
90 Day Utilization	59.5%	60.3%	-0.8
Retail - Maintenance 90 Utilization	30.3%	28.7%	1.6
Home Delivery Utilization	29.3%	31.6%	-2.3
Member Cost Net %	24.9%	25.6%	-0.7

END OF REPORT

12.

12. SFY 25 Year End Report and SFY 26 Q1 Budget Report.
(Monica McJoy, Chief Financial Officer)
(Information/Discussion)

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

[ ] Action Item

[X] Information Only

Date: December 12, 2025

Item Number: 12

Title: SFY 25 Year End Report and SFY 26 Q1 Budget Report

Summary

This report addresses the Operational Budget as of September 30, 2025, fiscal year end, to include:

1. Budget Status
2. Budget Totals
3. FY 25 Year End Totals

Budget Account 1338 – Operational Budget – Shown below is a summary of the Fiscal Year 26 operational budget account status as of September 30, 2025, with comparisons to the same period in Fiscal Year 2025. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $129.2 million as of September 30, 2025, compared to $127.9 million as of September 30, 2024, or an increase of 1%. Total expenses for the period have increased by $25 million or 19% for the same period.

The budget status report shows Realized Funding Available (cash) at $61.4 million. This compares to $112.7 million for the same period of last year. The table below reflects the actual revenues and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2026			FISCAL YEAR 2025		
	Actual as of 9/30/2025	Work Program	Percent	Actual as of 9/30/2024	Fiscal Year 2024 Close	Percent
Beginning Cash	66,888,128	66,888,128	100%	94,373,969	94,373,969	100%
Premium Income	119,139,668	577,316,074	21%	107,099,019	427,002,012	25%
All Other Income	10,067,965	45,957,505	22%	20,873,108	57,013,752	37%
Total Income	129,207,633	623,273,579	21%	127,972,127	484,015,764	26%
Personnel Services	547,464	3,856,037	14%	714,211	3,357,172	21%
Operating - Other than Personnel	505,903	3,410,757	15%	430,300	2,951,072	15%
Insurance Program Expenses	133,560,203	561,337,488	24%	108,417,702	504,985,651	21%
All Other Expenses	21,061	254,446	8%	66,818	207,710	21%
Total Expenses	134,634,632	568,858,728	24%	109,629,031	511,501,605	21%
Change in Cash	(5,426,999)	54,414,851		18,343,095	(27,485,841)	
REALIZED FUNDING AVAILABLE	61,461,129	121,302,979	51%	112,717,064	66,888,128	169%
Incurred But Not Reported Liability	(25,096,147)	(25,196,147)		(39,999,273)	(52,874,000)	
Catastrophic Reserve	(53,670,132)	(33,892,991)		(33,892,991)	(38,212,000)	
HRA Reserve	(42,536,700)	(42,536,700)		(14,864,089)	(20,600,889)	
NET REALIZED FUNDING AVAILABLE	**(59,841,850)**	-0-		23,960,711	(17,312,920)	

Current Budget Projections

The following table represents projections for FY 2026. The projection reflects total income to be less than budgeted by 14.7% ($690.1 million vs $588.7 million), total expenditures are projected to be less than budgeted by 8.4% ($ 568.8 million vs $ 521.2 million); and total reserves are projected to be less than budgeted by 44.3% ($ 121.3 million vs $ 67.5 million).

State Subsidies are projected to be less than the budgeted amount by $61.4 million (14%), Non-State Subsidies are projected to be less than budgeted by $2.7 million (12.2%), and Premium Income is projected to be less than budgeted by $32.9 million (28.7%).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/25**	**Projected**	**Difference**	**% Remain**
Carryforward	66,888,128	66,888,128	66,888,128	0	0.0%
State Subsidies	440,038,912	94,540,522	378,609,300	(61,429,612)	-14%
Non-State Subsidies	22,214,260	4,381,053	19,510,428	(2,703,832)	-12.2%
Premium	115,062,902	20,218,093	82,093,896	(32,969,006)	-28.7%
Appropriations	0	0	0	0	0
All Other	45,957,505	10,067,965	41,638,873	(4,318,632)	-9.4%
Total	690,161,707	196,095,761	588,740,625	(101,421,082)	-14.7%

Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/25**	**Projected**	**Difference**	
Operating	7,521,240	1,074,429	5,258,714	2,262,526	30.1%
State Insurance Costs	504,507,236	122,491,530	471,670,368	32,836,868	6.5%
Non-State Insurance Costs	7,716,969	1,344,129	5,376,517	2,340,452	30.3%
Medicare Retiree Insurance Costs	49,113,283	9,724,543	38,898,174	10,215,109	20.8%
Total Insurance Costs	561,337,488	133,560,203	515,945,059	45,392,429	8.2%
Total Expenses	568,858,728	134,634,772	521,203,772	47,654,956	8.4%
Restricted Reserves	121,302,979	121,302,979	67,536,852	(53,766,127)	-44.3%
Total Projected Revenue	588,740,625				
Total Projected Expenses	521,203,772				
Balance Remaining	67,536,852				
Less Reserves	(121,302 979)				
Over/Under Projected Reserves	(53,766,127)				
Pending Prior Year REGI Pmt	15,334,302				
Over/Under Projected Reserves	(38,431,425)				

Expenses for Fiscal Year 2026 are projected to be $47.6 million (8.4%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $2.2million (30.1%). Employee and Retiree insurances costs are projected to be less than budgeted by $45.3 million (8.4%) when taken in total (see table above for specific information).

Recommendations

None

13.

13. Presentation and possible action on current PEBP plans and possible revisions to future plan years. (Richard Ward, Segal)
(**For Possible Action**)
    - 13.1 Medical Pharmacy Coupon Program
    - 13.2 Prior Authorization
        - 13.2.1 Biopsy Coverage
        - 13.2.2 Board consideration and potential approval for UMR to review PA approval rates for all prior authorizations twice per year, and report to board any services that are above a 95% approval rate for the review period for the board to consider removal of PAs for such services/codes
    - 13.3 Diagnostic breast imaging and colonoscopies to be covered at 100% as preventative services
    - 13.4 Network Lab Access and Education
    - 13.5 Vision
    - 13.6 Pharmacy
        - 13.6.1 Increase non-preferred brand cost from $75 to 30% coinsurance
        - 13.6.2 3 Tier specialty co-pay structure
            - 13.6.2.1 3 Tier Bio similar only
            - 13.6.2.2 3 Tier for Specialty Drugs
    - 13.7 Mountain West Comparison of LDPPO plan

Nevada
Public Employees' Benefits Program

December 12, 2025

Segal

Approved Plan Changes

Approved at the July Board meeting

- Wigs/alopecia
  - Expand coverage to include alopecia (in addition to those undergoing cancer treatment)
- Speech therapy (statutory requirement)
  - Increase eligibility age from 19 to 26
  - Expand coverage to include stuttering and stammering
- Increase deductible of CDHP in line with federally mandated increase in minimum deducible levels for HSA-qualified plans
  - $1,650/$3,300 (single/family) to $1,700/$3,400
- Mental Health Therapy
  - More than one mental health therapy session/ therapy type may be scheduled in a single day; treated as separate sessions/ therapy types for copay and billing even if same provider.
- Autism – coverage to clarify the following are included
  - Ongoing assessment
  - Medication
  - Behavioral therapy (social skills training, applied behavioral analysis, etc)
  - Physical, as well as speech and language therapy

Medical Pharmacy Coupon Program

Implement coupon program for specialty drugs administered through the medical benefit

Why?

- UMR program that could reduce costs for both PEBP and patients
- Leverages manufacturer coupons like ESI's SaveOnSP, but for drugs administered in an inpatient setting
- SaveOnSP applies only to outpatient medications
- UMR confirms program can apply to all three self-insured plans
  - Deductible will still apply in CDHP (unless already satisfied by other care)

Next steps

- Evaluate member impact versus plan savings (shared savings terms)

Medical Pharmacy Coupon Program

Implement coupon program for specialty drugs administered through the pharmacy benefit

How It Works

- UMR MedicalRx Advisor patient advocate team handles member outreach and support
- Patient advocates contact members to introduce UMR MedicalRx Advisor and enroll them in qualifying copay assistance programs
- Participation is voluntary and can be added or removed at any time by calling the patient advocate team
- Member receives billing for treatment that reflects $0 or low-cost share, thanks to copay assistance (terms can vary by coupon)
- Copay assistance amounts are excluded from accumulators that track deductible and out-of-pocket maximum (OPMax) amounts
- UMR retains 25% of savings to administer the program (reduced from 30% standard rate)

UMR estimates annual plan impact = ($1,120,000) annually
($840,000) net of 25% administrative fee

Member annual impact = ($400,000)

Medical Pharmacy Coupon Program

Estimated Annual Plan and Patient Impact

Claims	**762**
Patients	**360**
Net Plan Impact	**($840,000)**
Patient Impact	**($400,000)**

- Coupon values generally range from about $5,000 - $25,000 and include a range of classes, including:
  - Oncology
  - Hemophilia
  - Immunodeficiency/autoimmune
  - Growth hormone
  - Spinal muscular atrophy
- Some very high-cost medications have higher coupon values, such as Zolgensma's $50,000 coupon
- Coupons are generally not per script; but are generally annual

Drug	Class	Annual Spend	Scripts	Per/Rx	Full Coupon
ULTOMIRIS	AUTOIMMUNE/ HEMATOLOGY	$600,000	12	$50,000	$15,000
SOLIRIS	TRANSPLANT REJECTION	$1,200,000	30	$40,000	$15,000
OCREVUS	AUTOIMMUNE	$500,000	25	$20,000	$20,000
KEYTRUDA	ONCOLOGY	$3,000,000	200	$15,000	$25,000
RITUXAN	ONCOLOGY	$90,000	6	$15,000	$15,000
PERJETA	ONCOLOGY	$520,000	40	$13,000	$25,000
IMFINZI	ONCOLOGY	$360,000	30	$12,000	$26,000
ENHERTU	ONCOLOGY	$400,000	40	$10,000	$26,000
DARZALEX	ONCOLOGY	$420,000	60	$7,000	$9,450
TRODELVY	ONCOLOGY	$300,000	50	$6,000	$25,000
SOMATULINE	GROWTH HORMONE	$200,000	40	$5,000	$6,000
FULPHILA	HEMATOLOGY	$200,000	50	$4,000	$10,000
ENTYVIO	AUTOIMMUNE	$360,000	90	$4,000	$20,000
YERVOY	ONCOLOGY	$32,000	8	$4,000	$25,000
PRIVIGEN	IVIG	$18,000	6	$3,000	$5,000

Medical Pharmacy Coupon Program – How It Works

Illustrative Example provided by UMR

- Drug has $2,500 available per claim in copay assistance
- Estimated cost is $4,000 per claim

Today

No copay assistance	
Coinsurance	**$800**
Copay card	$0
Member pay (20% coinsurance)	$800
Employer cost	**$3,200**
Applied to accumulators	**$800**

Copay assistance without UMR MedicalRx Advisor	
Coinsurance	**$800**
Copay card	$775
Member pay	$25
Employer cost	**$3,200**
Applied to accumulators	**$800**

With Program

Copay assistance with UMR MedicalRx Advisor	
Coinsurance	**$2,525**
Copay card	$2,500
Member pay	$25
Employer cost	**$1,475**
Applied to accumulators	**$25**

Note: All numbers are illustrative only.

With UMR MedicalRx Advisor, member saves $775 per claim and PEBP saves $1,725 per claim

Care Access (Prior Authorizations)

Streamline Access to Care

Why?

- Current plan structure may add to provider burden without managing care or costs
- Current plan requirements may limit access to early intervention care

What?

- Remove Prior Authorization requirement for biopsy coverage
  - Nearly 100% approval rate
  - Removes administrative step that slows access to care
  - Net cost to PEBP

Next Steps

- Evaluate cost and member impact

Care Access (Prior Authorizations)

Recent Biopsy Prior Authorization Approval Rate

Year	Submitted	Approved	Approval %
2024	1,194	1,192	99.8%
2025	807	805	99.8%

Additional Prior Authorizations with 99%+ Approval Rate

Treatment	Submitted	Approved	Approval %
MRIs	6,500	6,487	99.8%
Dialysis	19	19	100%

Current contract includes monthly administrative fee of $6.30 per member, which covers prior authorizations, case management and the nurse line.

UMR indicates removing the PA requirement will not affect this monthly fixed fee.

Care Access (Diagnostic Services)

Streamline Access to Care

Why?

- Current plan provisions may limit access to early intervention care

What?

- Cover diagnostic breast imaging and colonoscopies at 100%
  - Would need to be subject to deductible in CDHP
  - Removes barrier to early detection
  - May be net cost to PEBP in short-term, but provide long-term benefits to PEBP and patients

Next Steps

- Determine cost and member impact

Care Access (Diagnostic Services)

Breast Imaging

- Change would impact 1,300 – 1,400 members annually
- Expected cost increase to the Plan = $150,000

	PY2023	PY2024	PY2025
Total Services	6,499	6,767	7,389
Diagnostic Services	1,516	1,605	1,819
Plan Paid (Diagnostic)	$550K	$570K	$670K
Plan impact with change	$100K	$130K	$150K
Total Members with Imaging	5,679	5,894	6,358
Members with Diagnostic	999	1,304	1,412
Members with both Diagnostic/Preventive	497	554	609

Colonoscopies

- Change would impact about 900 – 1,000 members annually
- Expected cost increase to the Plan = $200,000

	PY2023	PY2024	PY2025
Total Services	2,893	3,157	3,412
Diagnostic Services	908	927	964
Plan Paid (Diagnostic)	$620K	$710K	$780K
Plan impact with change	$170K	$200K	$220K
Total Members with a Colonoscopy	2,744	2,998	3,259
Members with Diagnostic	856	882	912
Members with both Diagnostic/Preventive	15	57	47

Network Lab Access and Education

Steerage and Member Education

Why?

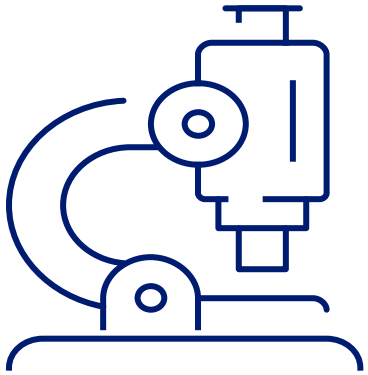
- Patients often utilize labs as directed by physician without considering network status
- Result can be higher costs for PEBP and for member

What?

- Cover first non-network lab at network cost share
  - Can be first every year or first ever
- Provide educational materials about network lab access and cost impact

Next Steps

- Determine cost and member impact



Network Lab Access and Education

First Annual OON Lab Paid as if in Network

- Change would impact 150-200 members annually
- Savings for some subsequent visits being network rather than OON
- Expected cost increase to the Plan = $2,000 annually

	PY2023	PY2024	PY2025
First Annual Lab is OON			
Patients/Visits	198	177	128
Plan Paid	$13,000	$15,000	$7,000
Plan Impact with change	$3,000	$3,000	$1,000
Subsequent OON Labs for Same Patients			
Patients	47	36	22
Visits	111	103	49
Plan Paid	$7,000	$7,000	$6,000
Plan Impact with change	-$1,000	-$1,000	-$1,000
Total Plan Impact with change	$2,000	$2,000	$0

First Ever OON Lab Paid as if in Network

- Change would impact about 100 members annually
- Savings for some subsequent visits being network rather than OON
- Expected cost increase to the Plan = $1,000 annually

	PY2023	PY2024	PY2025
First Ever Lab is OON			
Patients/Visits	129	119	65
Plan Paid	$8,000	$9,000	$3,000
Plan Impact with change	$2,000	$2,000	$1,000
Subsequent OON Labs for Same Patients (Same Year)			
Patients	31	24	11
Visits	73	69	25
Plan Paid	$4,000	$5,000	$1,000
Plan Impact with change	-$1,000	-$1,000	-$1,000
Total Plan Impact with change	$1,000	$1,000	$0

Vision (Annual Benefit Maximum)

Modernize and Update Vision Benefit

Why?

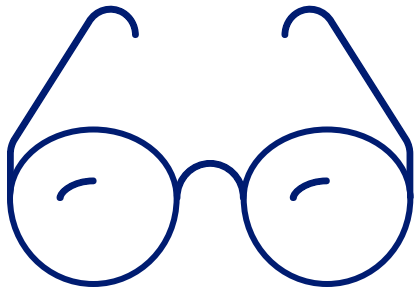
- $100 Annual Benefit Maximum may be out-of-step with current market

What?

- Increase current $100 annual benefit limit to align with market

Next Steps

- Develop specific options
- Benchmark benefits
- Determine cost impact



Vision (Annual Benefit Maximum)

- Since the last Board meeting it has been determined the CDHP does NOT currently have an Annual Benefit Maximum (ABM)
- In the CDHP, vision benefits must be subject to the deductible, but can have a maximum benefit for adults over 19
- Recommendation is to apply the same ABM to all three plans.

- Benchmarked vision benefits for other Western state health plans
  - Alaska
  - Arizona
  - Colorado
  - Hawai'i
  - Idaho
  - Montana
  - New Mexico
  - Oregon
  - Utah
  - Washington
  - Wyoming
- These plans do not provide an explicit Annual Benefit Maximum for all services
- Instead, they provide exam coverage, which is generally worth $100, and an annual allowance for contacts/glasses, which falls in the $120-$200 range
- Therefore, an equivalent ABM range is about $220-$300 for these state plans

	$200 ABM	$250 ABM	$300 ABM
Annual Cost Increase	$100,000	$140,000	$170,000

Vision (Cover Hardware in CDHP)

Modernize and Update Vision Benefit

Why?

- Covered services/materials varies by plan

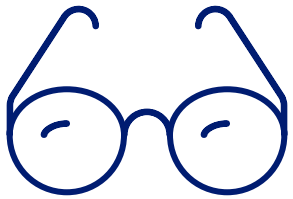
What?

- Add hardware coverage to CDHP to align with LDPPO and EPO coverage

Next Steps

- Develop specific options
- Benchmark benefits
- Determine cost impact

Estimated annual cost increase: $100,000



Pharmacy (Increase Non-Preferred Brand Copay)

Copay Incentives to Steer Towards Lower Net Cost Options

Why?

- Costs for Specialty and Non-Preferred Brands continue to drive trend

What?

- Increase Non-Preferred Brand cost share from $75 to 30% coinsurance with a min/max
  - Incentivize more Generic and Preferred Brand utilization

Next Steps

- Develop specific options
- Determine member impact
- Determine Rebate impact

Pharmacy (Increase Non-Preferred Brand Copay)

Three options considered

- Only 0.4% of scripts are for Non-Preferred Brands
- Limited savings opportunity for Options 1 and 2
- Removing coverage for Non-Preferred Brands from the LDPPO and EPO (to align with CDHP) has $600,000 savings opportunity, but affects approximately 825 patients (with 2,700 scripts)

	Retail 30	Retail90/MO	Plan Impact
Current	$75 copay	$150 copay	
Option 1	30% coinsurance Min $75; Max $150	30% coinsurance Min $150; Max $300	($100,000)
Option 2	30% coinsurance Min $100; Max $250	30% coinsurance Min $200; Max $500	($200,000)
Option 3	Not covered (member pays 100%)	Not covered (member pays 100%)	($600,000)

Pharmacy (Three Tier Specialty Copay Structure)

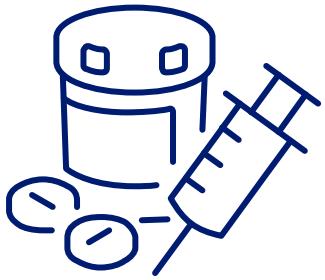
Copay Incentives to Steer Towards Lower Net Cost Options

Why?

- Costs for Specialty and Non-Preferred Brands continue to drive trend
- Increasing availability of biosimilars provides steerage option for specialty

What?

- Implement three-tier specialty copay structure
  - Increasing availability of biosimilars
  - Cost structure will incentivize biosimilars when available
  - Structure analogous to Generic, Preferred Brand and Non-Preferred Brand approach



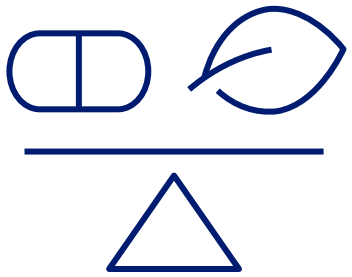
Next Steps

- Develop specific options
- Determine member impact
- Determine Rebate impact

Pharmacy (Three Tier Specialty Copay Structure)

- Current 30% coinsurance provides incentive to utilize lower cost options
- Current strategy has included excluding high-cost brand specialty drugs when there are viable alternatives.
  - Humira is a recent example: 1,000 scripts in PY24, 400 in PY25 and currently a single user
- Biosimilars and generic specialty medications are in the early stages.
- Three-tier cost structure may make sense long-term, but for PY2027, this is expected to be an investment

		Specialty	Plan Cost
	Current (all tiers)	30% coinsurance Min $100; Max $250	
Alternative	**Tier 1**	30% coinsurance No Min; Max $50	**$25,000**
	Tier 2	30% coinsurance Min $150; Max $250	
	Tier 3	30% coinsurance Min $250; Max $350	



Adjust Plan Provisions and Actuarial Values

Realign spread in actuarial values between current plans

Why?

- Ongoing migration from EPO and CDHP to LDPPO
- Actuarial values for LDPPO and EPO should be further apart

What?

- Adjust deductibles and out-of-pocket maximums
  - LDPPO does not currently have a deductible

Next Steps

- Develop specific options
- Determine plan and member impact

Adjust Plan Provisions and Actuarial Values

- Adjust deductible and OPMax level to better align differences in actuarial value
- Determine plan and member impact
- Adjust OPMax levels so richest plan (EPO) has lowest OMPax exposure

		CDHP	LDPPO	EPO	PEBP Impact
Current	Actuarial Value	79.0%	85.1%	88.7%	
	Deductible (EE/Fam)	IN: $1,650/$3,300 OON: $1,650/$3,300	IN: $0/$0 OON: $0/$0	IN: $100/$200 OON: N/A	
	OPMax (EE/Fam)	IN: $4,000/$8,000 OON: $10,600/$21,200	IN: $4,000/$8,000 OON: $10,600/$21,200	IN: $5,000/$10,000 OON: N/A	
Scenario 1	Actuarial Value	77.0%	83.0%	89.1%	
	Deductible (EE/Fam)	IN: $1,700/$3,400 OON: $1,700/$3,400	IN: $300/$600 OON: $600/$1,200	IN: $100/$200 OON: N/A	**($5.9M)**
	OPMax (EE/Fam)	IN: $6,000/$10,000 OON: $15,000/$25,000	IN: $5,000/$10,000 OON: $12,500/$25,000	IN: $4,000/$8,000 OON: N/A	
Scenario 2	Actuarial Value	76.2%	83.0%	89.1%	
	Deductible (EE/Fam)	IN: $2,000/$4,000 OON: $2,000/$4,000	IN: $300/$600 OON: $600/$1,200	IN: $100/$200 OON: N/A	**($6.8M)**
	OPMax (EE/Fam)	IN: $6,000/$10,000 OON: $15,000/$25,000	IN: $5,000/$10,000 OON: $12,500/$25,000	IN: $4,000/$8,000 OON: N/A	

Adjust Plan Provisions and Actuarial Values

Offset increases in CDHP Deductible with increased HSA/HRA Plan contributions

Coverage Tier	November 2025	Current Annual Contribution
Participant Only	18,500	$700
Participant & Spouse	2,400	$900
Participant & Child(ren)	4,100	$900 - $1,300
Participant & Family	2,500	$1,000 - $1,300
Total	**27,500**	

Increase in Annual Employer Contribution	Annual Cost
$50	$0.7M
$100	$1.4M
$200	$2.8M

Annual net impact for different Deductible/OPMax and HSA/HRA combinations

		Scenario 1	Scenario 2
Annual HSA/HRA Increase	**$0**	($5.9M)	($6.8M)
	$50	($5.2M)	($6.1M)
	$100	($4.5M)	($4.6M)
	$200	($3.1M)	($4.1M)

Restore LTD Benefit

Why?

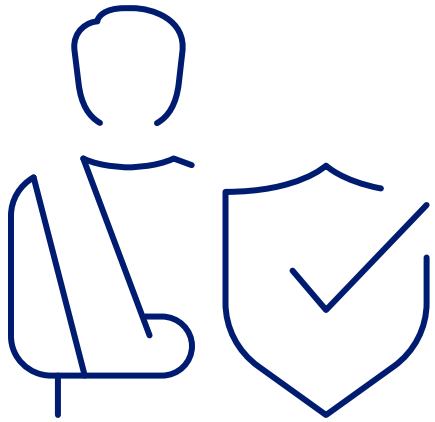
- Interest in investigating potential cost to restore prior LTD benefits (PEBP paid)

What?

- Restore prior LTD benefit
  - Eligibility: FTEs working 30+ hours/week
  - Benefit qualification: Cannot perform own occupation for 24 months; cannot perform any occupation thereafter
  - Elimination period: 180 days
  - Benefit: 60% of income, up to $7.500 monthly
  - Restore prior LTD benefit:
- **Cost: $5.5M - $6.0M annually**

Next Steps

- Draft and Issue RFP (if approved)



Summary

Option	Description	PY27 Cost/(Savings)
UMR Rx Coupon Program	Variable Coupon Program for medical Rx, similar to SaveOnSP for outpatient Rx	**Net PEBP: ($840,000)** **Members: ($400,000)**
Prior Authorizations	Remove PAs for biopsies (and potentially other services with 99%+ approval rate)	**$0**
Out-of-Network Lab	Pay first OON lab at network benefit and educate member on network access and savings – two options: • First ever incidence • First incidence annually	**$1,000 - $2,000**
Diagnostic colonoscopies and breast imaging	Cover at 100% (deducible applies in CDHP)	• **Colonoscopies: $200,000** • **Breast Imaging: $150,000**
Vision: Annual Benefit Maximum	Increase ABL from $100 to $200, $250 or $300	• **$200 ABL: $100,000** • **$250 ABL: $140,000** • **$300 ABL: $170,000**
Vision: Hardware Coverage	Cover frames/hardware in CDHP	**$100,000**
Rx: 3-tier Specialty Copay	Introduce 3 tier-specialty copays to incentivize biosimilar and generic utilization	**$25,000**
Rx: Increase Non-Preferred Brand Cost Share	Increase non-preferred brand copays to incentivize generic utilization or eliminate coverage for Non-Preferred Brands	**($100,000 - $600,000)**
Modify Current Plans	Adjust deductibles/OPMaxes and/or HSA/HRA contributions	**($3.1M-$6.8M)**
Restore LTD	Restore PEBP-paid LTD benefit	**$5.5M - $6.0M**

Questions

Appendix

Current Plan Designs and Premiums

In-network benefits

	CDHP	LDPPO	EPO	HMO
Actuarial Value	76.0%	85.1%	88.7%	91.4%
Service Area	Global	Global	Northern Nevada	Southern Nevada
Annual Deductible	$1,600 Individual $3,200 Family $3,200 Individual Family Member Deductible	$0	$100 Individual $200 Family $100 Individual Family Member Deductible	N/A With exception of Tier 4 prescription drug coverage
Medical Coinsurance	20% after deductible	20% after deductible	20% after deductible	N/A
Out-of-Pocket Maximum	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
Primary Care/ Specialist Office Visit	20% after deductible	$30/ $50 copay per visit	$20/ $40 copay per visit	$25/ $40 ($25 with referral) copay per visit
Urgent Care Visit	20% after deductible	$80 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Visit	20% after deductible	$750 copay per visit	$600 copay per visit	$600 copay per visit
In-Patient Hospital	20% after deductible	20% after deductible	$600 copay per visit	$600 copay per visit
Outpatient Surgery	20% after deductible	$500 copay per visit	$350 copay per visit	Ambulatory Facility $50 copay Hospital $350 copay
PY2026 Employee Only Premium	$55.26	$91.79	$219.91	$219.91

* Actuarial Value based on FY22 and FY23 data.
** 30-day supply Tier 1 / Tier 2 / Tier 3 / Tier 4
***Deductible: $100 Individual, $200 Family

Top 10 Non-Preferred Brand Drug Utilization

Top 10 by Rx Count

Drug Name	# Distinct Patients	# Scripts	Plan Paid	Average Plan Paid per Rx
Vraylar	117	526	$788,651	$1,499.34
Vyvanse	121	386	$91,928	$238.15
Rexulti	30	133	$204,787	$1,539.76
Xcopri	10	101	$125,110	$1,238.71
Veozah	32	86	$49,782	$578.86
Trintellix	26	76	$56,563	$744.26
Caplyta	24	72	$108,678	$1,509.42
Briviact	13	72	$121,296	$1,684.67
Zoryve	29	66	$35,496	$537.82
Gemtesa	28	56	$52,394	$935.60

Top 10 by Average Cost per Rx

Drug Name	# Distinct Patients	# Scripts	Plan Paid	Average Plan Paid per Rx
Fintepla	3	28	$475,621	$16,986.47
Jynarque	3	25	$470,447	$18,817.90
Koselugo	1	7	$157,962	$22,566.01
Galafold	1	6	$178,991	$29,831.82
Tepezza	1	5	$223,944	$44,788.83
Onureg	1	4	$101,311	$25,327.81
Nexviazyme	1	4	$293,528	$73,382.09
Vowst Capsule	2	2	$36,696	$18,347.97
Supprelin LA	1	1	$48,563	$48,563.33
Mavenclad	1	1	$90,712	$90,712.15

* Non-preferred drugs dispensed between May 1, 2024 and April 30, 2025
** Top 10 based on # Scripts dispensed
***Patient Count is approximate given multiple strengths may be used by a patient

		CDHP	All Other	Copay	EPO	Employee Cont	Change in EE Contributions
Current (PY2026)	**State Actives**						
	Employee	6.5%	12.1%	10.4%	21.7%	$6,219,564	
	Dependents	31.0%	35.2%	33.9%	42.4%	$6,219,703	Check
	State Retirees						
	Retiree	33.0%	38.9%	35.8%	43.9%		
	Dependents	50.9%	54.3%	53.0%	59.0%		
Alternative	**State Actives**						
	Employee	7.5%	15.0%	15.0%	15.0%	$6,781,919	$562,355
	Dependents	35.0%	35.0%	35.0%	35.0%		
	State Retirees						
	Retiree	30.0%	40.0%	40.0%	40.0%		
	Dependents	50.0%	60.0%	60.0%	60.0%		
From Theresa	**State Actives**						
	Employee	10.0%	20.0%	20.0%	20.0%	$7,366,266	$1,146,702
	Dependents	20.0%	35.0%	35.0%	35.0%		
	State Retirees						
	Retiree	30.0%	40.0%	40.0%	40.0%		
	Dependents	55.0%	70.0%	70.0%	70.0%		

Current PY2026 Employee Contributions

State Active Rates	CDHP	Copay	EPO
Participant	$55.26	$91.79	$219.91
Participant + Spouse	$313.94	$386.99	$643.23
Participant + Children	$152.27	$202.48	$378.65
Participant + Family	$410.94	$497.68	$801.97
State Retiree Rates			
Participant	$278.06	$314.58	$442.70
Participant + Spouse	$702.81	$775.85	$1,032.09
Participant + Children	$437.34	$487.56	$663.73
Participant + Family	$862.09	$948.83	$1,253.12

Illustrative PY2026 Employee Contribution - based on Weighted Avg All Other

State Active Rates	CDHP	Copay	EPO
Participant	$55.26	$107.22	$122.73
Participant + Spouse	$313.94	$413.91	$461.36
Participant + Children	$152.27	$222.23	$249.72
Participant + Family	$410.94	$528.92	$588.35
State Retiree Rates			
Participant	$278.06	$342.11	$391.95
Participant + Spouse	$702.81	$815.37	$921.08
Participant + Children	$437.34	$519.59	$590.38
Participant + Family	$862.09	$992.85	$1,119.51

Differences

CDHP	Copay	EPO
$0.00	$15.43	-$97.18
$0.00	$26.92	-$181.87
$0.00	$19.75	-$128.93
$0.00	$31.24	-$213.62
$0.00	$27.53	-$50.75
$0.00	$39.52	-$111.01
$0.00	$32.03	-$73.35
$0.00	$44.02	-$133.61

Illustrative PY2026 Employee Contribution - Alternative

State Active Rates	CDHP	Copay	EPO
Participant	$63.69	$132.86	$152.08
Participant + Spouse	$355.70	$437.65	$501.71
Participant + Children	$173.19	$247.15	$283.19
Participant + Family	$465.20	$551.94	$632.82
State Retiree Rates			
Participant	$252.89	$351.79	$403.04
Participant + Spouse	$670.04	$874.28	$1,002.40
Participant + Children	$409.32	$547.73	$627.81
Participant + Family	$826.47	$1,070.22	$1,227.17

Differences

CDHP	Copay	EPO
$8.43	$41.07	-$67.83
$41.75	$50.66	-$141.52
$20.92	$44.67	-$95.46
$54.26	$54.26	-$169.15
-$25.17	$37.21	-$39.66
-$32.77	$98.43	-$29.69
-$28.02	$60.17	-$35.92
-$35.62	$121.39	-$25.95

Illustrative PY2026 Employee Contribution - based on Theresa's Notes

State Active Rates	CDHP	Copay	EPO
Participant	$84.92	$177.15	$202.77
Participant + Spouse	$251.78	$481.94	$552.40
Participant + Children	$147.49	$291.44	$333.88
Participant + Family	$314.35	$596.23	$683.51
State Retiree Rates			
Participant	$252.89	$351.79	$403.04
Participant + Spouse	$711.76	$961.36	$1,102.30
Participant + Children	$424.96	$580.38	$665.27
Participant + Family	$883.83	$1,189.96	$1,364.53

Differences

CDHP	Copay	EPO
$29.66	$85.36	-$17.14
-$62.16	$94.95	-$90.83
-$4.78	$88.96	-$44.77
-$96.59	$98.55	-$118.46
-$25.17	$37.21	-$39.66
$8.95	$185.51	$70.21
-$12.38	$92.82	$1.54
$21.74	$241.13	$111.41

		CDHP	All Other	Copay	EPO	Employee Cont	Change in EE Contributions
Current (PY2026)	**State Actives**						
	Employee	6.5%	12.1%	10.4%	21.7%	$6,219,564	
	Dependents	31.0%	35.2%	33.9%	42.4%	$6,219,703	Check
	State Retirees						
	Retiree	33.0%	38.9%	35.8%	43.9%		
	Dependents	50.9%	54.3%	53.0%	59.0%		
Alternative	**State Actives**						
	Employee	10.0%		18.0%	30.0%	$7,402,516	$1,182,952
	Dependents	20.0%		35.0%	45.0%		
	State Retirees						
	Retiree	30.0%		37.0%	45.0%		
	Dependents	55.0%		67.0%	75.0%		

Current PY2026 Employee Contributions

State Active Rates	CDHP	Copay	EPO
Participant	$55.26	$91.79	$219.91
Participant + Spouse	$313.94	$386.99	$643.23
Participant + Children	$152.27	$202.48	$378.65
Participant + Family	$410.94	$497.68	$801.97
State Retiree Rates			
Participant	$278.06	$314.58	$442.70
Participant + Spouse	$702.81	$775.85	$1,032.09
Participant + Children	$437.34	$487.56	$663.73
Participant + Family	$862.09	$948.83	$1,253.12

Illustrative PY2026 Employee Contribution - based on Weighted Avg All Other

State Active Rates	CDHP	Copay	EPO
Participant	$55.26	$107.22	$122.73
Participant + Spouse	$313.94	$413.91	$461.36
Participant + Children	$152.27	$222.23	$249.72
Participant + Family	$410.94	$528.92	$588.35
State Retiree Rates			
Participant	$278.06	$342.11	$391.95
Participant + Spouse	$702.81	$815.37	$921.08
Participant + Children	$437.34	$519.59	$590.38
Participant + Family	$862.09	$992.85	$1,119.51

Differences

CDHP	Copay	EPO
$0.00	$15.43	-$97.18
$0.00	$26.92	-$181.87
$0.00	$19.75	-$128.93
$0.00	$31.24	-$213.62
$0.00	$27.53	-$50.75
$0.00	$39.52	-$111.01
$0.00	$32.03	-$73.35
$0.00	$44.02	-$133.61

Illustrative PY2026 Employee Contribution - Alternative

State Active Rates	CDHP	Copay	EPO
Participant	$84.92	$159.44	$304.16
Participant + Spouse	$251.78	$464.23	$753.68
Participant + Children	$147.49	$273.73	$472.73
Participant + Family	$314.35	$578.52	$922.25
State Retiree Rates			
Participant	$252.89	$325.41	$453.42
Participant + Spouse	$711.76	$908.86	$1,202.63
Participant + Children	$424.96	$544.21	$734.38
Participant + Family	$883.83	$1,127.65	$1,483.58

Differences

CDHP	Copay	EPO
$29.66	$67.65	$84.25
-$62.16	$77.24	$110.45
-$4.78	$71.25	$94.08
-$96.59	$80.84	$120.28
-$25.17	$10.83	$10.72
$8.95	$133.01	$170.54
-$12.38	$56.65	$70.65
$21.74	$178.82	$230.46

14.

14. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitation. (Monica McJoy, Chief Financial Officer) (**For Possible Action**)
    14.1 Contract Overview
    14.2 New Contracts
    14.3 Contract Amendments
        14.3.1 Carrum Health – Centers of Excellence
    14.4 Status of Current Solicitations

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Joe Lombardo
Governor

Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 12, 2025

Item Number: 14

Title: Contract Status Report

Summary

This report addresses the status of PEBP's contracts, including an overview of its current contracts, potential new contracts, contract amendments for the Board's consideration, and the status of current solicitations.

14.1 Contracts Overview

PEBP Active Contracts Summary			
VENDOR	**SERVICE**	**EFFECTIVE DATE**	**EXPIRATION DATE**
Brown & Brown of Mass.	Health Plan Auditor	04/13/2021	06/30/2027
Carrum Health	Centers of Excellence	02/12/2024	06/30/2028
Carrum Health	Oncology Concierge	05/14/2024	06/30/2028
Diversified Dental Services	Dental PPO	07/01/2021	06/30/2026
Eide Bailly	Financial Auditor	07/11/2023	12/31/2026
Express Scripts	Pharmacy Benefit Manager	07/01/2025	06/30/2026
Health Plan of Nevada	Southern Nevada HMO	07/01/2025	06/30/2030
HSA Bank	HSA/HRA Account Manager	07/01/2022	06/30/2028
Lifeworks/TELUS Health	Benefits Management System	05/10/2022	12/31/2026
Segal Company	Consulting Services	07/01/2022	06/30/2027
United Healthcare Insurance	Group Basic Life Insurance	07/01/2022	06/30/2028
UMR, Inc.	TPA & Other Services	07/01/2022	06/30/2028
Willis Towers Watson (Via Benefits)	Medicare Exchange	07/01/2025	06/30/2030

Staff is currently seeking approval of an extension of PEBP's contract with Diversified Dental Services for the dental PPO and will update the Board on the status of such extension as a future meeting.

Staff is currently discussing details of a potential extension of PEBP's contract with Express Scripts for pharmacy benefit management services. If the parties agree on terms, staff will seek

necessary approvals from State Purchasing and present such extension for the Board's consideration at a future meeting.

No action necessary.

14.2 New Contracts

PEBP has no new contracts for the Board's consideration.

No action necessary.

14.3 Contract Amendments (FOR POSSIBLE ACTION)

14.3.1. Carrum Health – Centers of Excellence:

Amendment to:

(1) add additional types of procedures (gastroenterological; ear, nose, and throat; general surgery, pain management, and urological) that PEBP members may access at Carrum's National Centers of Excellence (COE); and

(2) add an "assessment-only" fee to the payment schedule to address situations when a necessary preoperative medical assessment is conducted but the patient does not proceed to surgery at Carrum's COE network.

Recommendation: ***Approve amendment to Carrum Centers of Excellence contract as described above.***

14.4 Current Solicitations

PEBP continues to work on negotiations with the vendor chosen to provide a Benefits Management System. There are no other solicitations in progress.

No action necessary.

15.

15. Executive Officer Report. (Theresa Carsten, Executive Officer) (**For Possible Action**)

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

[ ] Action Item
[x] Information Only

Date: December 12, 2025

Item Number: 15

Title: Executive Officer Report

SUMMARY

This report provides the Board, PEBP members and other stakeholders with information on agency operations.

REPORT

FOR INFORMATION ONLY:

1. CARSON TAHOE HOSPITAL/UMR UPDATE
   Carson Tahoe and UMR have finalized a contract amendment to extend participation in the PEBP network through June 30, 2027. The amendment was signed October 24, 2025.

2. INTERIM RETIREMENT AND BENEFITS COMMITTEE
   PEBP has been notified that IRBC will likely be scheduled in January or February 2026. In accordance with NRS 287.0425, PEBP will be presenting information relating to PY 25 utilization and PY 27 benefit plan design. The fiscal year 24 Financial Statements from Eide Bailey have been presented here today, and the OPEB report was provided at the October 2025 board meeting. This information will be included in the IRBC packet submission.

3. HPN LARGE GROUP MEDICAL LOSS RATIO PREMIUM REBATE
   Staff provided Segal a file of members enrolled in Health Plan of Nevada's HMO plan for November 2025 so they could determine the final amount of the one-time premium reduction. Attached in Segal's memo it notes the calculated amount to be $72.77 per subscriber. PEBP's accounting staff have worked with TELUS to apply the reduction of $72.77 to the 3,213 members enrolled in HPN the month of November applied in the month of December 2025. Letters to non-state employers will be sent, as they relate to

the premium reductions made by TELUS, as well as email notifications PEBP staff will distribute to impacted state members.

Segal

Richard Ward, FSA, FCA, MAAA
West Region Market Director, Public Sector
T 956.818.6714
M 619.710.9952
RWard@Segalco.com

500 North Brand Boulevard
Suite 1400
Glendale, CA 91203-3338
segalco.com

Memorandum

To: Theresa Carsten, Executive Officer
Nevada Public Employees' Benefits Program (PEBP)

From: Richard Ward, FSA, FCA, MAAA

Date: November 25, 2025

Re: Medical Loss Ratio Rebate from Health Plan of Nevada (HPN)

The Affordable Care Act requires that health insurance issuers provide rebates to policyholders and subscribers in large group health plans when the issuer's Medical Loss Ratio (MLR) is below 85% for the large group market in the state in which the policy is located. Issuers must also send notices concerning the rebate directly to both the policyholder and the individual subscribers. This memo provides an analysis on the suggested base rebate amount for consideration to the plan members. The decision regarding how to disburse the rebates involves fiduciary considerations; therefore, legal counsel should be consulted before finalizing any decisions regarding payment of funds.

On September 17, 2025, HPN notified PEBP staff that it would be issuing a rebate of $891,657.35 for the 2024 benefit plan year (i.e., calendar year 2024) and this would be paid directly to PEBP as the policyholder. The calendar year measurement period differs from PEBP's July-June plan year cycle, but this does not affect how the rebate should be calculated.

The portion required to be refunded to plan participants is to be based on enrollment and cost share provisions during the period the refund was earned. Using calendar year 2024 enrollments and premium rates, the portion to be allocated to reducing member costs is $233,811.77, based on a 26.2% member cost share of the full premium rates in CY2024 for the HMO.[1]

PEBP has the discretion to vary the subsidy by such factors as coverage tier election. But the administrative effort required to operationalize that may outweigh the intended additional precision. Therefore, our recommendation is to provide a uniform rebate to all eligible members, and PEBP has opted to provide a one-time payment as soon as administratively possible. Using the PEBP provided plan census showing 3,213 subscribers electing the HMO option in November 2025, the rebate equates to $72.77 per subscriber.

For Non-State members, the employer collects the premium and provides PEBP the full cost for both the employer and the subscriber. Federal regulations require the rebate reduce costs for the subscribers. Therefore, PEBP should provide this same amount to the Non-State employers and instruct these employers to reduce their current subscribers' HMO premiums by the appropriate amount or provide a similar payment to appropriately disperse the refund.

[1] The allocated premium calculation has been refined from the illustrative figure provided in the October 24, 2025 memo. The refinement reflects actual monthly calendar year 2024 enrollment and cost split.

16.

16. CY 26 Meeting Dates. (Theresa Carsten, Executive Officer) (**For Possible Action**)

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY

PUBLIC EMPLOYEES' BENEFITS PROGRAM

3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

2026 PEBP Board Meeting Calendar

Meeting Dates and Topics may be subject to change

Month	Date	Major Topics - *TENTATIVE*	Location
January	**22**	• Election of Board Chair • Governor Recommended Budget Overview • Plan Year 2027 Master Plan Documents Update • Annual PEBP Appeals and Complaints Summary • Status of PEBP Contracts • Vendor reports • Strategic Plan Design	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
February	**No Meeting**		
March	**19**	• Approve plan rates for Plan Year 2027 • Plan Year 2027 Summary of Benefits and Coverage • Status of PEBP Contracts	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
April	**No Meeting**		
May	**21**	• Update on Budget Closing • Status of PEBP Contracts • Vendor Reports	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
June	**No Meeting**		
July	**23**	• Status of PEBP Contracts • Vendor reports • Actuarial report on Retiree Medicare Enrollment	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
August	**No Meeting**		
September	**24**	• Annual State of PEBP report • Plan Year 2028 plan design options discussion • Status of PEBP Contracts	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
October	**No Meeting**		
November	**17**	• Approve program design options for Plan Year 2028 • Status of PEBP Contracts • Vendor reports	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
December	**No Meeting**		

17.

17. Strategic Planning Meeting Discussion. (Theresa Carsten, Executive Officer) (**For Possible Action**)

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109
Carson City, Nevada 89706
(775) 684-7000 | (702) 486-3100 | (800) 326-5496
NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

[x] Action Item
[ ] Information Only

Date: December 12, 2025

Item Number: 17

Title: Strategic Planning Discussion

SUMMARY

The board and Chair Wells received a memo from the Nevada Health Authority Director, Stacie Weeks, addressing the three-year department strategic plan goals. The memo is found on page 2 of this document for consumption.

Chair Wells has previously suggested that the January board meeting be utilized to update the PEBP strategic plan. I believe the current strategic plan is outdated and requires revisions and I support the board bringing our strategic plan current in alignment with the goals and objectives outlined by Director Weeks. Of note, if the PEBP strategic plan does not align with the department level strategic plan upon its completion, revisions will be required at that time.

At the time of the development of this document Director Weeks hopes to be available for questions and discussion, but if her schedule does not permit her attendance, then I am happy to communicate any questions or concerns from the board and provide updated information at the January board meeting.

Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
NEVADA MEDICAID
4070 Silver Sage Drive
Carson City, Nevada 89701
NVHA.NV.GOV

Stacie Weeks, Director

To: Jim Wells, PEBP Board Chair
Members of PEBP Board

From: Stacie Weeks, Director, NVHA

Date: November 27, 2025

Re: NVHA Strategic Priorities & Alignment Opportunities with PEBP

Governor Joe Lombardo and state policymakers established the Nevada Health Authority (NVHA) to unify state health agencies, reduce health care costs for Nevadans, and improve the quality and access to care. Its creation was driven by the goal of increasing the state's buying power, streamlining services, and making health care more affordable and accessible by bringing programs like Medicaid, Public Employees' Benefits Program, and the State's health exchange under one umbrella.

To realize this vision and mission, the NVHA Executive Leadership Team (ELT), which includes the PEBP Executive Officer, settled on four main goals to guide the work of the new department as a whole. NVHA ELT also identified several strategic priorities in support of these goals that would serve as the foundation for a 3-year Strategic Business Plan. This plan and the needed activities for achieving each strategic priority are currently under development at NVHA. The goal is for a public release of this plan in February or March of 2026.

In support of the PEBP Board's efforts surrounding priority setting, I am pleased to offer the focus areas of these strategic priorities prior to the public release. Per state law and the legislative intent behind the establishment of NVHA, we seek to align efforts with those of the PEBP Board, including strategic priorities to the extent feasible, so we can best maximize our impact across programs and harness shared resources and expertise in support of our shared goals for the PEBP program.

Each strategic priority is organized below by the goal it is intended to support. Some priorities are more pertinent or specific to the needs of PEBP and are noted as such below.

A. **Goal: Improving the state's performance on key health indicators.**

1. Strategic Priority Focus Areas
a. Healthier Pregnancies & Births for Members
b. Behavioral Health System Transformation
c. Chronic Disease Prevention & Management*
d. Population Health Management*

e. More Affordable Coverage Options*

B. **Increasing the financial sustainability of all NVHA coverage programs.**

1. Strategic Priority Focus Areas
a. Smarter Purchasing & Contracting*
b. Market Reform Options*
c. Controls for Program Cost Drivers*
d. Stronger Program Integrity Efforts (Provider Fraud, Waste, & Abuse)*
e. Better Government & Administrative Efficiency*

C. **Expanding the capacity of the health care workforce to meet needs of Nevadans.**

1. Graduate Medical Education (GME) Residency Expansion
2. Rural Health Care Investments
3. Attractive Healthcare Ecosystem for Providers (includes network provider incentives) *

D. **Driving better value, coordination, and innovation in Nevada's health system.**

1. Multi-Market Value-Based Payment Alignment for Providers*
2. Consumer/Member Engagement in Health & Wellness*
3. Data-Driven Decisions for Programs*
4. Community & Provider Engagement *

** The focus areas are more likely to involve specific strategies for PEBP with the goal of improving coverage options and program operations.*

Over the coming months, NVHA will further develop the objectives for each of these strategic priorities with staff and teams with the goal of hosting a public workshop in January for stakeholder and community engagement. As always, NVHA welcomes any and all feedback and requested specific activities that the PEBP Board would like to have added or considered for the NVHA 3-Year Strategic Plan.

Additionally, in early 2026, the NVHA will be contracting with a set of actuaries and firms for modeling several options for market and purchasing strategies or reforms across its coverage programs as provided under state law. The goals of these efforts are to identify the changes needed to improve health outcomes, achieve more financially stable programs, and support better value and innovation across NVHA coverage programs. NVHA ELT looks forward to sharing the results of these activities next summer with the PEBP Board and other stakeholders.

If you have any questions or need more information, please do not hesitate to reach out.

18.

18. Quarter 4 Vendor Reports. (Information/Discussion)
    - 18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        - 18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        - 18.1.2 Q4 Doctor on Demand Engagement Report
        - 18.1.3 Q4 CDHP Performance Review
        - 18.1.4 Q4 LD PPO Performance Review
        - 18.1.5 Q4 EPO Performance Review
        - 18.1.6 Q4 HPN Performance Review
        - 18.1.7 Q4 Dental Performance Review
    - 18.2 Questions or discussion related to any reports provided (Board)

18.1.1

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
    18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

Public Employees Benefit Program

Quarterly Update – 4th Quarter Plan Year 2025

WTW's Individual Marketplace (Via Benefits)

August 19, 2025

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2025

Executive Summary

Plan Enrollment:

- At the end of FY Q4 2025, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace decreased slightly to 11,2434. Since PEBP started with Via Benefits back on July 1, 2011, 124 carriers have been selected by PEBP's retirees with current enrollment in 2,357 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 83% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 5,720 and 1,509 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 17%. Top MA carriers include Aetna with 640 individual plan selections and Humana with 347 individual plan selections. The average monthly premium cost to PEBP participants remained consistent at $7.

Customer Satisfaction:

- In Q4 2025, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.8 out of 5.0 based on 20 surveys returned.
- For Q4 2025, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 267 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q4 2025.

Health Reimbursement Arrangement:

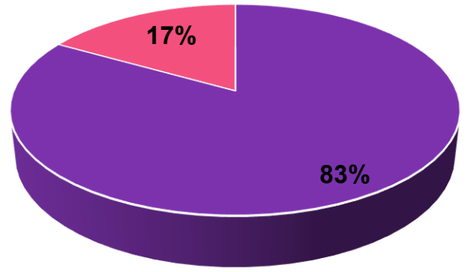
- At the end of Q4 2025 there were 12,410 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 117,032 claims processed in Q4, with 88.3% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 103,318 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q4 was $8,459,457 paid from 47,267 payments for an average of $178.97 per claim payment.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2024		Previous Qtr.
Total enrolled through individual marketplace	11,243	11,314
Number of carriers**	124	124
Number of plans**	2,357	2,352

Plan Type Selection Through 12/31/2024		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,886	1,877
Medicare Supplement (MS)	9,366	9,451

Medical Enrollment



"The percentage of Medicare Advantage plans selected by PEBP's retiree population is slightly below the average for WTW's Book of Business.

Plan Type	Number Enrolled	Average Premium
Medicare Supplement (MS)	9,336	$150
Medicare Advantage (MA,MAPD)	1,886	$6 / $17
Part D drug coverage	5,321	$26
Dental coverage	841	$35
Vision coverage	1,663	$10

** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

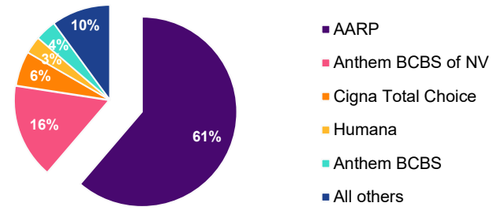
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2025

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	5,720
Anthem BCBS of NV	1,509
Humana	553
Cigna Total Choice	277
Anthem BCBS	338

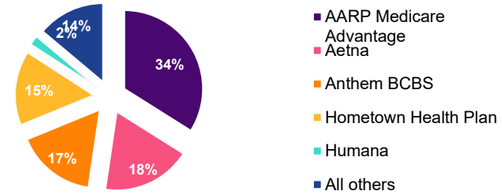
Medicare Supplement Carrier Choice



Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$140
Maximum	$464

Top Medicare Advantage Plans	Total
Aetna	640
Humana	347
AARP	311
Hometown Health Plan	289
Anthem BCBS	37

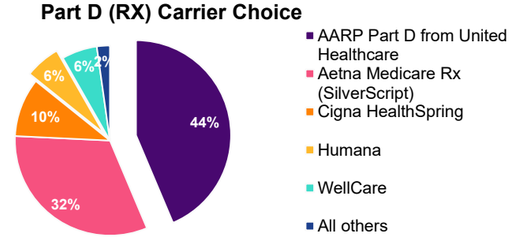
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$7
Median	$0
Maximum	$230

Top Medicare Part D (RX)	Total
WellCare	2,322
Humana	1,709
AARP Part D from United Healthcare	532
Aetna Medicare Rx (SilverScript)	319
Cigna HealthSpring	321

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$0
Average	$17
Median	$15
Maximum	$156

The Public Employees Benefit Program Executive Dashboard

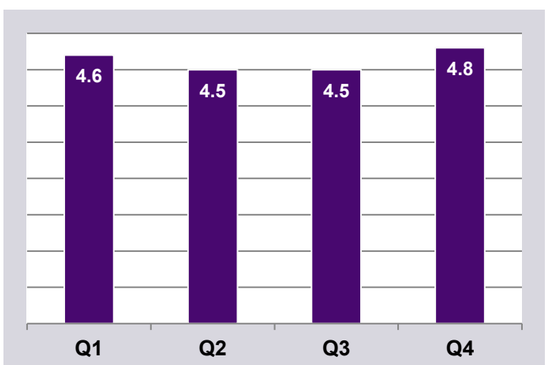
Quarterly Update – 4th Quarter Plan Year 2025

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

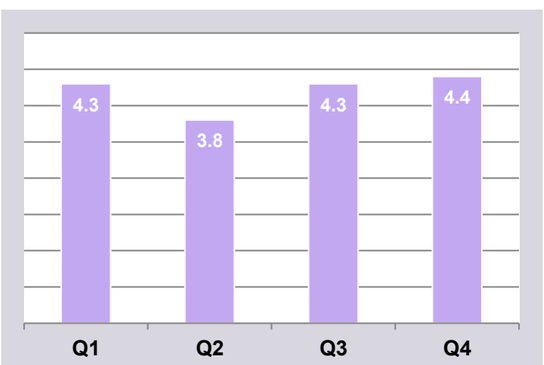
Q4 Enrollment Satisfaction

CSAT score	Count	%
5	16	60%
4	4	20%
3	0	0%
2	0	0%
1	0	0%
	20	**100%**



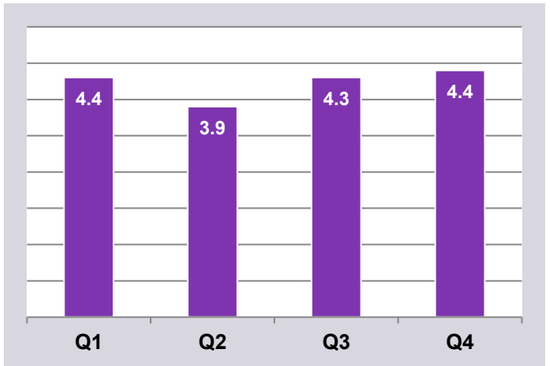
Q4 Service Satisfaction

CSAT score	Count	%
5	190	71%
4	28	11%
3	23	9%
2	11	4%
1	15	5%
	267	**100%**



Q4 Enrollment & Service Combined

CSAT score	Count	%
5	206	64%
4	32	16%
3	23	12%
2	11	3%
1	15	5%
	287	**100%**

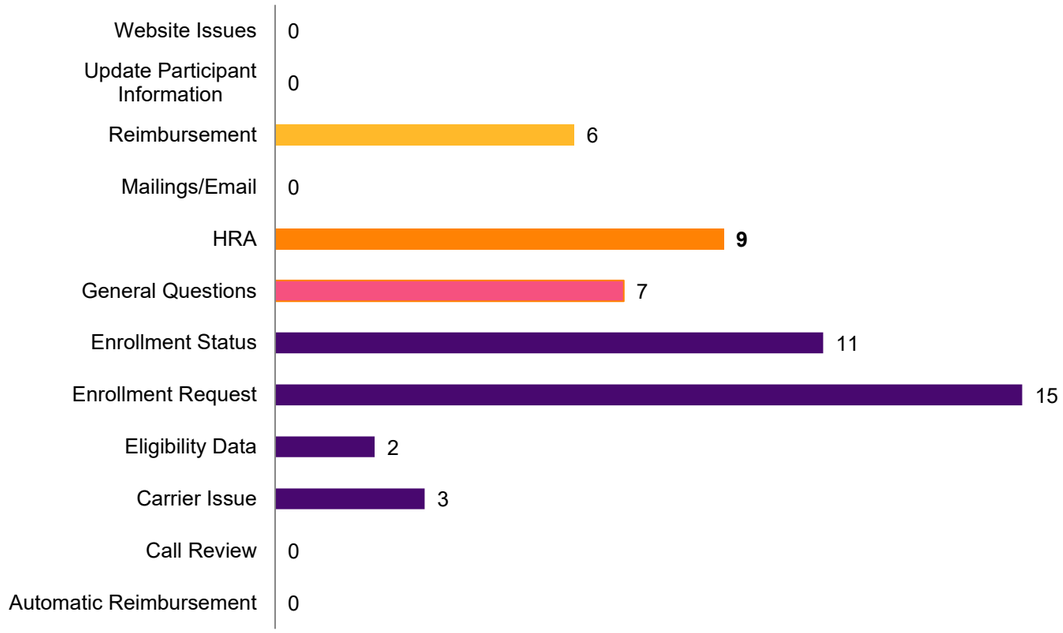


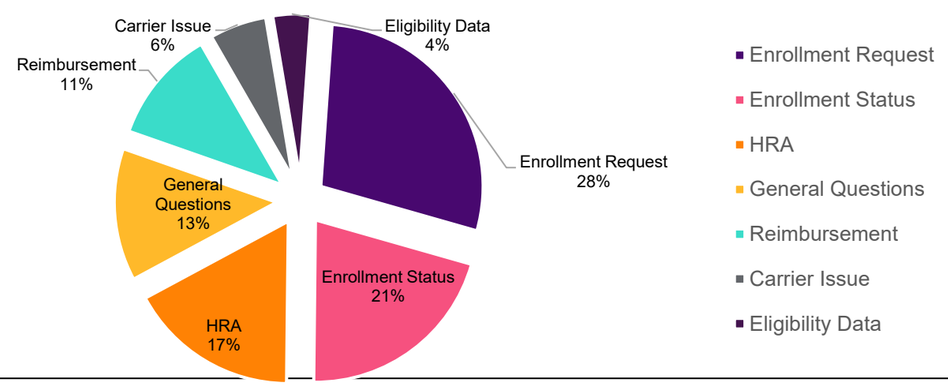
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2025

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and WTW that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned WTW staff until resolution is reached. The total number of inquiries reviewed during Q4-FY 2025 is 53 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Q4 Total	Prior Quarter
HRA accounts	12,410	13,256
Number of payments	47,267	46,157
Accounts with no balance	8,076	8,230
Accounts with Direct Deposit	9,712	10,204
Percentage of Accounts with Direct Deposit	78%	77%
Claims paid amount	$8,459,457	$8,559,513

Claims By Source	Q4 Total	Prior Quarter
A/R file	103,318	105,373
Mail	5,938	7,980
Web	5,938	7,754
Mobile App	2,935	3,911
TOTAL	117,032	125,018

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2025

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.11 Days	Yes
Claim Financial Precision	≥ 98%	99.9%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.0%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q2 and Q3 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	6 seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	0.26%	Yes
Customer Satisfaction	≥ 80%	90.91%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2025

Operations Report

HRA Available Balance Cap of $8,000:

On May 30, 2025, Via Benefits processed the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. This year we adjusted 537 accounts that had balances larger than $8,000. The total adjustment amount was $906,546.

Direct Deposit Only Plan Design:

Effective September 1, 2025, Nevada PEBP's HRA will incorporate a Direct Deposit Only reimbursement plan design. This means that all reimbursements for the HRA must be made through direct deposit rather than via a check. Communications to the approximately 22% of HRA account holders who do not currently have direct deposit set up started in July with an additional communication being sent August and another targeted for September. The communications advise participants of the upcoming Direct Deposit account requirement and encourages them to set on the account ASAP. Any participants who have a payment from the HRA approved but do not have a direct deposit account will have their payments placed on hold.

Outbound Call Campaign to Accounts with Large Balances:

In August, Via Benefits started a new outbound call campaign to Nevada PEBP participants with large available balances of $5,000 or more to try to help educate participants on how to effectively utilize their HRA accounts. The calls will be designed to walk participants through setting up Auto Reimbursement, submitting manual claims for out-of-pocket expenses, and setting up a direct deposit account if their HRA does not currently have one. Educational material about how to utilize the HRA is also available on the Nevada PEBP Via Benefits website at https://my.viabenefits.com/PEBP.

Fall 2025 Retiree Meetings:

WTW and Nevada PEBP are planning on holding virtual retiree meetings in October, with a live attendance option at the PEBP offices in Carson City. The meetings are designed to help age-in participants and employees who are 65 or older who are considering retiring get educated on the transition to Medicare as well as assist those who are already enrolled through Via Benefits with Medicare and the HRA. The meeting for those already enrolled through Via Benefits will also have a focus on the upcoming Medicare Open Enrollment period which is from October 15th to December 7th. The meetings will occur on October 13 and 14 and registration links will be posted to the Nevada PEBP Via Benefits website at https://my.viabenefits.com/PEBP.

The Public Employees Benefit Program Executive Dashboard

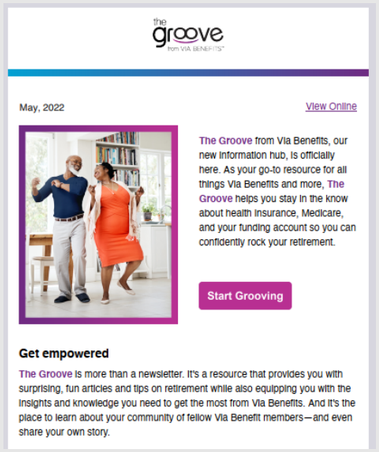
Quarterly Update – 4th Quarter Plan Year 2025

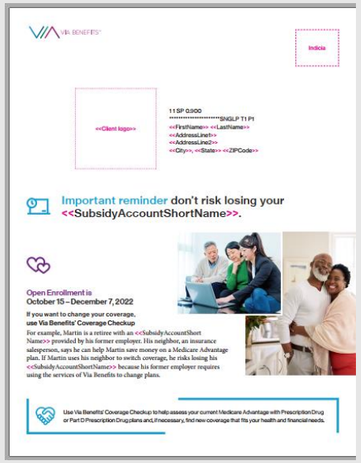
Operations Report Continued

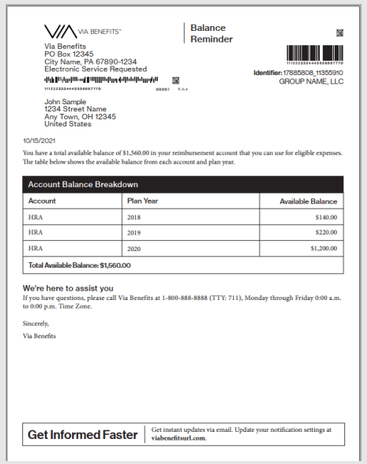
Communications:

Below is information on communications that will be coming up.

- Fall “The Groove” Newsletter
  - “The Groove”, is our digital newsletter communication that is normally sent bi-monthly. The version that is sent in mid/late September and will focus on educating participants on Medicare and the upcoming Medicare Open Enrollment Period that is from October 15 – December 7.
- HRA Qualification Reminder Notification
  - This communication reminds retirees that have a funding qualification requirement to contact Via Benefits during Medicare Open Enrollment if they want to change plans so they do not negatively impact their HRA qualification. This communication is expected to mail in mid/late September.
- Fall Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days and have a positive available balance in their HRA. It is designed to remind them of their HRA balance so they can take action and submit new claims for reimbursement from their account. The Balance Reminder is expected to mail in early/mid September.







18.1.2

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report

Included HEALTH

dr+ on demand by Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

Reporting Period

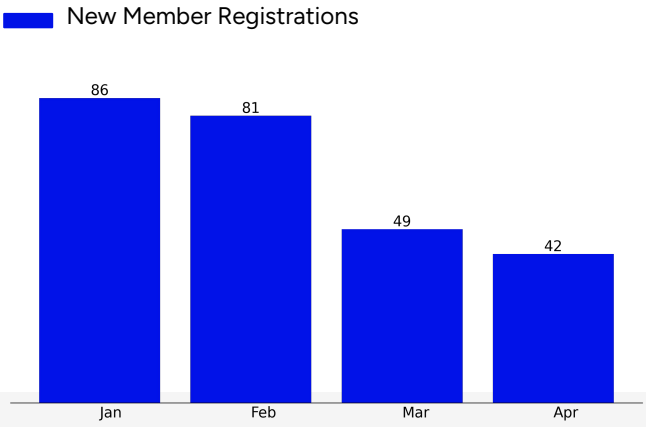
2025-04-01-2025-05-01

Member Engagement

42	334	428
Registrations This Month	Unique Visitors This Month	Total Visits This month

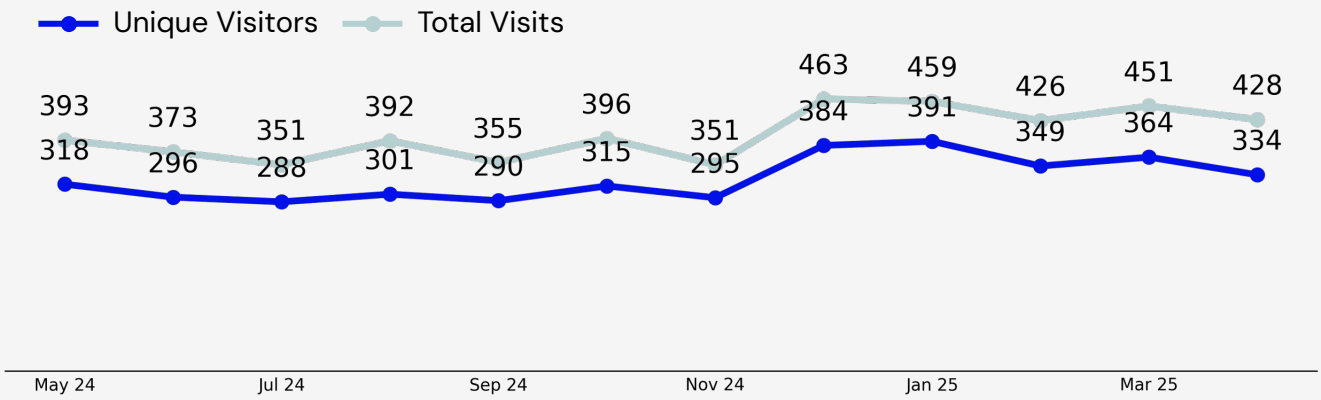
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)



48,935	13,550	27.7%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	258	0.5%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

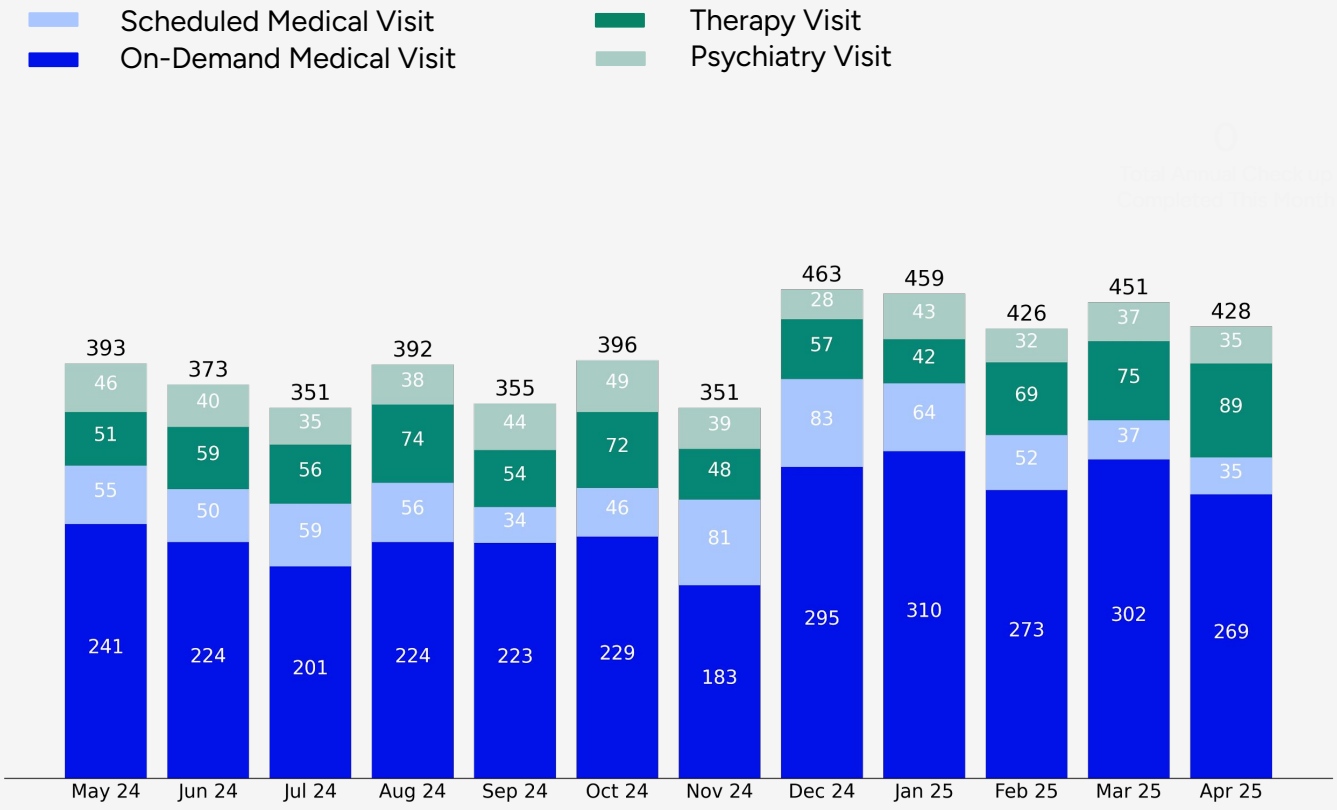
Visits Last 12 Months



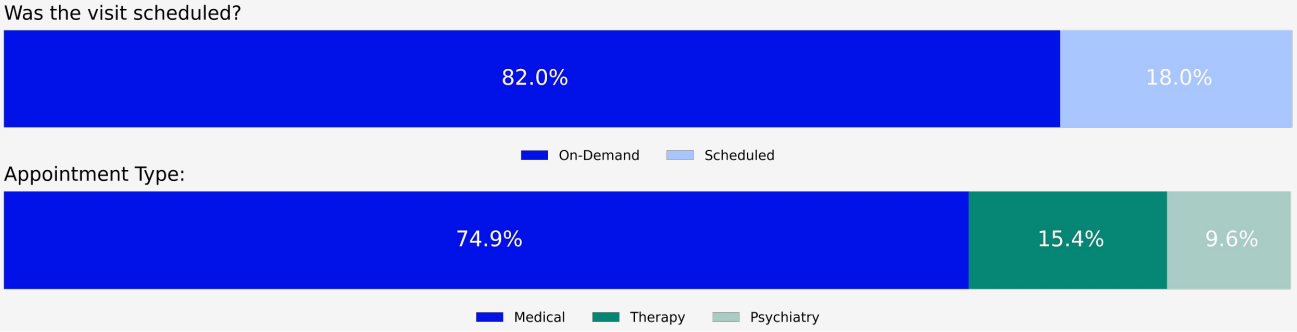
24,486	7,909	3.1	16.2%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
1,764	1,103	1.6	2.3%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Tuesday

Most Popular Time for Visits Year to Date

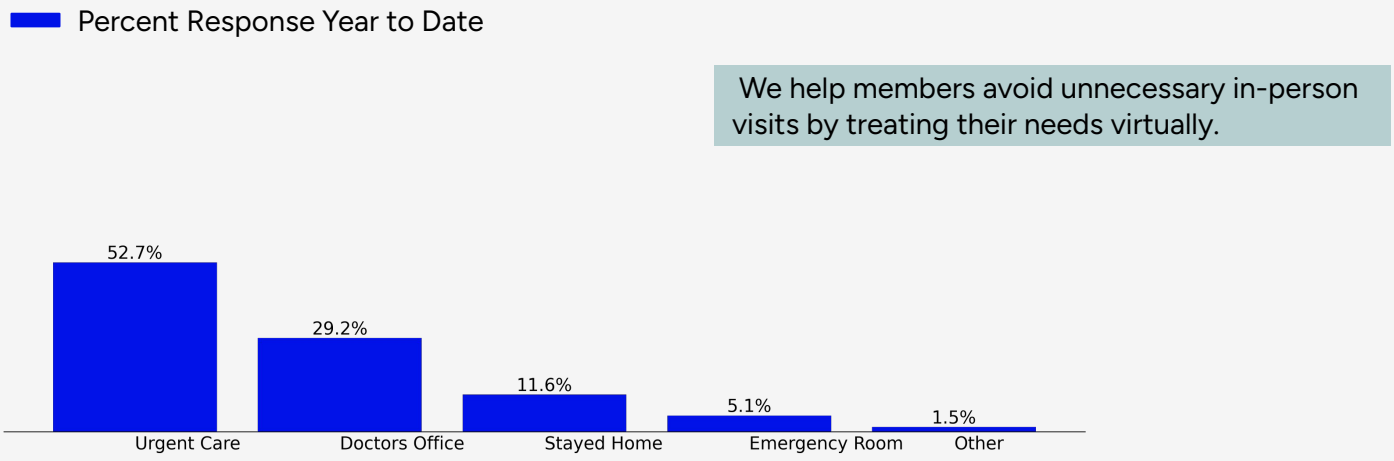
8AM - 10AM

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

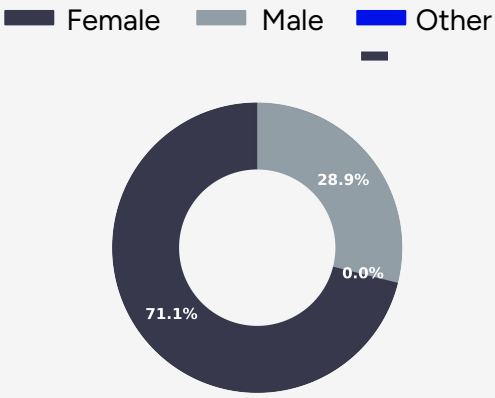
Member Access

This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider during business hours.

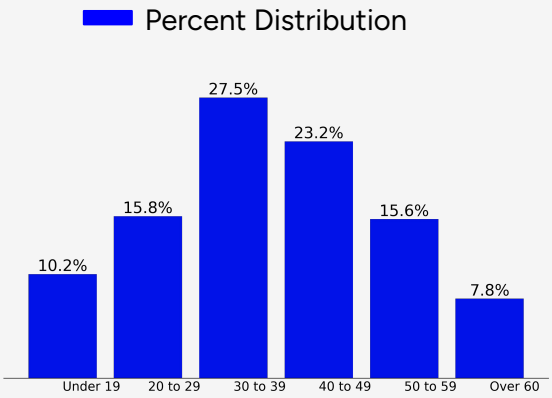
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	April	Year to Date
Average Member Rating	4.9 / 5 (N = 227)	4.9 / 5 (N = 433)
Median Wait Time for On-Demand Medical Appointments	4.0 min	6.4 min
Median Days to Scheduled Appointment (MD & BH)	3.0 days	2.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	180
Cough	125
Urinary tract infection (UTI)	122
Eye issue	87
Sore throat	77
Other injury	76
Anxiety	56
Influenza	47
Nasal congestion	46
Fever	46

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	421
Anxiety disorders	294
Mood disorders	146
Urinary tract infections	118
Inflammation; infection of eye..	96
Adjustment disorders	89
Administrative/social admission	87
Cough, unspecified	75
Attention-deficit conduct and ..	67
Viral infection	63

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

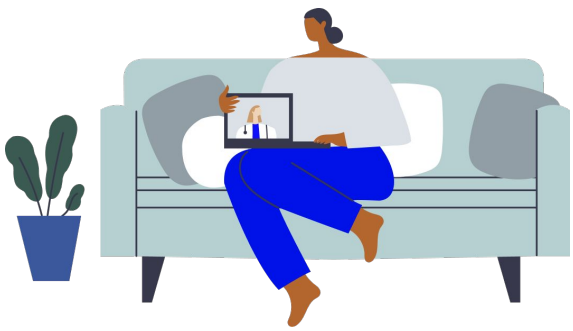
Prescriptions and Testing Summary

346	62.4%	27	1.6%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
prednisone	89
fluticasone propionate	88
amoxicillin and clavulanate po	84
nitrofurantoin (monohydrate/ma	74
albuterol sulfate	71
ondansetron	58
oseltamivir phosphate	57
ipratropium bromide	49
benzonatate	44
methylprednisolone	42

Top Labs	Count (YTD)
urinalysis complete, reflex culture	11
RPR (rapid plasma reagin), serum	6
TSH + free T4, serum	5
CT + NG RNA, PCR, unspecified specimen	4
HIV 1+2 Ab + HIV1 p24 Ag, quantitative immunoassay, serum	4
CBC w/ auto diff	4
CMP, serum or plasma	4
trichomonas vaginalis RNA	4
culture, urine	3
mycoplasma genitalium DNA, qualitative, PCR	3



For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

Included HEALTH

dr. on demand by Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

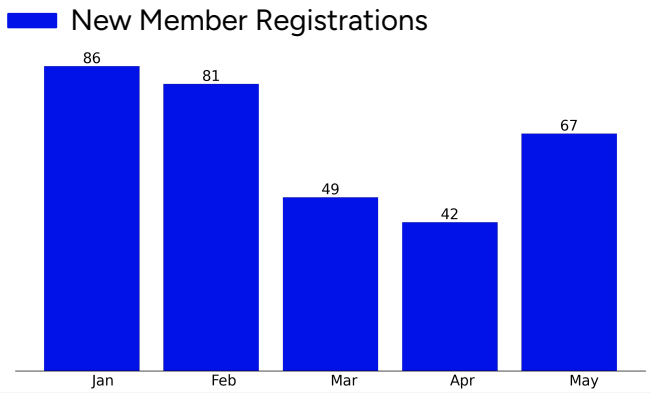
May 2025

Member Engagement

67	339	429
Registrations This Month	Unique Visitors This Month	Total Visits This month

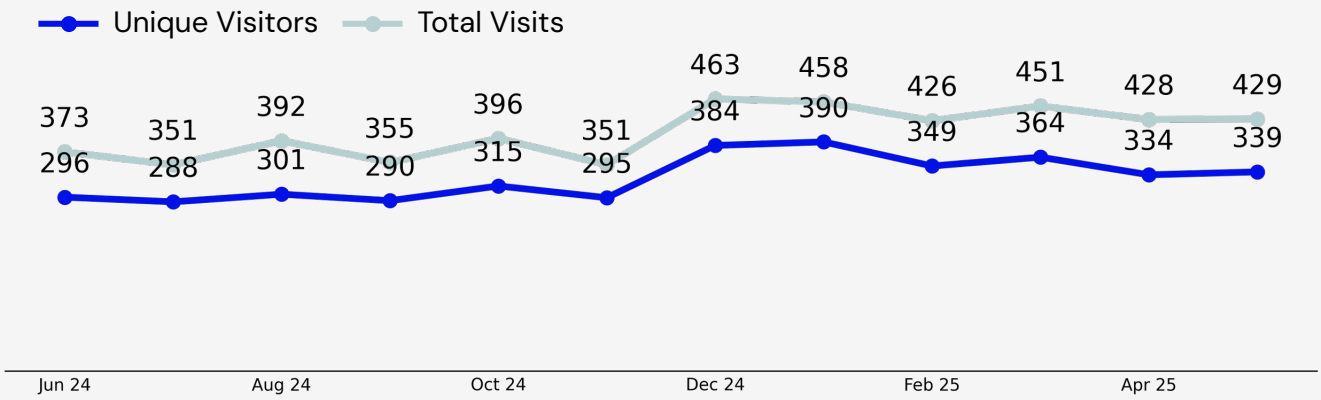
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)



48,935	13,617	27.8%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	325	0.7%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

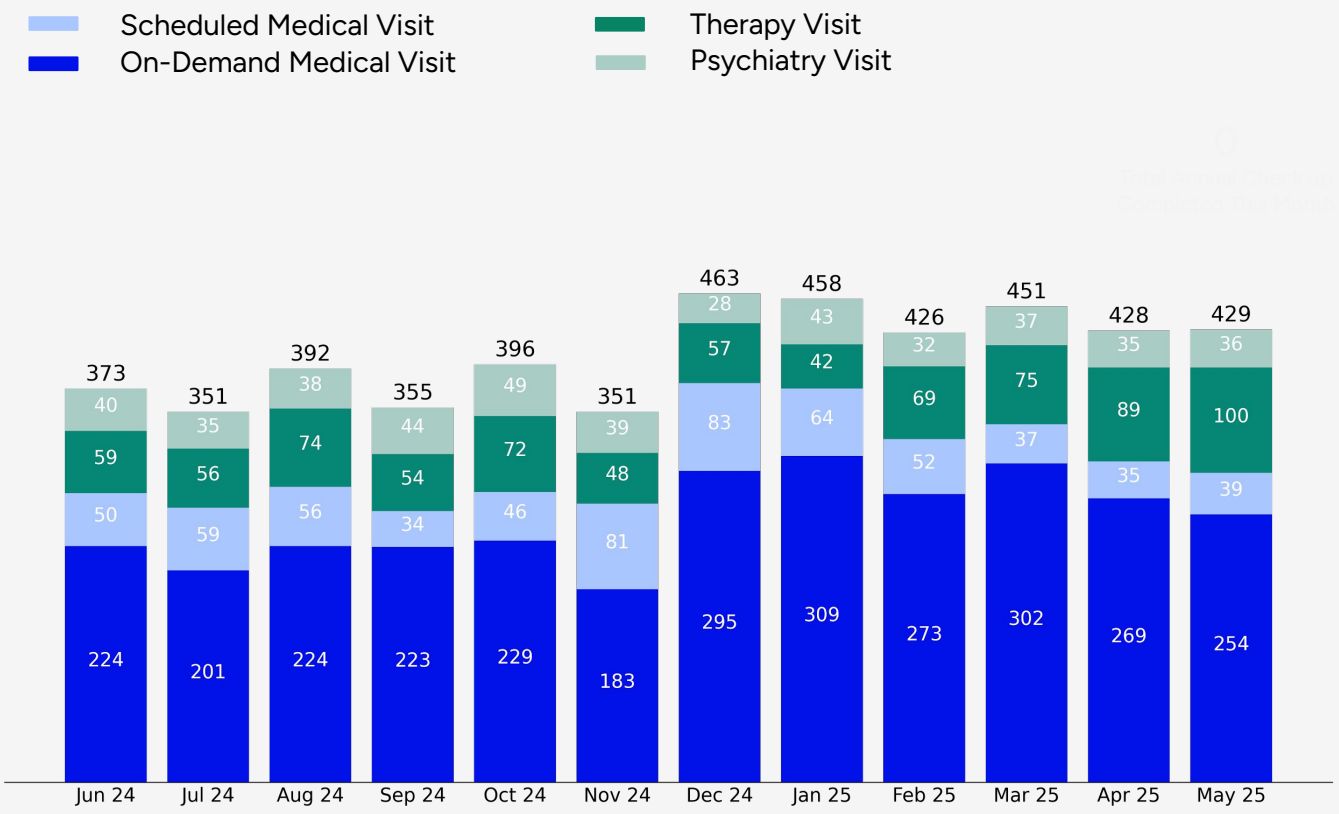
Visits Last 12 Months



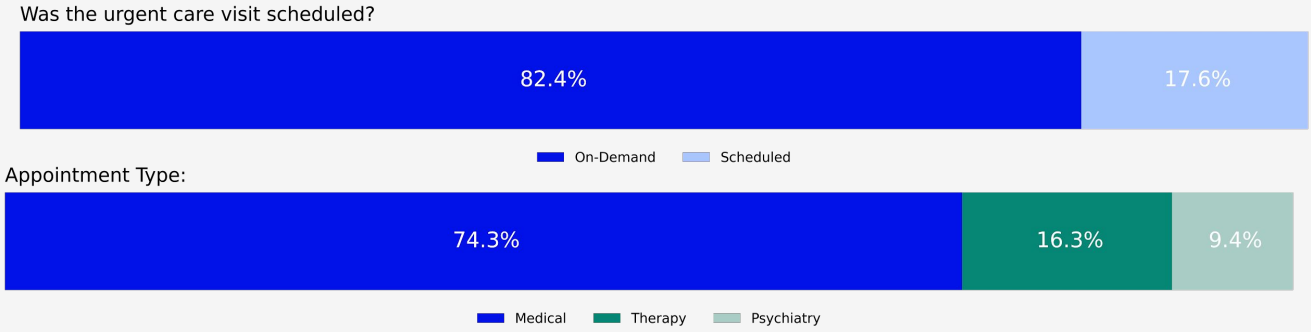
24,914	7,982	3.1	16.3%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
2,192	1,282	1.7	2.6%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Wednesday

Most Popular Time for Visits Year to Date

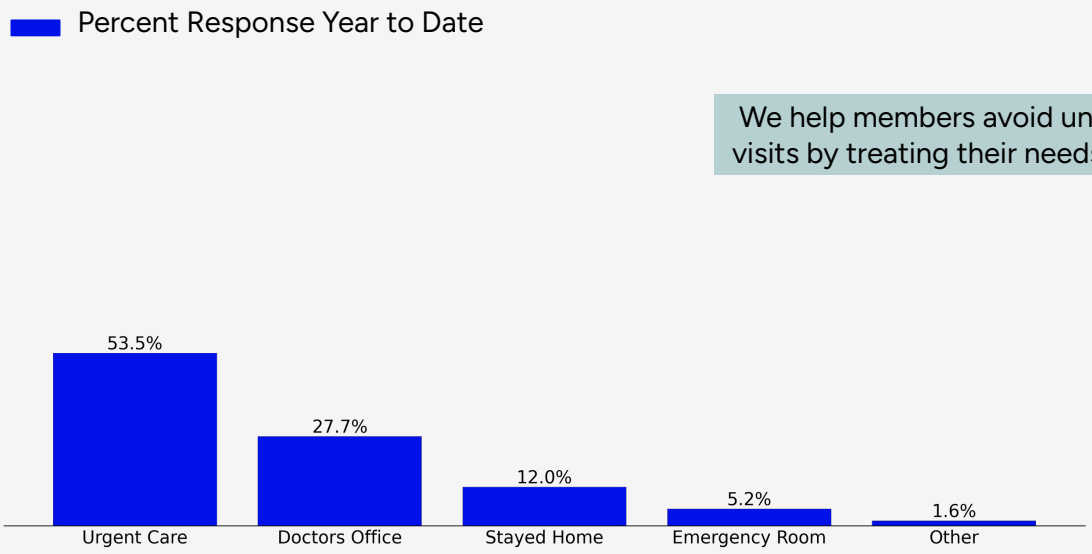
10AM - Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

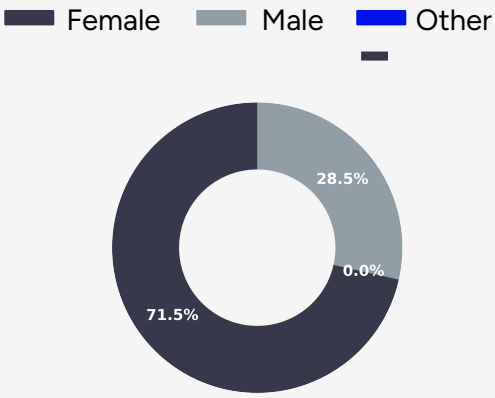
Supporting your population

Member access, demographics, and experience

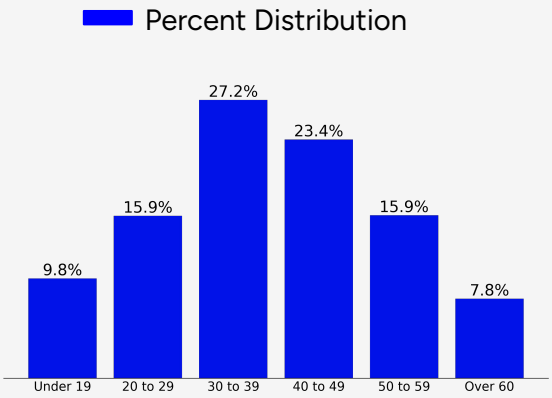
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	May	Year to Date
Average Member Rating	4.9 / 5 (N = 242)	4.9 / 5 (N = 675)
Median Wait Time for On-Demand Medical Appointments	4.2 min	5.8 min
Median Days to Scheduled Appointment (BH)	9.0 days	7.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	202
Urinary tract infection (UTI)	151
Cough	147
Eye issue	105
Other injury	96
Sore throat	87
Anxiety	66
Nasal congestion	63
Fever	54
Influenza	54

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	493
Anxiety disorders	390
Mood disorders	186
Urinary tract infections	147
Adjustment disorders	119
Inflammation; infection of eye..	116
Administrative/social admission	101
Attention-deficit conduct and ..	87
Cough, unspecified	78
Viral infection	71

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

Prescriptions and Testing Summary

415	79.6%	22	3.9%
Prescriptions This Month	of Medical and Psychiatry visits resulted in a prescription order Year to Date	Lab Orders This Month	of Medical visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
benzonatate 200 mg capsule	152
albuterol sulfate hfa 90 mcg/a	116
amoxicillin 875 mg-potassium c	102
nitrofurantoin monohydrate/mac	96
prednisone 20 mg tablet	91
fluticasone propionate 50 mcg/	88
azelastine 137 mcg (0.1 %) nas	83
ondansetron 4 mg disintegratin	60
ipratropium bromide 42 mcg (0.	51
benzonatate 100 mg capsule	[illegible]

Top Labs	Count (YTD)
urinalysis complete, reflex culture	27
cmp, serum or plasma	15
cbc w/ auto diff	9
lipid panel, serum	8
hba1c (hemoglobin a1c), blood	8
tsh + free t4, serum	8
culture, urine	8
rpr (rapid plasma reagin), serum	7
urinalysis, complete	6
trichomonas vaginalis rna	6

For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

Included HEALTH

dr. on demand by Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

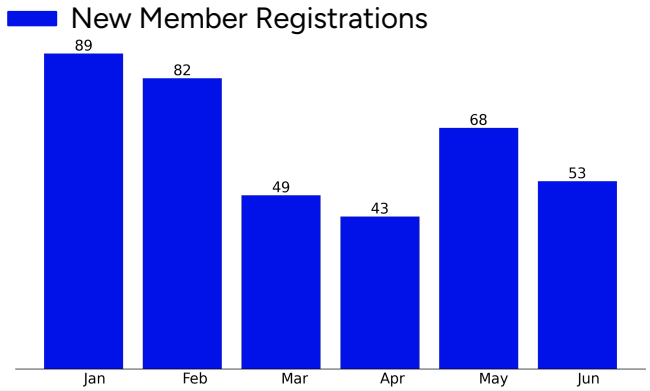
June 2025

Member Engagement

53	298	389
Registrations This Month	Unique Visitors This Month	Total Visits This month

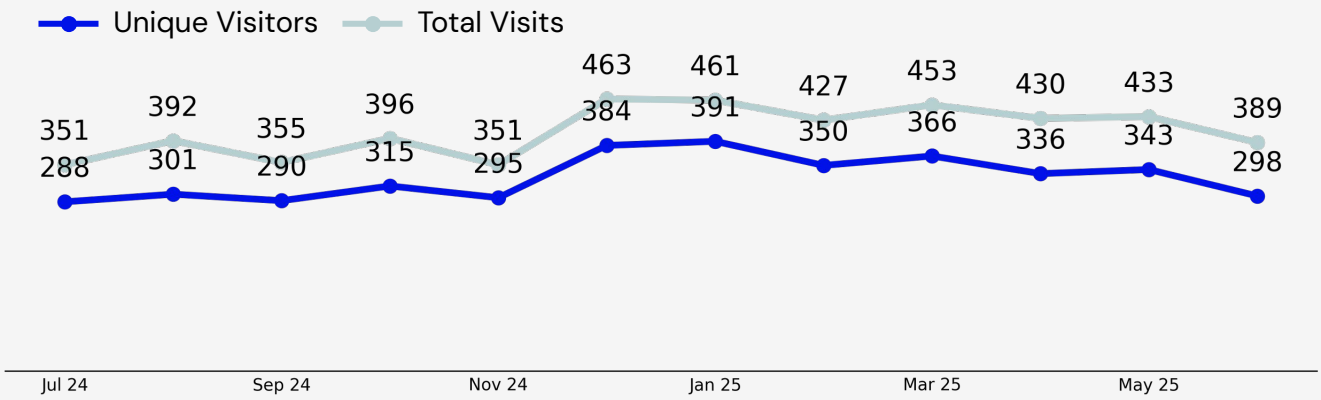
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)



48,935	13,690	28.0%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	384	0.8%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

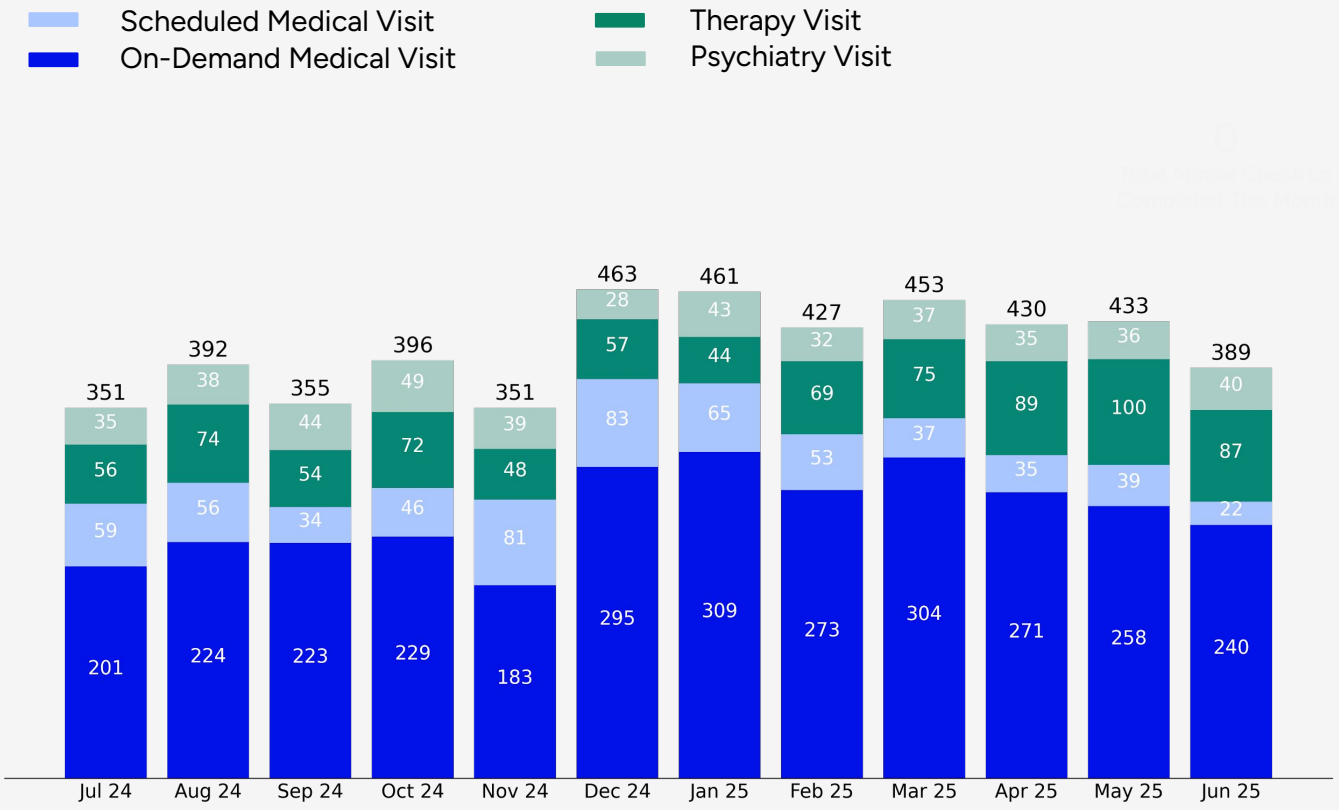
Visits Last 12 Months



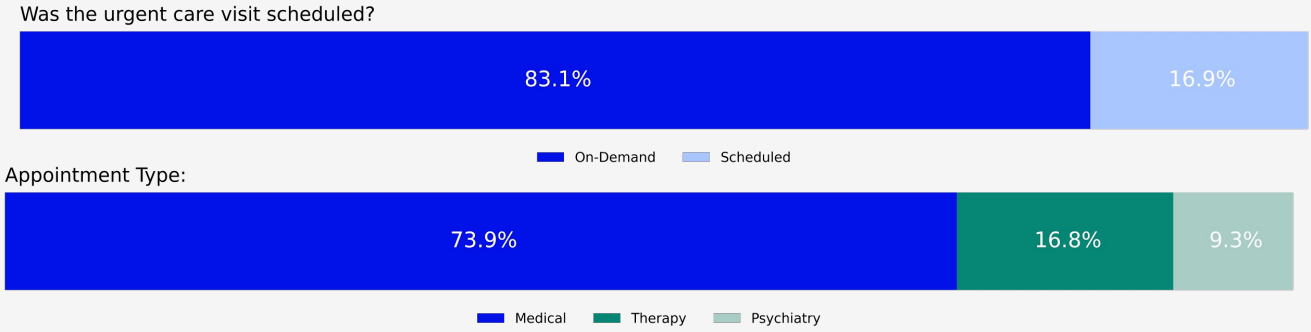
25,315	8,055	3.1	16.5%
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Avg Visits Per Visitor Lifetime to Date	Engagement Rate (Visitors/Lives) Lifetime to Date
2,593	1,439	1.8	2.9%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

Member Engagement

Medical & Behavioral Health Visits (Rolling)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Monday

Most Popular Time for Visits Year to Date

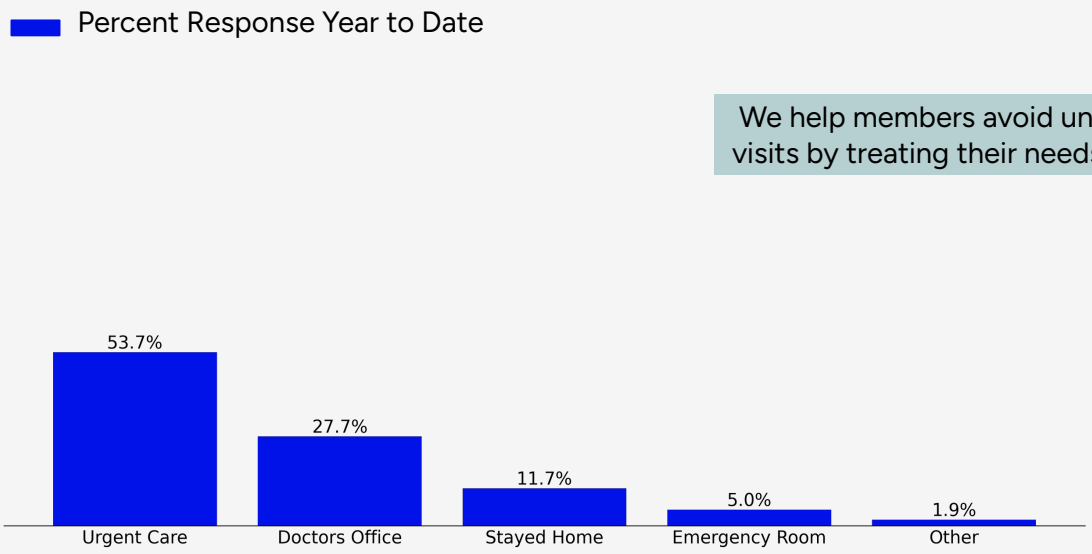
10AM - Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

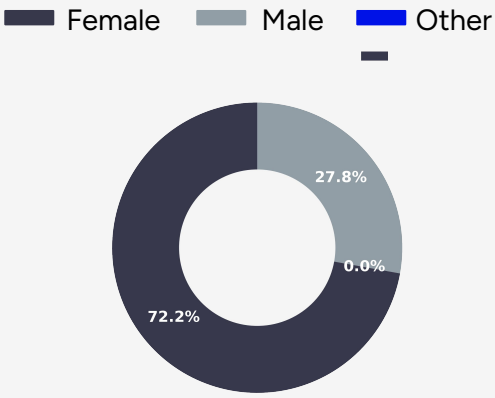
Supporting your population

Member access, demographics, and experience

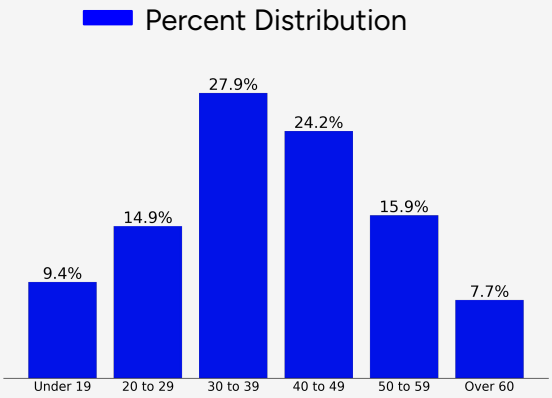
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	June	Year to Date
Average Member Rating	5.0 / 5 (N = 209)	4.9 / 5 (N = 888)
Median Wait Time for On-Demand Medical Appointments	3.5 min	5.4 min
Median Days to Scheduled Appointment (BH)	9.0 days	7.0 days

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Cold	213
Urinary tract infection (UTI)	176
Cough	164
Eye issue	113
Other injury	108
Sore throat	99
Anxiety	83
Nasal congestion	72
Fever	63
Earache	59

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	545
Anxiety disorders	474
Mood disorders	233
Urinary tract infections	170
Adjustment disorders	151
Administrative/social admission	131
Inflammation; infection of eye..	125
Attention-deficit conduct and ..	101
Viral infection	89
Cough, unspecified	79

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

Prescriptions and Testing Summary

357
Prescriptions
This Month

79.1%
of Medical and Psychiatry visits resulted in a prescription order
Year to Date

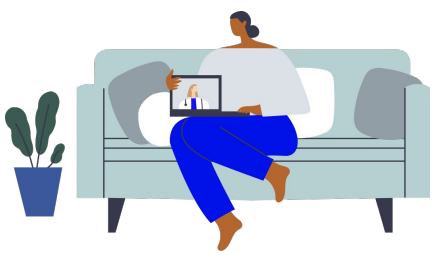
11
Lab Orders
This Month

3.6%
of Medical visits resulted in a lab order
Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
benzonatate 200 mg capsule	163
amoxicillin 875 mg-potassium c	123
albuterol sulfate hfa 90 mcg/a	123
nitrofurantoin monohydrate/mac	114
prednisone 20 mg tablet	106
fluticasone propionate 50 mcg/	97
azelastine 137 mcg (0.1 %) nas	90
ondansetron 4 mg disintegratin	71
ipratropium bromide 42 mcg (0.	54
doxycycline hyclate 100 mg cap	53

Top Labs	Count (YTD)
urinalysis complete, reflex culture	30
cmp, serum or plasma	15
cbc w/ auto diff	9
culture, urine	8
tsh + free t4, serum	8
lipid panel, serum	8
hba1c (hemoglobin a1c), blood	8
rpr (rapid plasma reagin), serum	8
urinalysis, complete	6
hiv 1+2 ab + hiv1 p24 ag, quantitative immunoassay...	6



For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

18.1.3

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report
        18.1.3 Q4 CDHP Performance Review

Quarterly Plan Performance Review

HDHP Plan • 2025-4Q

UMR
A UnitedHealthcare Company

RPG 4.90 • Run Date: 8/28/2025

Report Criteria & Contents

Experience Periods*

- **2025 Plan Year (Current)**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024
- **2023 Plan Year**
  - 2023-4Q.1st four Quarters: Claims Paid 7/1/2022 - 6/30/2023
  - 2023 Full Year: Claims paid 7/1/2022 - 6/30/2023

Group Data

- Data reported is for the HDHP Plan only:
- Contract = 7670-06-414946 or 7670-10-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,077 groups with approximately 7.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2024 - 6/30/2025

* Additional date ranges for specific figures are defined on the page if applicable

Executive Summary

Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: -2.8%
- High-Cost Claimants Paid PMPM trend: -19.8%; Non HCCs trend: +9.3%
- Top Paid Diagnostic Chapters: Health Status & Services (+10.4% Paid PMPM), Musculoskeletal (+13.4%), Circulatory System (−3.8%)

Membership & Demographics

- Total membership is 4.6% lower than prior period
- Employees decreased 3.1%, while Dependents were down 7.0%
- 84.0% of members had < $2,500 medical paid, with 21.8% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $24,505, which is 22.0% lower than 2024-4Q
- Paid per ER Visit was $2,486, which is 7.9% higher than 2024-4Q

Network Utilization & Savings

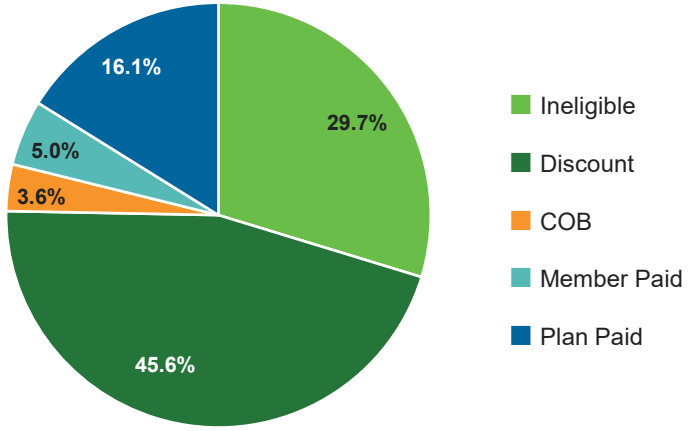
- 97.7% of all Medical spend dollars were to In Network providers
- The average In Network discount was 69.4%, which is 0.9 pts above the 2024 average discount of 68.5%

Medical Total Savings Summary

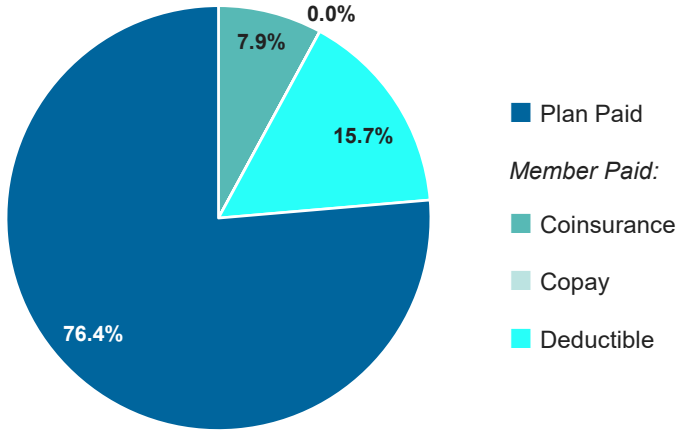
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2025-4Q Total Dollars	2025-4Q PMPM*	2024 PMPM*	*Trend*
Medical Billed	**$549,405,715**	**$1,981**	$1,916	***3.4%***
(-) Ineligible	**$163,132,795**	**$588**	$590	***-0.3%***
Medical Covered	**$386,272,921**	**$1,393**	$1,326	***5.0%***
(-) Discount	**$250,274,019**	**$902**	$870	***3.8%***
Medical Allowed	**$135,998,902**	**$490**	$456	***7.4%***
(-) COB	**$19,522,228**	**$70**	$27	***159.3%***
(-) Coinsurance	**$9,191,214**	**$33**	$32	***3.1%***
(-) Copay	**$1,978**	**$0**	$0	***-80.6%***
(-) Deductible	**$18,248,621**	**$66**	$63	***4.0%***
Total Member Paid	**$27,441,813**	**$99**	$95	***3.6%***
Total Plan Paid	**$88,624,170**	**$320**	$324	***-1.2%***

Breakout of Billed Dollars



Breakout of Paid Dollars: Plan vs. Member Paid



* PMPM (per member per month): Amount per the average total membership (both primary subscribers and dependents) per month.

Medical & Rx Paid Claims by Age Range

Age	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)						Change	
	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Total Paid	Tot Paid PMPM
<1	$3,492,823	$2,526	-$1,583	-$1	**$3,491,241**	**$2,525**	$2,647,119	$1,954	$9,137	$7	$2,656,255	**$1,960**	*-23.9%*	*-22.4%*
1	$385,404	$253	$76,084	$50	**$461,488**	**$303**	$208,040	$167	$754	$1	$208,794	**$168**	*-54.8%*	*-44.6%*
2 - 4	$802,031	$126	$137,570	$22	**$939,601**	**$148**	$1,139,754	$203	$54,939	$10	$1,194,692	**$212**	*27.1%*	*43.5%*
5 - 9	$1,620,235	$121	$382,283	$29	**$2,002,518**	**$150**	$1,646,759	$132	$467,963	$38	$2,114,722	**$170**	*5.6%*	*13.3%*
10 - 14	$1,844,848	$111	$518,616	$31	**$2,363,464**	**$142**	$1,469,092	$92	$281,370	$18	$1,750,462	**$110**	*-25.9%*	*-22.6%*
15 - 19	$4,852,161	$248	$527,944	$27	**$5,380,105**	**$275**	$3,168,759	$172	$574,140	$31	$3,742,900	**$203**	*-30.4%*	*-26.2%*
20 - 24	$3,655,629	$156	$1,670,114	$71	**$5,325,743**	**$228**	$3,052,089	$132	$1,494,714	$65	$4,546,802	**$197**	*-14.6%*	*-13.4%*
25 - 29	$2,875,892	$183	$520,871	$33	**$3,396,764**	**$216**	$2,468,272	$153	$831,846	$52	$3,300,118	**$204**	*-2.8%*	*-5.4%*
30 - 34	$4,958,574	$257	$944,797	$49	**$5,903,371**	**$306**	$5,031,738	$270	$1,128,744	$61	$6,160,483	**$330**	*4.4%*	*8.1%*
35 - 39	$5,149,469	$241	$1,550,847	$72	**$6,700,316**	**$313**	$5,465,875	$270	$1,722,481	$85	$7,188,356	**$355**	*7.3%*	*13.2%*
40 - 44	$4,728,628	$203	$2,097,094	$90	**$6,825,722**	**$293**	$4,647,232	$205	$1,971,375	$87	$6,618,607	**$292**	*-3.0%*	*-0.1%*
45 - 49	$6,311,486	$290	$2,784,244	$128	**$9,095,731**	**$418**	$6,146,027	$296	$3,634,415	$175	$9,780,442	**$471**	*7.5%*	*12.8%*
50 - 54	$9,055,739	$365	$4,479,587	$180	**$13,535,325**	**$545**	$7,997,810	$343	$4,479,922	$192	$12,477,732	**$535**	*-7.8%*	*-1.8%*
55 - 59	$12,001,180	$448	$4,252,486	$159	**$16,253,665**	**$606**	$12,104,456	$480	$5,146,330	$204	$17,250,786	**$684**	*6.1%*	*12.9%*
60 - 64	$19,106,554	$587	$7,930,908	$244	**$27,037,463**	**$831**	$18,503,663	$620	$7,280,599	$244	$25,784,262	**$865**	*-4.6%*	*4.0%*
65+	$13,259,066	$578	$7,045,603	$307	**$20,304,669**	**$886**	$12,927,486	$577	$7,103,137	$317	$20,030,623	**$894**	*-1.3%*	*0.9%*
Total	**$94,099,719**	**$324**	**$34,917,466**	**$120**	$129,017,185	$444	**$88,624,170**	**$320**	**$36,181,865**	**$130**	**$124,806,035**	$450	***-3.3%***	***1.4%***

Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Average Enrollment							
Employees	5,418	*172.7%*	14,776	*-3.1%*	14,314		
Spouses	1,058	*161.5%*	2,766	*-7.8%*	2,550		
Children	2,552	*162.2%*	6,692	*-6.7%*	6,247		
Tot. Members	**9,029**	***168.4%***	**24,235**	***-4.6%***	**23,111**		
Avg. Family Size	1.7	*-1.6%*	1.6	*-1.6%*	1.6	1.9	*-15.9%*
Financial Summary							
Allowed	$49,761,451	*166.7%*	$132,731,482	*2.5%*	$135,998,902		
Plan Paid	$35,215,564	*167.2%*	$94,099,719	*-5.8%*	$88,624,170		
Member Paid (OOP)	$8,398,035	*230.6%*	$27,764,440	*-1.2%*	$27,441,813		
Paid PEPY	$6,499	*-2.0%*	$6,368	*-2.8%*	$6,191	$10,136	*-38.9%*
Paid PMPY	$3,900	*-0.4%*	$3,883	*-1.2%*	$3,835	$5,280	*-27.4%*
Paid PEPM	$542	*-2.0%*	$531	*-2.8%*	$516	$845	*-38.9%*
Paid PMPM	$325	*-0.4%*	$324	*-1.2%*	$320	$440	*-27.4%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	108	*37.0%*	148	*-13.5%*	128		
HCCs per 1000	12.0	*-48.9%*	6.1	*-9.3%*	5.5	6.9	*-19.3%*
Paid per HCC	$244,463	*-5.8%*	$230,303	*-11.6%*	$203,621	$230,655	*-11.7%*
HCC Paid % of Tot	75.0%	*-38.8 pts*	36.2%	*-6.8 pts*	29.4%	30.1%	*-0.7 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$1,095	*14.1%*	$1,249	*-23.7%*	$953	$1,318	*-27.7%*
Outpatient	$1,213	*-6.2%*	$1,137	*14.9%*	$1,306	$1,552	*-15.9%*
Physician	$1,529	*-5.8%*	$1,440	*4.5%*	$1,505	$2,299	*-34.5%*
Ancillary	$64	*-11.2%*	$57	*25.7%*	$71	$110	*-35.4%*

- *With $66.1M paid, the State Active population is 74.6% of total 2025-4Q med spend*
- *On a Paid PMPM basis, State Actives are down 5.8% compared to prior year*
- *Total HDHP Plan Paid PMPM trend is -1.2%*

PEPY (per employee per year) and **PEPM** (per employee per month) represent amounts per the primary subscriber (employee or retiree).

PMPY (per member per year) and **PMPM** (per member per month) represent amounts per all covered members, including dependents.

Amounts **Per Year** (**PEPY** and **PMPY**) have been annualized.

HCCs (High-cost Claimants) are based on patients with $100,000+ paid medical in the period.

Claim Type: Ancillary includes Durable Medical Equipment, prosthetics, some drugs paid on the medical plan, et al.

Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	4,414	*172.1%*	12,012	*-1.7%*	11,809	1	*258.3%*	4	*44.2%*	5
Spouses	812	*159.5%*	2,107	*-6.9%*	1,961	0	*75.0%*	1	*57.1%*	1
Children	2,339	*162.2%*	6,132	*-6.1%*	5,755	1	*81.3%*	2	*-62.1%*	1
Tot. Members	**7,565**	***167.7%***	**20,251**	***-3.6%***	**19,525**	**3**	***146.9%***	**7**	***6.3%***	**7**
Avg. Family Size	1.7	*-1.6%*	1.7	*-1.9%*	1.7	2.7	*-31.1%*	1.8	*-26.3%*	1.4
Financial Summary										
Allowed	$33,624,440	*187.4%*	$96,646,156	*-5.3%*	$91,514,620	$10,060	*716.7%*	$82,160	*-59.2%*	$33,497
Plan Paid	$26,265,259	*177.3%*	$72,836,689	*-9.2%*	$66,141,692	$8,408	*690.1%*	$66,431	*-64.4%*	$23,665
Member Paid (OOP)	$6,408,253	*228.7%*	$21,061,579	*0.7%*	$21,217,588	$1,702	*824.0%*	$15,729	*-37.5%*	$9,832
Paid PEPY	$5,951	*1.9%*	$6,064	*-7.6%*	$5,601	$8,408	*120.5%*	$18,539	*-75.3%*	$4,580
Paid PMPY	$3,472	*3.6%*	$3,597	*-5.8%*	$3,388	$3,153	*220.1%*	$10,091	*-66.5%*	$3,381
Paid PEPM	$496	*1.9%*	$505	*-7.6%*	$467	$701	*120.5%*	$1,545	*-75.3%*	$382
Paid PMPM	$289	*3.6%*	$300	*-5.8%*	$282	$263	*220.1%*	$841	*-66.5%*	$282
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	79	*39.2%*	110	*-20.9%*	87	0	-	0	-	0
HCCs per 1000	10.4	*-48.0%*	5.4	*-18.0%*	4.5	0.0	-	0.0	-	0.0
Paid per HCC	$245,944	*-0.3%*	$245,319	*-14.3%*	$210,234	$0	-	$0	-	$0
HCC Paid % of Tot	74.0%	*-36.9 pts*	37.0%	*-9.4 pts*	27.7%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$994	*19.1%*	$1,184	*-26.7%*	$868	$0	-	$0	-	$0
Outpatient	$1,082	*-4.6%*	$1,032	*10.6%*	$1,142	$830	*595.9%*	$5,778	*-57.5%*	$2,456
Physician	$1,339	*-0.8%*	$1,329	*0.1%*	$1,330	$2,259	*90.8%*	$4,310	*-78.7%*	$916
Ancillary	$57	*-9.8%*	$51	*-7.8%*	$47	$63	*-95.4%*	$3	*197.6%*	$9

Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	887	*175.5%*	2,443	*-9.4%*	2,212	117	*172.4%*	318	*-9.5%*	288
Spouses	232	*168.5%*	623	*-10.2%*	560	14	*163.2%*	36	*-19.3%*	29
Children	207	*162.7%*	544	*-11.9%*	479	5	*171.7%*	14	*-12.9%*	12
Tot. Members	**1,326**	***172.3%***	**3,610**	***-9.9%***	**3,251**	**135**	***171.4%***	**367**	***-10.5%***	**329**
Avg. Family Size	1.5	*-1.2%*	1.5	*-0.5%*	1.5	1.2	*-0.3%*	1.2	*-1.2%*	1.1
Financial Summary										
Allowed	$12,588,080	*147.6%*	$31,168,930	*18.3%*	$36,877,665	$3,538,871	*36.6%*	$4,834,236	*56.7%*	$7,573,121
Plan Paid	$7,713,149	*147.4%*	$19,082,580	*6.3%*	$20,280,083	$1,228,749	*72.0%*	$2,114,018	*3.1%*	$2,178,730
Member Paid (OOP)	$1,754,458	*229.8%*	$5,786,040	*-6.2%*	$5,428,023	$233,622	*285.7%*	$901,093	*-12.7%*	$786,370
Paid PEPY	$8,699	*-10.2%*	$7,812	*17.4%*	$9,169	$10,525	*-36.8%*	$6,648	*13.8%*	$7,567
Paid PMPY	$5,817	*-9.1%*	$5,286	*18.0%*	$6,238	$9,079	*-36.6%*	$5,755	*15.2%*	$6,631
Paid PEPM	$725	*-10.2%*	$651	*17.4%*	$764	$877	*-36.8%*	$554	*13.8%*	$631
Paid PMPM	$485	*-9.1%*	$440	*18.0%*	$520	$757	*-36.6%*	$480	*15.2%*	$553
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	24	*54.2%*	37	*-5.4%*	35	3	*0.0%*	3	*100.0%*	6
HCCs per 1000	18.1	*-43.4%*	10.2	*5.0%*	10.8	22.2	*-63.2%*	8.2	*123.6%*	18.3
Paid per HCC	$226,331	*-22.5%*	$175,418	*14.4%*	$200,660	$406,605	*-56.8%*	$175,672	*-28.8%*	$125,018
HCC Paid % of Tot	*70.4%*	*-36.4 pts*	*34.0%*	*0.6 pts*	*34.6%*	*99.3%*	*-74.3 pts*	*24.9%*	*9.5 pts*	*34.4%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,263	*14.4%*	$1,445	*-15.4%*	$1,222	$5,119	*-42.7%*	$2,932	*14.6%*	$3,362
Outpatient	$1,879	*-9.3%*	$1,705	*33.4%*	$2,275	$2,010	*-39.0%*	$1,227	*14.3%*	$1,402
Physician	$2,601	*-20.9%*	$2,058	*22.8%*	$2,527	$1,613	*-9.5%*	$1,460	*23.0%*	$1,795
Ancillary	$74	*4.8%*	$77	*176.3%*	$213	$338	*-59.7%*	$136	*-47.2%*	$72

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2024-4Q (7/1/2023 - 6/30/2024) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Inpatient	$23,982,277	$3,795,559	$1,421,692	**$29,199,528**	$16,949,955	$2,760,117	$1,214,245	**$20,924,317**	*-28.3%*
Outpatient	$20,905,149	$5,253,650	$901,771	**$27,060,570**	$22,300,507	$6,237,552	$1,158,319	**$29,696,377**	*9.7%*
Physician	$26,907,476	$5,681,779	$1,749,224	**$34,338,479**	$25,965,507	$6,743,646	$1,472,138	**$34,181,291**	*-0.5%*
Ancillary	$1,041,788	$195,306	$83,598	**$1,320,693**	$925,724	$160,377	$533,689	**$1,619,791**	*22.6%*
Total	**$72,836,689**	**$14,926,295**	**$4,156,286**	$91,919,270	**$66,141,692**	**$15,901,692**	**$4,378,391**	$86,421,776	***-6.0%***
PMPM	**$299.73**	**$454.72**	**$396.01**	$321.03	**$282.30**	**$551.46**	**$430.20**	$316.21	***-1.5%***
Non-State Members									
Inpatient	$0	$104,579	$972,467	**$1,077,046**	$0	$141,870	$962,696	**$1,104,566**	*2.6%*
Outpatient	$38,037	$220,452	$230,110	**$488,599**	$17,192	$210,358	$250,235	**$477,784**	*-2.2%*
Physician	$28,375	$201,419	$334,956	**$564,749**	$6,413	$185,050	$404,912	**$596,374**	*5.6%*
Ancillary	$19	$6,726	$43,311	**$50,055**	$60	$13,211	$10,399	**$23,670**	*-52.7%*
Total	**$66,431**	**$533,175**	**$1,580,843**	$2,180,449	**$23,665**	**$550,488**	**$1,628,241**	$2,202,395	***1.0%***
PMPM	**$840.90**	**$498.46**	**$473.54**	$485.95	**$281.73**	**$717.30**	**$512.74**	$546.91	***12.5%***
All Members									
Inpatient	$23,982,277	$3,900,138	$2,394,159	**$30,276,574**	$16,949,955	$2,901,987	$2,176,941	**$22,028,882**	*-27.2%*
Outpatient	$20,943,186	$5,474,102	$1,131,881	**$27,549,169**	$22,317,699	$6,447,909	$1,408,553	**$30,174,162**	*9.5%*
Physician	$26,935,850	$5,883,198	$2,084,180	**$34,903,228**	$25,971,920	$6,928,696	$1,877,049	**$34,777,665**	*-0.4%*
Ancillary	$1,041,807	$202,032	$126,909	**$1,370,748**	$925,784	$173,589	$544,089	**$1,643,461**	*19.9%*
Total	**$72,903,120**	**$15,459,470**	**$5,737,129**	$94,099,719	**$66,165,358**	**$16,452,180**	**$6,006,632**	$88,624,170	***-5.8%***
PMPM	**$299.90**	**$456.10**	**$414.72**	$323.57	**$282.30**	**$555.76**	**$449.83**	$319.56	***-1.2%***

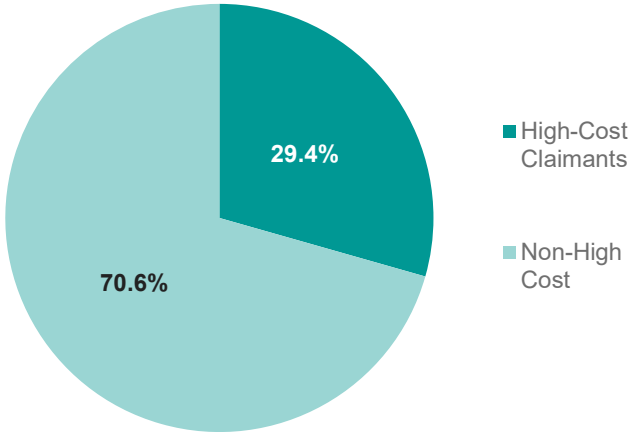
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)					
	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot
No Claims	6,281	21.6%	$0	0.0%	$0	0.0%	6,078	21.8%	$0	0.0%	$0	0.0%
< $0 - $0	5,240	18.0%	-$501,543	-0.5%	$1,965,172	7.1%	5,019	18.0%	-$604,577	-0.7%	$1,878,470	6.8%
> $0 - $2,500	13,126	45.1%	$7,976,000	8.5%	$10,458,579	37.7%	12,284	44.1%	$7,524,346	8.5%	$10,183,879	37.1%
> $2,500 - $5,000	1,670	5.7%	$5,883,052	6.3%	$3,825,619	13.8%	1,610	5.8%	$5,739,774	6.5%	$3,737,028	13.6%
> $5,000 - $10,000	1,231	4.2%	$8,685,331	9.2%	$4,036,714	14.5%	1,212	4.4%	$8,516,610	9.6%	$3,835,716	14.0%
> $10,000 - $25,000	869	3.0%	$13,762,482	14.6%	$4,010,569	14.4%	954	3.4%	$14,797,381	16.7%	$4,343,510	15.8%
> $25,000 - $50,000	325	1.1%	$11,252,506	12.0%	$1,598,767	5.8%	350	1.3%	$12,046,598	13.6%	$1,623,468	5.9%
> $50,000 - $100,000	187	0.6%	$12,956,992	13.8%	$997,665	3.6%	207	0.7%	$14,540,487	16.4%	$1,132,283	4.1%
> $100,000	148	0.5%	$34,084,899	36.2%	$871,354	3.1%	128	0.5%	$26,063,550	29.4%	$707,461	2.6%
Total	**29,077**	**100.0%**	**$94,099,719**	**100.0%**	**$27,764,440**	**100.0%**	**27,842**	**100.0%**	**$88,624,170**	**100.0%**	**$27,441,813**	**100.0%**

* Unique Members are counted equally regardless of length of coverage. Note that because data is on a paid basis, member counts may also include those not active in the period.

Cost Distribution: HCCs vs. Non-HCCs



HCC Cost Breakout by Diagnostic Chapter

#	Diagnostic Chapter	Patients	Total Paid	% of Tot
1	Health Status & Health Services	120	$4,429,883	17.0%
2	Neoplasms	63	$4,341,958	16.7%
3	Circulatory System	91	$3,857,375	14.8%
4	Injury, Poisoning & External Causes	52	$2,711,515	10.4%
5	Infectious & Parasitic Diseases	48	$1,642,381	6.3%
6	Musculoskeletal System	63	$1,466,446	5.6%
7	Perinatal Originating Conditions	8	$1,414,341	5.4%
8	Digestive System	61	$1,177,126	4.5%
9	Endocrine, Nutritional & Metabolic	71	$946,467	3.6%
10	Genitourinary System	60	$944,596	3.6%
...	*All Others*		*$3,131,463*	*12.0%*
=	**Total**	**128**	**$26,063,550**	**100.0%**

Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Inpatient Admissions							
# of Admits	1,045	*3.3%*	1,080	*-13.4%*	935		
# of Admit Days	6,605	*14.1%*	7,535	*-38.4%*	4,644		
Paid per Admit	$31,926	*-1.6%*	$31,404	*-21.8%*	$24,562	$28,787	*-14.7%*
Paid per Admit Day	$5,051	*-10.9%*	$4,501	*9.9%*	$4,945	$5,622	*-12.0%*
Admits per 1000	115.7	*-61.5%*	44.6	*-9.2%*	40.5	47.9	*-15.5%*
Average LOS	6.3	*10.4%*	7.0	*-28.8%*	5.0	5.1	*-3.0%*
Emergency Room Visits							
# of ER Visits	4,368	*9.1%*	4,764	*-2.1%*	4,665		
~ % resulting in Admit	13.0%	*1.0 pts*	14.0%	*-1.5 pts*	12.6%	11.1%	*1.4 pts*
ER Visits per Patient	1.4	*2.6%*	1.5	*1.5%*	1.5		
ER Visits per 1000	483.8	*-59.4%*	196.6	*2.7%*	201.8	233.5	*-13.6%*
Paid per ER Visit	$2,158	*6.7%*	$2,304	*7.9%*	$2,486	$2,114	*17.6%*
Urgent Care Visits							
# of UC Visits	7,151	*7.7%*	7,700	*-2.6%*	7,501		
UC Visits per Patient	1.5	*6.9%*	1.6	*0.1%*	1.6		-
UC Visits per 1000	792.0	*-59.9%*	317.7	*2.1%*	324.5	263.2	*23.3%*
Paid per UC Visit	$45	*7.9%*	$49	*12.2%*	$55	$112	*-51.1%*
Office Visits							
Off Visits per Patient	4.3	*9.5%*	4.7	*4.1%*	4.9		
Paid per Office Visit	$44	*6.8%*	$47	*8.9%*	$51	$89	*-42.0%*
Office Visits Paid PMPY	$416	*-58.6%*	$172	*12.2%*	$193	$350	*-44.8%*
Services							
Radiology Svcs per 1000	9,261.0	*-60.0%*	3,701.7	*6.5%*	3,942.3	3,999.8	*-1.4%*
Radiology Paid PMPY	$621	*-56.8%*	$268	*15.1%*	$309		
Lab Services per 1000	25,224.0	*-62.9%*	9,366.9	*11.7%*	10,458.6	11,047.4	*-5.3%*
Labs Paid PMPY	$408	*-59.2%*	$167	*20.4%*	$201		

- *Inpatient Admission rate per 1000 decreased 9.2%, and amount paid per Admission is significantly (–21.8%) lower than prior period*
- *ER utilization increased 2.7%, and amount paid per ER visit is 7.9% higher than prior period*

Admissions and all other **Visits** are counted for utilization if the *initial Paid Date* for the first primary claim (facility claim for non-Office Visits) fell within the time period. For cost purposes, however, all visit costs paid within the time period are included.

Counts **per 1000** and amounts **PMPY** (per member per year) have been annualized.

Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	794	*2.4%*	813	*-12.9%*	708	0	-	0	-	0
# of Admit Days	4,805	*22.0%*	5,862	*-40.7%*	3,479	0	-	0	-	0
Paid per Admit	$32,484	*0.8%*	$32,758	*-20.8%*	$25,933	$0	-	$0	-	$0
Paid per Admit Day	$5,368	*-15.4%*	$4,543	*16.2%*	$5,278	$0	-	$0	-	$0
Admits per 1000	105.0	*-61.8%*	40.1	*-9.7%*	36.3	0.0	-	0.0	-	0.0
Average LOS	6.1	*19.1%*	7.2	*-31.8%*	4.9	0.0	-	0.0	-	0.0
Emergency Room Visits										
# of ER Visits	3,473	*9.8%*	3,814	*-0.2%*	3,805	4	*25.0%*	5	*-80.0%*	1
~ % resulting in Admit	11.8%	*0.7 pts*	12.6%	*-1.6 pts*	11.0%	0.0%	*0.0 pts*	0.0%	*0.0 pts*	0.0%
ER Visits per Patient	1.4	*3.4%*	1.4	*1.1%*	1.5	2.0	*-16.7%*	1.7	*-40.0%*	1.0
ER Visits per 1000	459.1	*-59.0%*	188.3	*3.5%*	194.9	1,500.0	*-49.4%*	759.5	*-81.2%*	142.9
Paid per ER Visit	$2,227	*8.1%*	$2,407	*5.4%*	$2,538	$3,446	*26.9%*	$4,375	*317.8%*	$18,276
Urgent Care Visits										
# of UC Visits	6,297	*6.5%*	6,708	*-2.0%*	6,576	7	*-42.9%*	4	*-25.0%*	3
UC Visits per Patient	1.5	*6.9%*	1.6	*0.4%*	1.6	1.4	*42.9%*	2.0	*-50.0%*	1.0
UC Visits per 1000	832.4	*-60.2%*	331.2	*1.7%*	336.8	2,625.0	*-76.9%*	607.6	*-29.5%*	428.6
Paid per UC Visit	$45	*9.1%*	$49	*10.1%*	$54	$83	*61.4%*	$134	*-30.4%*	$93
Office Visits										
Off Visits per Patient	4.0	*9.4%*	4.4	*4.4%*	4.5	4.1	*-3.4%*	4.0	*-50.0%*	2.0
Paid per Office Visit	$44	*7.9%*	$48	*7.7%*	$51	$70	*65.4%*	$116	*-59.0%*	$47
Office Visits Paid PMPY	$377	*-57.8%*	$159	*10.5%*	$176	$762	*-53.8%*	$352	*-80.7%*	$68
Services										
Radiology Svcs per 1000	8,008.6	*-59.7%*	3,229.6	*5.9%*	3,420.0	7,500.0	*-41.3%*	4,405.1	*-70.8%*	1,285.7
Radiology Paid PMPY	$538	*-54.8%*	$244	*2.1%*	$249	$1,086	*192.0%*	$3,172	*-74.1%*	$822
Lab Services per 1000	23,644.0	*-63.1%*	8,713.7	*11.4%*	9,710.6	27,750.0	*-84.7%*	4,253.2	*-63.1%*	1,571.4
Labs Paid PMPY	$388	*-59.3%*	$158	*18.3%*	$187	$813	*-74.9%*	$204	*29.0%*	$263

Utilization Summary – YTD Trend

Retired Members

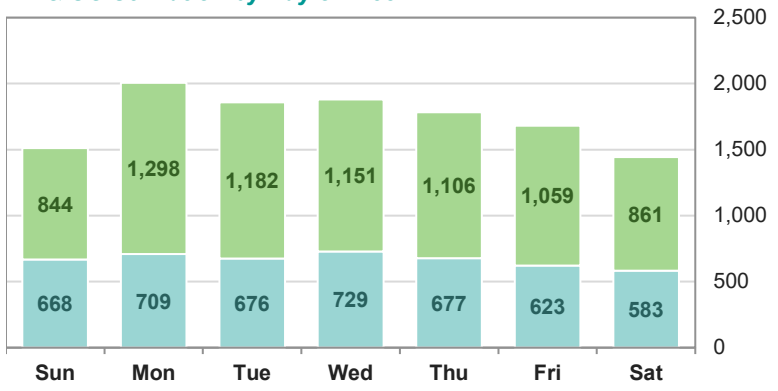
Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	201	*8.5%*	218	*-17.9%*	179	50	*-2.0%*	49	*4.1%*	51
# of Admit Days	1,205	*13.9%*	1,373	*-34.5%*	900	595	*-49.6%*	300	*-7.0%*	279
Paid per Admit	$27,078	*2.7%*	$27,807	*-15.8%*	$23,413	$42,561	*-41.4%*	$24,936	*-65.9%*	$8,507
Paid per Admit Day	$4,517	*-2.3%*	$4,415	*5.5%*	$4,657	$3,577	*13.9%*	$4,073	*-61.8%*	$1,555
Admits per 1000	151.6	*-60.2%*	60.4	*-8.8%*	55.1	369.5	*-63.9%*	133.4	*16.4%*	155.2
Average LOS	6.0	*5.1%*	6.3	*-20.2%*	5.0	11.9	*-48.6%*	6.1	*-10.6%*	5.5
Emergency Room Visits										
# of ER Visits	762	*3.1%*	786	*-13.2%*	682	129	*23.3%*	159	*11.3%*	177
~ % resulting in Admit	17.2%	*1.6 pts*	18.8%	*1.7 pts*	20.5%	20.9%	*5.5 pts*	26.4%	*-10.0 pts*	16.4%
ER Visits per Patient	1.6	*-4.9%*	1.5	*3.7%*	1.5	1.7	*28.3%*	2.1	*1.7%*	2.2
ER Visits per 1000	574.7	*-62.1%*	217.7	*-3.7%*	209.8	953.2	*-54.6%*	432.8	*24.4%*	538.7
Paid per ER Visit	$1,949	*8.6%*	$2,116	*22.8%*	$2,598	$1,506	*-54.5%*	$685	*23.1%*	$843
Urgent Care Visits										
# of UC Visits	765	*16.2%*	889	*-6.7%*	829	82	*20.7%*	99	*-6.1%*	93
UC Visits per Patient	1.4	*7.8%*	1.5	*-0.7%*	1.5	1.7	*2.0%*	1.7	*-13.5%*	1.5
UC Visits per 1000	576.9	*-57.3%*	246.3	*3.5%*	255.0	605.9	*-55.5%*	269.5	*5.0%*	283.0
Paid per UC Visit	$47	*-0.2%*	$47	*33.3%*	$62	$49	*-2.3%*	$48	*-21.8%*	$37
Office Visits										
Off Visits per Patient	5.2	*8.9%*	5.7	*4.7%*	5.9	7.7	*22.1%*	9.4	*0.5%*	9.5
Paid per Office Visit	$47	*4.3%*	$49	*11.9%*	$55	$27	*-4.6%*	$26	*20.1%*	$31
Office Visits Paid PMPY	$616	*-61.1%*	$240	*20.6%*	$289	$625	*-62.6%*	$234	*21.0%*	$283
Services										
Radiology Svcs per 1000	14,459.3	*-61.5%*	5,566.1	*13.5%*	6,318.2	28,367.0	*-59.8%*	11,390.2	*1.3%*	11,543.5
Radiology Paid PMPY	$1,072	*-62.4%*	$403	*65.3%*	$667	$771	*-69.8%*	$233	*35.4%*	$315
Lab Services per 1000	31,515.1	*-63.0%*	11,647.8	*15.8%*	13,483.8	51,849.8	*-55.5%*	23,052.6	*9.3%*	25,202.1
Labs Paid PMPY	$529	*-58.7%*	$218	*28.1%*	$280	$324	*-58.2%*	$135	*71.0%*	$231

On Demand Care Summary

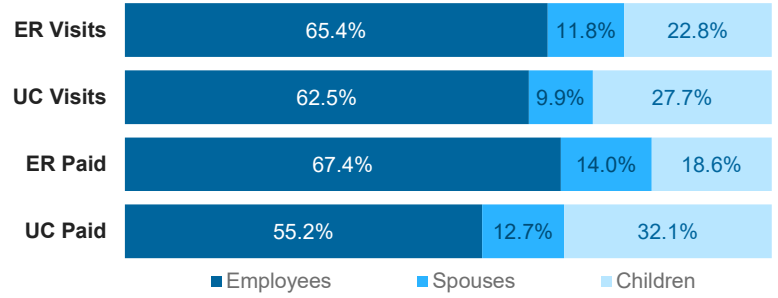
Emergency Room & Urgent Care

Measure	2024-4Q	2025-4Q	Change	UMR Norm	Variance
Emergency Room					
# of Visits	4,764	4,665	*-2.1%*		
# of Patients	3,237	3,124	*-3.5%*		
Total Plan Paid	$10,975,004	$11,596,215	*5.7%*		
Total Mem Paid	$5,015,247	$5,073,309	*1.2%*		
Visits per 1000	196.6	201.8	*2.7%*	233.5	*-13.6%*
Paid per Visit	$2,304	$2,486	*7.9%*	$2,114	*17.6%*
Paid PMPM	$38	$42	*10.8%*	$41	*1.6%*
% ER Patients w/ Office Visit*	90.4%	91.8%	*1.4 pts*		
% Potentially Avoidable**	15.4%	16.0%	*0.6 pts*	16.9%	*-0.9 pts*
Urgent Care					
# of Visits	7,700	7,501	*-2.6%*		
# of Patients	4,936	4,805	*-2.7%*		
Total Plan Paid	$374,565	$409,264	*9.3%*		
Total Mem Paid	$972,324	$962,328	*-1.0%*		
Visits per 1000	317.7	324.5	*2.1%*	263.2	*23.3%*
Paid per Visit	$49	$55	*12.2%*	$112	*-51.1%*
Paid PMPM	$1	$1	*14.6%*	$2	*-39.8%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	Total	ER	UC	Total
Employee	3,050	4,685	**7,735**	$7,814,579	$226,027	**$8,040,606**
Spouse	551	740	**1,291**	$1,627,869	$51,791	**$1,679,660**
Child	1,064	2,076	**3,140**	$2,153,768	$131,446	**$2,285,214**
Total	**4,665**	**7,501**	**12,166**	**$11,596,215**	**$409,264**	**$12,005,479**

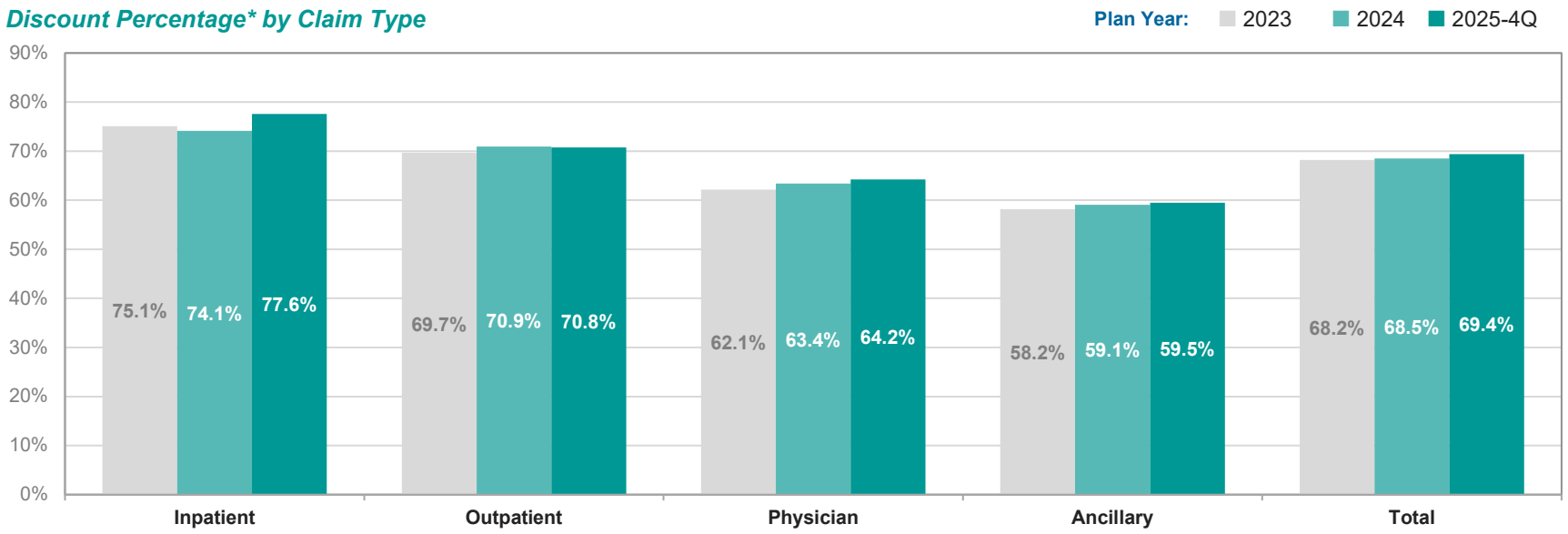
* Office Visit within prior 12 months..

** ER Visits are categorized as potentially avoidable based on primary and secondary diagnosis and do not necessarily indicate misuse of the ER for the patient's specific circumstances.

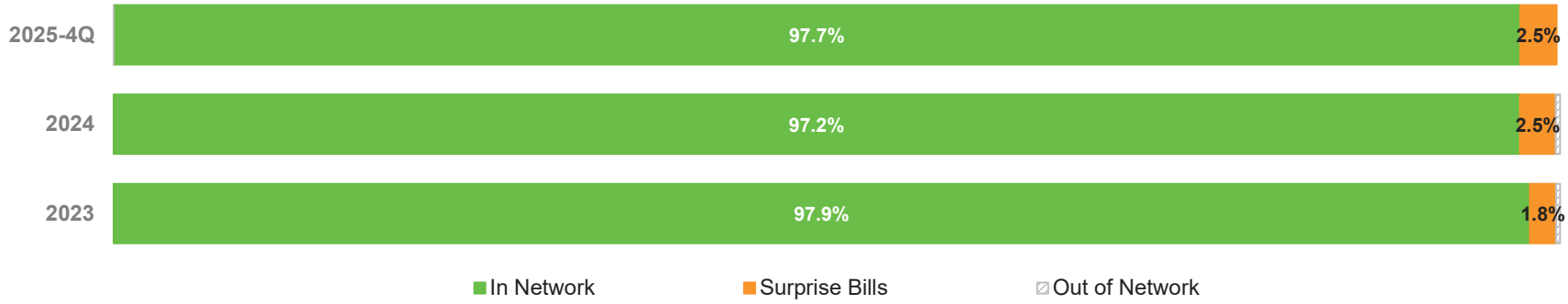
Network Summary

Discount Percentage & Network Utilization

Discount Percentage by Claim Type*



*Network Utilization**



* Network Discounts and Utilization exclude COB Claims, and Network Discounts additionally exclude Surprise Bills.

Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2024 (Full Year)		2025-4Q		CYTD Paid by Relationship			CYTD Paid by Sex	
	Patients	Total Paid	Patients	Total Paid	Employee	Spouse	Child	Male	Female
Health Status & Health Services	14,301	$11,677,955	13,867	$12,290,366	$8,781,050	$1,786,680	$1,722,636	$4,464,250	$7,826,032
Musculoskeletal System	6,363	$8,891,851	6,235	$9,614,034	$7,144,992	$1,754,059	$714,984	$3,768,392	$5,845,643
Circulatory System	4,299	$10,388,505	4,249	$9,533,462	$7,211,931	$1,437,808	$883,723	$5,932,665	$3,600,797
Neoplasms	3,094	$9,469,226	3,177	$8,496,372	$6,353,476	$1,911,718	$231,178	$4,288,836	$4,207,536
Injury, Poisoning & External Causes	3,089	$6,988,732	2,881	$7,432,651	$5,414,961	$678,920	$1,338,770	$4,419,629	$3,013,022
Digestive System	2,673	$7,363,331	2,875	$5,633,027	$4,324,360	$908,720	$399,948	$3,063,159	$2,569,869
Symptoms, Signs & Findings, NEC	8,898	$4,971,465	8,856	$5,378,622	$3,741,655	$830,427	$806,540	$2,194,801	$3,183,821
Genitourinary System	4,239	$4,643,464	4,241	$4,467,616	$3,402,908	$610,515	$454,193	$1,776,892	$2,690,724
Nervous System	2,989	$4,637,075	3,005	$3,876,394	$2,574,838	$686,623	$614,933	$1,078,114	$2,798,280
Mental, Behavioral & Neurodevelopmental	3,269	$4,218,922	3,387	$3,746,998	$1,344,700	$349,602	$2,052,696	$1,911,151	$1,835,847
Endocrine, Nutritional & Metabolic	6,419	$3,708,461	6,461	$3,685,436	$2,985,425	$444,463	$255,547	$1,627,600	$2,057,836
Respiratory System	5,447	$3,963,399	5,262	$3,232,126	$1,749,525	$598,797	$883,804	$1,412,291	$1,819,835
Infectious & Parasitic Diseases	1,853	$2,544,375	1,624	$2,894,059	$2,144,859	$560,856	$188,344	$1,747,126	$1,146,933
Pregnancy, Childbirth & the Puerperium	418	$2,643,975	410	$2,314,674	$1,661,028	$457,110	$196,537	$8,268	$2,306,406
Perinatal Originating Conditions	213	$2,826,203	190	$2,082,861	$281	$0	$2,082,580	$1,626,632	$455,274
Skin & Subcutaneous Tissue	4,799	$1,211,542	4,810	$1,242,481	$966,769	$144,457	$131,254	$573,447	$669,034
Eye and Adnexa	4,994	$1,059,135	4,098	$895,465	$702,787	$137,160	$55,518	$370,740	$524,725
Blood & Immune Disorders	932	$1,640,703	967	$752,337	$644,661	$52,747	$54,929	$245,459	$506,878
Congenital Malformations & Abnormalities	260	$676,174	271	$541,322	$123,456	$27,130	$390,736	$224,552	$316,770
Ear and Mastoid Process	1,692	$574,395	1,596	$513,866	$346,006	$78,284	$89,577	$296,674	$217,192
External Causes of Morbidity	6	$832	0	$0	$0	$0	$0	$0	$0
Total	**22,265**	**$94,099,719**	**21,073**	**$88,624,170**	**$61,619,666**	**$13,456,076**	**$13,548,428**	**$41,030,678**	**$47,592,453**

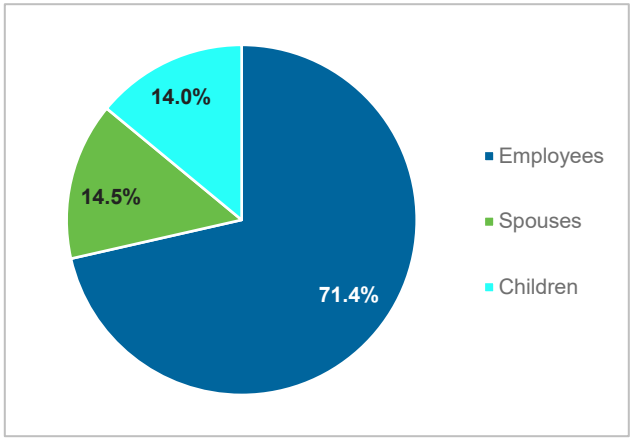
#1 Top Dx Chapter

Health Status & Health Services

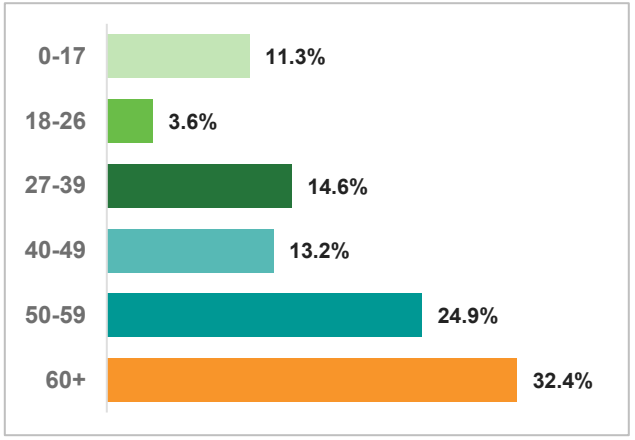
Breakout by Diagnostic Grouping & Demographics

#	Health Status & Services Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Encounter for antineoplastic therapies	79	618	$4,521,072	36.8%
2	Neoplasm-related encounters	4,399	8,012	$2,382,115	19.4%
3	Medical examination/evaluation	10,028	17,808	$1,986,576	16.2%
4	Exposure, enc, screen or contact w infectious dz	4,317	6,317	$1,146,393	9.3%
5	Contraceptive & procreative management	704	1,199	$503,330	4.1%
6	Other aftercare encounter	595	1,197	$448,402	3.6%
7	Implant, device or graft related encounter	462	1,270	$373,971	3.0%
8	Family history of disease	149	234	$142,270	1.2%
9	Other specified status	804	1,633	$122,923	1.0%
10	Organ transplant status	40	270	$114,809	0.9%
11	Encount for obs & exam for conds ruled out	1,755	2,239	$107,370	0.9%
12	Personal history of other disease	479	720	$94,144	0.8%
13	Other specified encounters & counseling	349	1,034	$73,917	0.6%
14	Genetic susceptibility to disease	14	31	$69,839	0.6%
15	Personal history of malignant neoplasm	132	200	$55,530	0.5%
16	Encounter for prophylactic or oth procedures	49	53	$39,566	0.3%
17	Enc for prophylactic measures (ex immuniz)	65	139	$28,390	0.2%
18	Acquired absence of limb or organ	51	82	$25,103	0.2%
19	Lifestyle/life management factors	64	134	$18,591	0.2%
20	Encounter for mental health conditions	1,386	1,754	$10,526	0.1%
...	*All Others*	*195*	*278*	*$25,529*	*0.2%*
=	**Total**	**13,867**	**47,301**	**$12,290,366**	**100.0%**

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



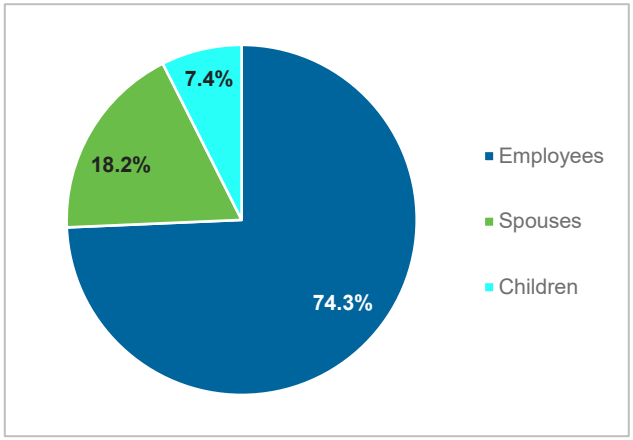
#2 Top Dx Chapter

Musculoskeletal System

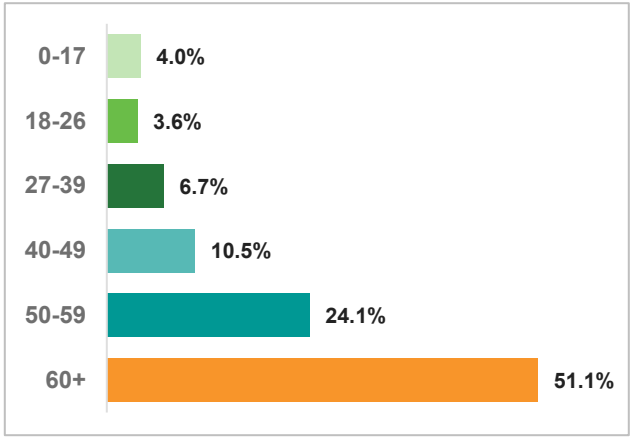
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	1,813	9,066	$3,004,467	31.3%
2	Osteoarthritis & osteoporosis	1,115	3,535	$2,671,186	27.8%
3	Other musculoskeletal pain	3,496	13,607	$1,122,373	11.7%
4	Tendon, tissue, muscle disorders	1,446	4,524	$774,832	8.1%
5	Scoliosis & oth deformities	617	1,334	$657,852	6.8%
6	Other MSK	144	473	$359,949	3.7%
7	Joint disorders & fractures	483	1,098	$351,098	3.7%
8	Low back pain	949	3,608	$318,811	3.3%
9	Rheumatoid arthritis & related disease	147	665	$233,871	2.4%
10	Biomechanical lesions	553	2,835	$49,801	0.5%
11	Lupus	108	442	$47,500	0.5%
12	Gout & crystal arthropathies	143	291	$22,294	0.2%
=	**Total**	**6,235**	**44,649**	**$9,614,034**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



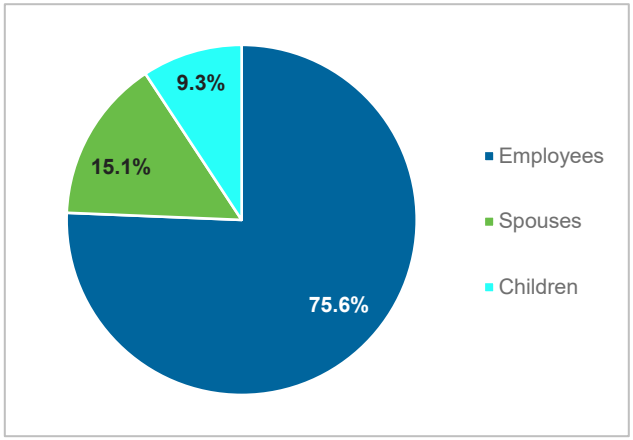
#3 Top Dx Chapter

Circulatory System

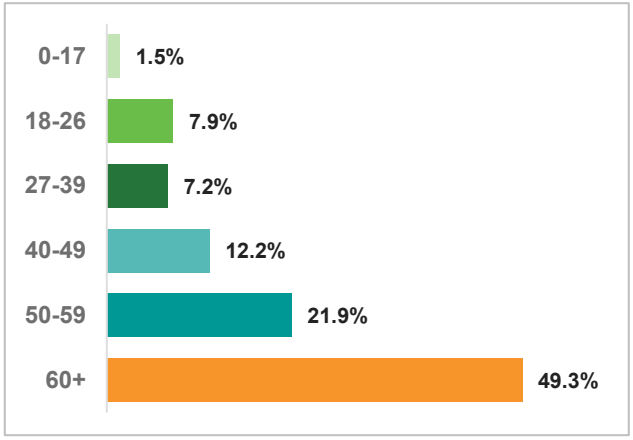
Breakout by Diagnostic Grouping & Demographics

#	Circulatory System Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Coronary atherosclerosis & oth heart disease	689	1,888	$1,887,030	19.8%
2	Cardiac dysrhythmias	591	2,340	$1,786,837	18.7%
3	Nonspecific chest pain	1,124	2,622	$1,199,358	12.6%
4	Cerebrovascular disease	207	679	$934,586	9.8%
5	Hypertension	2,563	6,070	$932,133	9.8%
6	Other circulatory	200	424	$766,564	8.0%
7	Myocardial infarction	58	258	$649,457	6.8%
8	Vascular disease	324	922	$536,084	5.6%
9	Heart failure	146	544	$297,421	3.1%
10	Acute pulmonary embolism, DVT	113	478	$294,437	3.1%
11	Nonrheumatic & unspecified valve disorders	260	519	$219,535	2.3%
12	Myocarditis & cardiomyopathy	50	107	$30,019	0.3%
=	**Total**	**4,249**	**18,896**	**$9,533,462**	**100.0%**

Circulatory System Paid by Relationship



Circulatory System Paid by Age Range



Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2023 (Full Year)		2024 (Full Year)		2025-4Q		2025-4Q Paid by Claim Type			
	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Inpatient	Outpatient	Physician	Ancillary
Neurodevelopmental disorders	440	$812,021	502	$1,242,281	532	$1,247,192	$0	$44,311	$1,202,738	$143
Depressive disorders	850	$890,095	1,005	$728,698	972	$640,203	$160,218	$33,845	$443,364	$2,776
Alcohol-related disorders	109	$462,127	124	$806,533	137	$565,545	$368,380	$101,092	$95,269	$803
Anxiety & related Disorders	1,099	$265,201	1,199	$362,534	1,284	$382,098	$11,990	$51,152	$316,551	$2,405
Trauma & stressor disorders	617	$182,525	760	$288,426	836	$376,394	$3,500	$26,450	$346,444	$0
Bipolar & related Disorders	133	$160,245	172	$99,260	174	$152,956	$85,316	$560	$65,863	$1,217
Other mental health	250	$144,033	258	$121,588	311	$82,352	$9,893	$7,146	$60,872	$4,440
Suicidal ideation, attempt or self-harm	50	$204,626	51	$205,797	44	$79,221	$0	$70,375	$8,845	$0
Obsessive compulsive disorders	57	$38,034	54	$72,146	57	$70,219	$0	$0	$70,219	$0
Schizophrenia spectrum disorders	45	$164,022	48	$121,142	41	$59,034	$14,658	$26,474	$17,867	$35
Opiod disorders	32	$43,726	35	$37,710	37	$36,077	$11,606	$6,654	$17,818	$0
Other substance use	74	$7,875	106	$12,377	114	$19,144	$8,882	$950	$7,646	$1,666
Eating disorders	24	$110,628	30	$83,704	23	$16,533	$0	$0	$16,533	$0
Cannabis-related disorders	25	$7,995	24	$15,571	28	$13,141	$0	$7,731	$5,409	$0
Stimulant disorders	8	$29,616	7	$21,155	12	$6,892	$0	$3,760	$3,133	$0
Total	**2,916**	**$3,522,768**	**3,269**	**$4,218,922**	**3,387**	**$3,746,998**	**$674,443**	**$380,499**	**$2,678,571**	**$13,485**

Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	49	2.1	*19.5%*	31	1.3	*10.7%*	$3,750	61.2	326.5
Asthma	607	26.0	*-4.9%*	227	9.7	*-8.8%*	$5,343	62.6	334.4
Atrial Fibrillation	233	10.0	*1.3%*	164	7.0	*4.5%*	$47,237	326.2	712.4
Blood Disorders	893	38.3	*-2.5%*	393	16.8	*-6.0%*	$16,176	164.6	362.8
CAD	374	16.0	*-9.2%*	197	8.4	*-10.9%*	$18,619	141.7	267.4
COPD	108	4.6	*-3.6%*	68	2.9	*3.0%*	$20,306	324.1	611.1
Cancer	1,745	74.8	*-2.6%*	907	38.9	*-2.2%*	$15,255	102.0	192.6
Chronic Pain	135	5.8	*-2.9%*	62	2.7	*-4.6%*	$38,642	540.7	918.5
CHF	99	4.2	*33.8%*	57	2.4	*46.2%*	$39,548	494.9	899.0
Demyelinating Diseases	62	2.7	*-11.4%*	39	1.7	*-22.0%*	$23,281	129.0	516.1
Depression	942	40.4	*-3.3%*	646	27.7	*3.2%*	$7,837	82.8	320.6
Diabetes	1,529	65.5	*2.5%*	1,022	43.8	*1.8%*	$12,634	73.9	231.5
ESRD	127	5.4	*19.8%*	97	4.2	*14.1%*	$64,769	984.3	1,755.9
Eating Disorders	18	0.8	*-30.8%*	10	0.4	*-28.6%*	$20,322	111.1	222.2
HIV/AIDS	40	1.7	*8.1%*	33	1.4	*10.0%*	$14,001	75.0	425.0
Hyperlipidemia	844	36.2	*2.7%*	296	12.7	*5.7%*	$3,644	14.2	64.0
Hypertension	2,446	104.8	*0.2%*	1,171	50.2	*2.0%*	$8,157	76.5	235.5
Immune Disorders	41	1.8	*-41.4%*	22	0.9	*-15.4%*	$31,611	122.0	634.1
IBD	60	2.6	*5.3%*	12	0.5	*9.1%*	$2,765	16.7	133.3
Liver Disease	7	0.3	*-12.5%*	6	0.3	*0.0%*	$94,004	1,714.3	3,000.0
Morbid Obesity	260	11.1	*36.8%*	118	5.1	*42.2%*	$10,277	107.7	230.8
Osteoarthritis	881	37.7	*-1.3%*	394	16.9	*-3.2%*	$15,209	56.8	186.2
Peripheral Vascular Disease	107	4.6	*-17.7%*	33	1.4	*-19.5%*	$19,228	130.8	280.4
Rheumatoid Arthritis	132	5.7	*9.1%*	95	4.1	*9.2%*	$10,315	53.0	242.4

- *Most prevalent chronic condition is Hypertension, with 2,446 members*
- *Hypertension is also the condition with the most moderate/high risk members (1,171)*
- *Members with mod/high risk Cancer have the highest combined cost: 907 members totaling $13.8M*

Date Range: Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

With Condition members are identified by having any covered claim with a diagnosis for the condition in Dx position 1.

Moderate/High-Risk Condition members had either multiple provider visits for the condition (based on Dx position 1) during the date range or at least one ER Visit or Admission for the condition in the range.

Cost & Utilization for All Members:

- **Allowed PMPY:** $5,492
- **Admits per 1000:** 41.3
- **ER Visits per 1000:** 194.2

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2023 - Mar 2024 Eligible	Apr 2023 - Mar 2024 Actual	Apr 2023 - Mar 2024 Rate	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	Rate Change	UMR Norm Rate	UMR Norm Variance
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	152.1	845	**5,557.3**	141.0	805	**5,709.3**	*2.7%*	**5,378.5**	*6.2%*
Well Child Visit	3 - 6 years	801.9	597	**744.4**	736.2	554	**752.5**	*1.1%*	**796.4**	*-5.5%*
Adults w/ Well Visit	Adults 18+	20,571	7,470	**36.3%**	19,345	7,062	**36.5%**	*0.2 pts*	**38.7%**	*-2.2 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	6,443	2,669	**41.4%**	5,925	2,599	**43.9%**	*2.4 pts*	**45.0%**	*-1.1 pts*
Cervical Cancer	Females 21 - 64	9,321	2,244	**24.1%**	8,604	2,052	**23.8%**	*-0.2 pts*	**22.4%**	*1.5 pts*
Prostate Cancer	Males 50 - 70	3,954	1,541	**39.0%**	3,683	1,534	**41.7%**	*2.7 pts*	**40.2%**	*1.5 pts*
Colorectal Cancer	Members 45 - 75	10,658	1,666	**15.6%**	9,888	1,567	**15.8%**	*0.2 pts*	**15.8%**	*0.0 pts*
Cholesterol	Female 45+ Male 35+	12,781	6,030	**47.2%**	11,986	5,769	**48.1%**	*1.0 pts*	**44.6%**	*3.5 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	638	516	**80.9%**	607	476	**78.4%**	*-2.5 pts*		
COPD	Spirometry Test	112	17	**15.2%**	108	19	**17.6%**	*2.4 pts*		
Type 2 Diabetes	A1c Test	1,401	1,171	**83.6%**	1,446	1,241	**85.8%**	*2.2 pts*	**83.1%**	*2.7 pts*
	Eye Exam	1,401	354	**25.3%**	1,446	372	**25.7%**	*0.5 pts*	**25.4%**	*0.3 pts*
	Lipid Panel	1,401	1,030	**73.5%**	1,446	1,106	**76.5%**	*3.0 pts*	**69.6%**	*6.8 pts*
	Urine Protein Test	1,401	867	**61.9%**	1,446	891	**61.6%**	*-0.3 pts*	**61.7%**	*-0.1 pts*
	Any Diabetes Screen	1,401	1,304	**93.1%**	1,446	1,342	**92.8%**	*-0.3 pts*	**91.7%**	*1.1 pts*
Hyperlipidemia	Lipid Profile	822	451	**54.9%**	844	418	**49.5%**	*-5.3 pts*		
Hypertension	Creatinine Test	2,440	458	**18.8%**	2,446	470	**19.2%**	*0.4 pts*		
	Lipid Profile	2,440	642	**26.3%**	2,446	552	**22.6%**	*-3.7 pts*		

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.

18.1.4

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report
        18.1.3 Q4 CDHP Performance Review
        18.1.4 Q4 LD PPO Performance Review

NEVADA PEBP

Public Employees' Benefits Program

Quarterly Plan Performance Review

Low Ded Plan • 2025-4Q

UMR℠

A UnitedHealthcare Company

RPG 4.90 • Run Date: 8/28/2025

Report Criteria & Contents

Experience Periods*

- **2025 Plan Year (Current)**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024
- **2023 Plan Year**
  - 2023-4Q.1st four Quarters: Claims Paid 7/1/2022 - 6/30/2023
  - 2023 Full Year: Claims paid 7/1/2022 - 6/30/2023

Group Data

- Data reported is for the Low Ded Plan only:
- Contract = 7670-07-414946 or 7670-11-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,077 groups with approximately 7.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2024 - 6/30/2025

* Additional date ranges for specific figures are defined on the page if applicable

Executive Summary

Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: +13.0%
- High-Cost Claimants Paid PMPM trend: +23.9%; Non HCCs trend: +10.9%
- Top Paid Diagnostic Chapters: Health Status & Services (+9.9% Paid PMPM), Neoplasms (Cancer) (+49.1%), Musculoskeletal (−0.8%)

Membership & Demographics

- Total membership is 21.9% higher than prior period
- Employees increased 23.1%, while Dependents were up 20.7%
- 75.2% of members had < $2,500 medical paid, with 15.3% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $28,736, which is 9.2% higher than 2024-4Q
- Paid per ER Visit was $3,185, which is 6.5% higher than 2024-4Q

Network Utilization & Savings

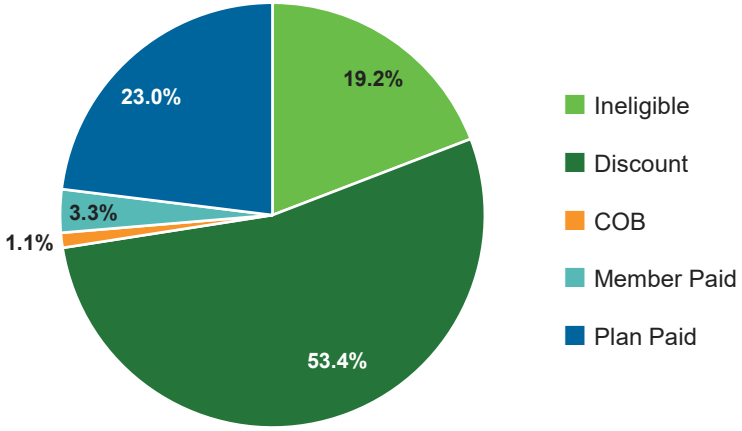
- 98.0% of all Medical spend dollars were to In Network providers
- The average In Network discount was 67.1%, which is 1.9 pts above the 2024 average discount of 65.2%

Medical Total Savings Summary

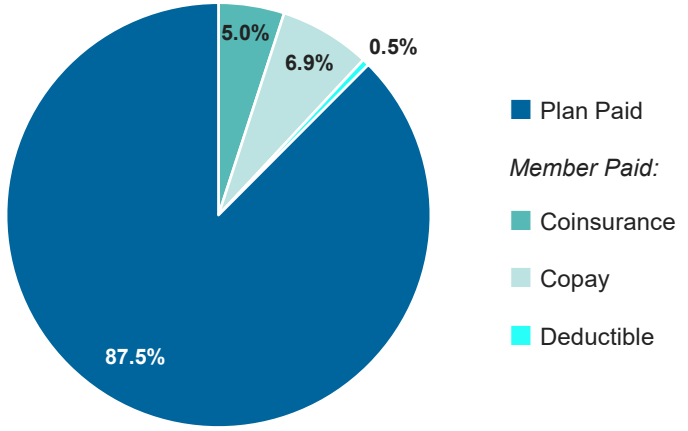
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2025-4Q Total Dollars	2025-4Q PMPM*	2024 PMPM*	*Trend*
Medical Billed	**$505,286,672**	**$1,796**	$1,519	***18.2%***
(-) Ineligible	**$96,795,940**	**$344**	$303	***13.7%***
Medical Covered	**$408,490,731**	**$1,452**	$1,216	***19.4%***
(-) Discount	**$269,593,098**	**$958**	$780	***22.8%***
Medical Allowed	**$138,897,633**	**$494**	$436	***13.3%***
(-) COB	**$5,733,948**	**$20**	$11	***87.5%***
(-) Coinsurance	**$6,663,113**	**$24**	$23	***4.1%***
(-) Copay	**$9,226,806**	**$33**	$32	***2.9%***
(-) Deductible	**$702,828**	**$2**	$2	***11.2%***
Total Member Paid	**$16,592,748**	**$59**	$57	***3.7%***
Total Plan Paid	**$116,413,291**	**$414**	$363	***14.0%***

Breakout of Billed Dollars



Breakout of Paid Dollars: Plan vs. Member Paid



* PMPM (per member per month): Amount per the average total membership (both primary subscribers and dependents) per month.

Medical & Rx Paid Claims by Age Range

Age	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)						Change	
	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Total Paid	Tot Paid PMPM
<1	$6,859,218	$2,982	$21,071	$9	**$6,880,289**	**$2,992**	$6,890,919	$2,406	$38,602	$13	$6,929,521	**$2,420**	*0.7%*	*-19.1%*
1	$637,127	$264	$6,085	$3	**$643,212**	**$267**	$932,891	$312	$22,769	$8	$955,660	**$320**	*48.6%*	*19.9%*
2 - 4	$1,220,008	$148	$39,628	$5	**$1,259,636**	**$153**	$1,879,975	$187	$94,174	$9	$1,974,149	**$197**	*56.7%*	*28.4%*
5 - 9	$1,927,812	$126	$614,010	$40	**$2,541,822**	**$165**	$2,464,990	$130	$1,058,729	$56	$3,523,719	**$186**	*38.6%*	*12.3%*
10 - 14	$2,349,206	$141	$445,047	$27	**$2,794,253**	**$168**	$3,347,809	$168	$402,682	$20	$3,750,491	**$188**	*34.2%*	*11.6%*
15 - 19	$3,308,854	$170	$843,313	$43	**$4,152,167**	**$213**	$4,913,298	$212	$1,465,329	$63	$6,378,627	**$275**	*53.6%*	*29.3%*
20 - 24	$4,247,778	$231	$1,230,039	$67	**$5,477,818**	**$298**	$4,469,258	$199	$1,655,592	$74	$6,124,850	**$273**	*11.8%*	*-8.5%*
25 - 29	$4,435,301	$284	$1,866,917	$120	**$6,302,218**	**$404**	$6,294,307	$324	$2,477,499	$128	$8,771,806	**$452**	*39.2%*	*11.9%*
30 - 34	$5,171,881	$283	$3,492,711	$191	**$8,664,592**	**$475**	$8,171,543	$369	$3,512,469	$158	$11,684,011	**$527**	*34.8%*	*11.0%*
35 - 39	$6,400,293	$323	$2,954,245	$149	**$9,354,538**	**$472**	$10,025,675	$403	$4,059,911	$163	$14,085,586	**$567**	*50.6%*	*20.2%*
40 - 44	$6,805,063	$343	$3,301,687	$166	**$10,106,750**	**$509**	$10,772,695	$445	$4,591,081	$190	$15,363,777	**$635**	*52.0%*	*24.8%*
45 - 49	$5,951,877	$346	$3,667,498	$213	**$9,619,375**	**$559**	$9,308,227	$437	$5,410,526	$254	$14,718,753	**$690**	*53.0%*	*23.4%*
50 - 54	$8,540,484	$442	$5,376,936	$278	**$13,917,420**	**$721**	$12,163,858	$537	$6,396,614	$282	$18,560,472	**$819**	*33.4%*	*13.7%*
55 - 59	$10,083,383	$589	$4,548,838	$266	**$14,632,221**	**$855**	$12,866,132	$618	$6,634,928	$319	$19,501,060	**$937**	*33.3%*	*9.6%*
60 - 64	$10,632,256	$718	$5,024,382	$339	**$15,656,638**	**$1,057**	$14,500,570	$804	$6,235,527	$346	$20,736,097	**$1,150**	*32.4%*	*8.8%*
65+	$5,170,871	$870	$2,019,837	$340	**$7,190,708**	**$1,210**	$7,411,144	$996	$3,046,996	$410	$10,458,139	**$1,406**	*45.4%*	*16.2%*
Total	**$83,741,413**	**$363**	**$35,452,245**	**$154**	**$119,193,658**	**$517**	**$116,413,291**	**$414**	**$47,103,426**	**$167**	**$163,516,717**	**$581**	***37.2%***	***12.5%***

Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Average Enrollment							
Employees	2,577	*288.0%*	9,999	*23.1%*	12,306		
Spouses	636	*284.7%*	2,446	*18.1%*	2,889		
Children	1,767	*284.1%*	6,788	*21.6%*	8,256		
Tot. Members	**4,980**	***286.2%***	**19,233**	***21.9%***	**23,451**		
Avg. Family Size	1.9	*-0.5%*	1.9	*-0.9%*	1.9	1.9	*-0.7%*
Financial Summary							
Allowed	$27,536,523	*265.3%*	$100,584,108	*38.1%*	$138,897,633		
Plan Paid	$23,143,911	*261.8%*	$83,741,413	*39.0%*	$116,413,291		
Member Paid (OOP)	$3,357,794	*290.9%*	$13,125,142	*26.4%*	$16,592,748		
Paid PEPY	$8,981	*-6.8%*	$8,375	*13.0%*	$9,460	$10,136	*-6.7%*
Paid PMPY	$4,647	*-6.3%*	$4,354	*14.0%*	$4,964	$5,280	*-6.0%*
Paid PEPM	$748	*-6.8%*	$698	*13.0%*	$788	$845	*-6.7%*
Paid PMPM	$387	*-6.3%*	$363	*14.0%*	$414	$440	*-6.0%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	48	*83.3%*	88	*36.4%*	120		
HCCs per 1000	9.6	*-52.5%*	4.6	*11.8%*	5.1	6.9	*-25.4%*
Paid per HCC	$234,319	*-2.3%*	$228,980	*10.8%*	$253,751	$230,655	*10.0%*
HCC Paid % of Tot	48.6%	*-24.5 pts*	24.1%	*2.1 pts*	26.2%	30.1%	*-4.0 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$942	*-11.3%*	$836	*24.1%*	$1,037	$1,318	*-21.3%*
Outpatient	$1,422	*-10.4%*	$1,274	*12.1%*	$1,428	$1,552	*-8.0%*
Physician	$2,150	*0.4%*	$2,159	*11.7%*	$2,412	$2,299	*4.9%*
Ancillary	$134	*-35.9%*	$86	*1.9%*	$87	$110	*-20.7%*

- *With $104M paid, the State Active population is 89.4% of total 2025-4Q med spend*
- *On a Paid PMPM basis, State Actives are up 15.9% compared to prior year*
- *Total Low Ded Plan Paid PMPM trend is +14.0%*

PEPY (per employee per year) and **PEPM** (per employee per month) represent amounts per the primary subscriber (employee or retiree).

PMPY (per member per year) and **PMPM** (per member per month) represent amounts per all covered members, including dependents.

Amounts **Per Year** (**PEPY** and **PMPY**) have been annualized.

HCCs (High-cost Claimants) are based on patients with $100,000+ paid medical in the period.

Claim Type: Ancillary includes Durable Medical Equipment, prosthetics, some drugs paid on the medical plan, et al.

Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	2,346	*289.9%*	9,150	*24.1%*	11,354	0	*275.0%*	1	*106.7%*	3
Spouses	564	*286.0%*	2,176	*19.0%*	2,589	0	*275.0%*	1	*26.7%*	2
Children	1,683	*285.0%*	6,478	*22.2%*	7,914	0	-	0	-	0
Tot. Members	**4,593**	***287.6%***	**17,804**	***22.8%***	**21,857**	**1**	***275.0%***	**3**	***66.7%***	**4**
Avg. Family Size	2.0	*-0.6%*	1.9	*-1.1%*	1.9	2.0	*0.0%*	2.0	*-19.4%*	1.6
Financial Summary										
Allowed	$23,647,230	*270.0%*	$87,492,756	*41.4%*	$123,713,482	$6,991	*372.8%*	$33,055	*-37.5%*	$20,653
Plan Paid	$19,828,613	*268.8%*	$73,120,641	*42.3%*	$104,078,363	$5,407	*389.9%*	$26,488	*-39.0%*	$16,151
Member Paid (OOP)	$3,016,389	*291.0%*	$11,795,191	*27.6%*	$15,053,276	$1,584	*314.6%*	$6,566	*-31.4%*	$4,503
Paid PEPY	$8,451	*-5.4%*	$7,992	*14.7%*	$9,167	$16,222	*30.6%*	$21,191	*-70.5%*	$6,252
Paid PMPY	$4,317	*-4.9%*	$4,107	*15.9%*	$4,762	$8,111	*30.6%*	$10,595	*-63.4%*	$3,876
Paid PEPM	$704	*-5.4%*	$666	*14.7%*	$764	$1,352	*30.6%*	$1,766	*-70.5%*	$521
Paid PMPM	$360	*-4.9%*	$342	*15.9%*	$397	$676	*30.6%*	$883	*-63.4%*	$323
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	37	*89.2%*	70	*50.0%*	105	0	-	0	-	0
HCCs per 1000	8.1	*-51.2%*	3.9	*22.2%*	4.8	0.0	-	0.0	-	0.0
Paid per HCC	$238,408	*-3.3%*	$230,519	*11.0%*	$255,813	$0	-	$0	-	$0
HCC Paid % of Tot	44.5%	*-22.4 pts*	22.1%	*3.7 pts*	25.8%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$894	*-11.1%*	$794	*26.5%*	$1,005	$0	-	$0	-	$0
Outpatient	$1,303	*-7.9%*	$1,199	*11.2%*	$1,334	$0	-	$527	*96.9%*	$1,037
Physician	$2,003	*1.3%*	$2,029	*15.1%*	$2,336	$8,111	*23.5%*	$10,017	*-71.7%*	$2,839
Ancillary	$118	*-28.7%*	$84	*3.4%*	$87	$0	-	$52	*-100.0%*	$0

Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	221	*270.4%*	820	*12.8%*	925	9	*221.7%*	28	*-13.5%*	25
Spouses	67	*280.6%*	256	*12.5%*	288	4	*182.7%*	12	*-16.3%*	10
Children	85	*265.3%*	309	*10.3%*	341	0	*500.0%*	1	*0.0%*	1
Tot. Members	**373**	***271.1%***	**1,385**	***12.2%***	**1,554**	**13**	***212.5%***	**42**	***-14.0%***	**36**
Avg. Family Size	1.7	*0.2%*	1.7	*-0.5%*	1.7	1.5	*-2.9%*	1.5	*-0.6%*	1.5
Financial Summary										
Allowed	$3,530,473	*251.9%*	$12,423,242	*17.9%*	$14,647,388	$351,828	*80.5%*	$635,055	*-18.7%*	$516,110
Plan Paid	$3,031,496	*240.7%*	$10,327,679	*16.8%*	$12,059,589	$278,395	*-4.2%*	$266,605	*-2.8%*	$259,189
Member Paid (OOP)	$313,596	*292.4%*	$1,230,503	*20.7%*	$1,485,264	$26,225	*254.2%*	$92,881	*-46.5%*	$49,705
Paid PEPY	$13,691	*-8.0%*	$12,593	*3.5%*	$13,039	$31,516	*-70.2%*	$9,382	*12.4%*	$10,543
Paid PMPY	$8,120	*-8.2%*	$7,456	*4.1%*	$7,761	$20,880	*-69.4%*	$6,399	*13.0%*	$7,233
Paid PEPM	$1,141	*-8.0%*	$1,049	*3.5%*	$1,087	$2,626	*-70.2%*	$782	*12.4%*	$879
Paid PMPM	$677	*-8.2%*	$621	*4.1%*	$647	$1,740	*-69.4%*	$533	*13.0%*	$603
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	10	*80.0%*	18	*-11.1%*	16	1	*0.0%*	1	*-100.0%*	0
HCCs per 1000	26.8	*-51.5%*	13.0	*-20.8%*	10.3	75.0	*-68.0%*	24.0	*-100.0%*	0.0
Paid per HCC	$215,577	*0.5%*	$216,572	*3.6%*	$224,337	$178,686	*-38.7%*	$109,572	*-100.0%*	$0
HCC Paid % of Tot	*71.1%*	*-33.4 pts*	*37.7%*	*-8.0 pts*	*29.8%*	*64.2%*	*-23.1 pts*	*41.1%*	*-41.1 pts*	*0.0%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,466	*-10.3%*	$1,315	*15.0%*	$1,512	$2,857	*-11.0%*	$2,544	*-91.7%*	$210
Outpatient	$2,437	*-8.7%*	$2,225	*21.7%*	$2,709	$14,062	*-90.2%*	$1,379	*149.0%*	$3,432
Physician	$3,884	*-2.0%*	$3,808	*-9.5%*	$3,445	$3,881	*-39.8%*	$2,338	*47.6%*	$3,451
Ancillary	$334	*-67.8%*	$108	*-12.2%*	$95	$80	*72.5%*	$138	*0.9%*	$139

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2024-4Q (7/1/2023 - 6/30/2024) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Inpatient	$14,144,820	$1,759,220	$61,901	**$15,965,941**	$21,965,361	$2,245,745	$103,687	**$24,314,793**	*52.3%*
Outpatient	$21,353,634	$2,947,326	$135,219	**$24,436,179**	$29,150,709	$4,057,472	$152,122	**$33,360,304**	*36.5%*
Physician	$36,127,689	$5,029,601	$245,214	**$41,402,505**	$51,065,401	$5,069,894	$283,650	**$56,418,945**	*36.3%*
Ancillary	$1,494,497	$135,818	$13,379	**$1,643,694**	$1,896,891	$140,166	$6,853	**$2,043,910**	*24.3%*
Total	**$73,120,641**	**$9,871,965**	**$455,714**	$83,448,320	**$104,078,363**	**$11,513,277**	**$546,312**	$116,137,952	***39.2%***
PMPM	**$342.25**	**$650.30**	**$315.98**	$362.39	**$396.82**	**$684.08**	**$300.80**	$413.41	***14.1%***
Non-State Members									
Inpatient	$0	$0	$106,000	**$106,000**	$0	$0	$7,523	**$7,523**	*-92.9%*
Outpatient	$1,317	$7,986	$49,461	**$58,765**	$4,321	$16,060	$106,936	**$127,317**	*116.7%*
Physician	$25,041	$32,513	$64,888	**$122,442**	$11,830	$65,406	$58,266	**$135,502**	*10.7%*
Ancillary	$130	$1,261	$4,496	**$5,887**	$0	$993	$4,004	**$4,997**	*-15.1%*
Total	**$26,488**	**$41,760**	**$224,845**	$293,093	**$16,151**	**$82,460**	**$176,729**	$275,339	***-6.1%***
PMPM	**$882.95**	**$333.77**	**$599.77**	$553.01	**$323.02**	**$992.94**	**$509.37**	$573.62	***3.7%***
All Members									
Inpatient	$14,144,820	$1,759,220	$167,900	**$16,071,941**	$21,965,361	$2,245,745	$111,210	**$24,322,316**	*51.3%*
Outpatient	$21,354,951	$2,955,312	$184,681	**$24,494,944**	$29,155,030	$4,073,532	$259,058	**$33,487,620**	*36.7%*
Physician	$36,152,731	$5,062,114	$310,102	**$41,524,947**	$51,077,231	$5,135,300	$341,916	**$56,554,447**	*36.2%*
Ancillary	$1,494,627	$137,079	$17,876	**$1,649,582**	$1,896,891	$141,159	$10,857	**$2,048,908**	*24.2%*
Total	**$73,147,129**	**$9,913,725**	**$680,559**	$83,741,413	**$104,094,514**	**$11,595,737**	**$723,040**	$116,413,291	***39.0%***
PMPM	**$342.33**	**$647.71**	**$374.53**	$362.83	**$396.81**	**$685.59**	**$334.25**	$413.68	***14.0%***

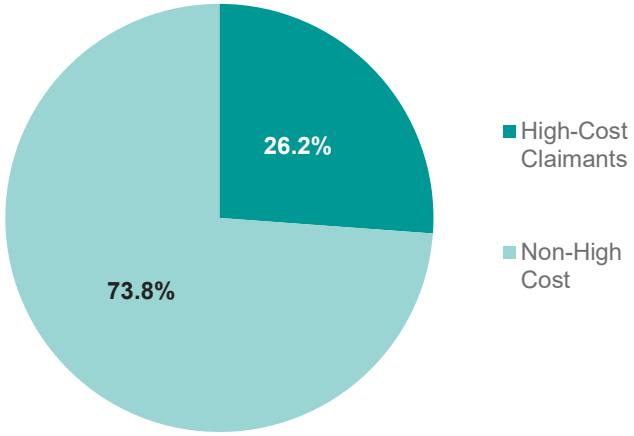
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)					
	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot
No Claims	4,153	17.8%	$0	0.0%	$0	0.0%	4,250	15.3%	$0	0.0%	$0	0.0%
< $0 - $0	509	2.2%	-$129,205	-0.2%	$18,023	0.1%	814	2.9%	-$226,897	-0.2%	$30,567	0.2%
> $0 - $2,500	13,467	57.6%	$9,942,041	11.9%	$3,498,022	26.7%	15,789	56.9%	$11,960,524	10.3%	$4,214,411	25.4%
> $2,500 - $5,000	2,203	9.4%	$7,769,851	9.3%	$2,299,752	17.5%	2,884	10.4%	$10,237,334	8.8%	$2,963,751	17.9%
> $5,000 - $10,000	1,495	6.4%	$10,461,928	12.5%	$2,449,621	18.7%	1,932	7.0%	$13,413,715	11.5%	$3,132,942	18.9%
> $10,000 - $25,000	994	4.3%	$15,388,931	18.4%	$2,727,762	20.8%	1,265	4.6%	$19,604,537	16.8%	$3,384,353	20.4%
> $25,000 - $50,000	325	1.4%	$11,126,383	13.3%	$1,177,073	9.0%	450	1.6%	$15,245,620	13.1%	$1,558,878	9.4%
> $50,000 - $100,000	134	0.6%	$9,031,202	10.8%	$552,263	4.2%	224	0.8%	$15,728,326	13.5%	$820,853	4.9%
> $100,000	88	0.4%	$20,150,282	24.1%	$402,626	3.1%	120	0.4%	$30,450,131	26.2%	$486,993	2.9%
Total	**23,368**	**100.0%**	**$83,741,413**	**100.0%**	**$13,125,142**	**100.0%**	**27,728**	**100.0%**	**$116,413,291**	**100.0%**	**$16,592,748**	**100.0%**

* Unique Members are counted equally regardless of length of coverage. Note that because data is on a paid basis, member counts may also include those not active in the period.

Cost Distribution: HCCs vs. Non-HCCs



HCC Cost Breakout by Diagnostic Chapter

#	Diagnostic Chapter	Patients	Total Paid	% of Tot
1	Neoplasms	57	$5,847,744	19.2%
2	Health Status & Health Services	113	$3,586,608	11.8%
3	Injury, Poisoning & External Causes	48	$3,110,356	10.2%
4	Perinatal Originating Conditions	13	$3,001,293	9.9%
5	Circulatory System	67	$2,800,714	9.2%
6	Blood & Immune Disorders	39	$2,153,319	7.1%
7	Nervous System	52	$1,933,337	6.3%
8	Endocrine, Nutritional & Metabolic	65	$1,650,877	5.4%
9	Mental, Behavioral & Neurodevelopmental	46	$1,042,890	3.4%
10	Musculoskeletal System	68	$967,707	3.2%
...	*All Others*		*$4,355,286*	*14.3%*
=	**Total**	**120**	**$30,450,131**	**100.0%**

Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Inpatient Admissions							
# of Admits	519	*50.7%*	782	*30.1%*	1,017		
# of Admit Days	2,268	*61.9%*	3,673	*31.4%*	4,825		
Paid per Admit	$26,498	*-0.7%*	$26,318	*9.3%*	$28,774	$28,787	*0.0%*
Paid per Admit Day	$6,064	*-7.6%*	$5,603	*8.2%*	$6,065	$5,622	*7.9%*
Admits per 1000	104.2	*-61.0%*	40.7	*6.7%*	43.4	47.9	*-9.5%*
Average LOS	4.4	*7.5%*	4.7	*1.0%*	4.7	5.1	*-7.3%*
Emergency Room Visits							
# of ER Visits	2,211	*62.1%*	3,584	*30.4%*	4,672		
~ % resulting in Admit	11.4%	*-0.5 pts*	10.9%	*0.4 pts*	11.3%	11.1%	*0.1 pts*
ER Visits per Patient	1.4	*3.7%*	1.4	*1.6%*	1.4		
ER Visits per 1000	444.0	*-58.0%*	186.3	*6.9%*	199.2	233.5	*-14.7%*
Paid per ER Visit	$2,820	*6.1%*	$2,991	*6.5%*	$3,185	$2,114	*50.6%*
Urgent Care Visits							
# of UC Visits	5,070	*46.8%*	7,444	*25.5%*	9,340		
UC Visits per Patient	1.5	*1.3%*	1.5	*0.9%*	1.5		-
UC Visits per 1000	1,018.0	*-62.0%*	387.0	*2.9%*	398.3	263.2	*51.3%*
Paid per UC Visit	$89	*14.9%*	$102	*7.5%*	$110	$112	*-1.7%*
Office Visits							
Off Visits per Patient	4.5	*11.9%*	5.0	*3.6%*	5.2		
Paid per Office Visit	$81	*6.6%*	$87	*5.3%*	$91	$89	*2.9%*
Office Visits Paid PMPY	$863	*-56.4%*	$376	*8.2%*	$407	$350	*16.5%*
Services							
Radiology Svcs per 1000	8,770.6	*-58.8%*	3,614.4	*5.6%*	3,815.7	3,999.8	*-4.6%*
Radiology Paid PMPY	$888	*-60.0%*	$355	*11.5%*	$396		
Lab Services per 1000	25,786.2	*-61.9%*	9,830.1	*12.2%*	11,030.4	11,047.4	*-0.2%*
Labs Paid PMPY	$562	*-58.0%*	$236	*16.2%*	$274		

- *Inpatient Admission rate per 1000 increased 6.7%, and amount paid per Admission is 9.3% higher than prior period*
- *ER utilization increased 6.9%, and amount paid per ER visit is 6.5% higher than prior period*

Admissions and all other **Visits** are counted for utilization if the *initial Paid Date* for the first primary claim (facility claim for non-Office Visits) fell within the time period. For cost purposes, however, all visit costs paid within the time period are included.

Counts **per 1000** and amounts **PMPY** (per member per year) have been annualized.

Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	471	*52.9%*	720	*33.3%*	960	0	-	0	-	0
# of Admit Days	2,055	*58.5%*	3,257	*36.9%*	4,458	0	-	0	-	0
Paid per Admit	$25,009	*-1.5%*	$24,642	*15.9%*	$28,549	$0	-	$0	-	$0
Paid per Admit Day	$5,732	*-5.0%*	$5,447	*12.9%*	$6,148	$0	-	$0	-	$0
Admits per 1000	102.6	*-60.6%*	40.4	*8.6%*	43.9	0.0	-	0.0	-	0.0
Average LOS	4.4	*3.7%*	4.5	*2.7%*	4.6	0.0	-	0.0	-	0.0
Emergency Room Visits										
# of ER Visits	2,027	*62.7%*	3,298	*32.1%*	4,358	0	-	1	*100.0%*	2
~ % resulting in Admit	11.0%	*-0.3 pts*	10.7%	*0.4 pts*	11.1%	0.0%	-	0.0%	*0.0 pts*	0.0%
ER Visits per Patient	1.4	*2.3%*	1.4	*2.7%*	1.4	0.0	-	1.0	*100.0%*	2.0
ER Visits per 1000	441.3	*-58.0%*	185.2	*7.6%*	199.4	0.0	-	400.0	*20.0%*	480.0
Paid per ER Visit	$2,828	*5.7%*	$2,990	*4.8%*	$3,133	$0	-	$1,686	*9.9%*	$1,852
Urgent Care Visits										
# of UC Visits	4,794	*46.5%*	7,025	*26.1%*	8,861	3	*-33.3%*	2	*-100.0%*	0
UC Visits per Patient	1.5	*0.8%*	1.5	*1.0%*	1.5	1.5	*-33.3%*	1.0	*-100.0%*	0.0
UC Visits per 1000	1,043.8	*-62.2%*	394.6	*2.7%*	405.4	4,500.0	*-82.2%*	800.0	*-100.0%*	0.0
Paid per UC Visit	$89	*14.9%*	$102	*7.6%*	$110	$104	*63.0%*	$170	*-100.0%*	$0
Office Visits										
Off Visits per Patient	4.3	*12.5%*	4.9	*3.9%*	5.1	14.5	*-42.5%*	8.3	*-22.0%*	6.5
Paid per Office Visit	$80	*6.4%*	$85	*5.8%*	$90	$107	*46.0%*	$156	*-3.2%*	$151
Office Visits Paid PMPY	$823	*-56.1%*	$361	*8.9%*	$393	$4,651	*-66.4%*	$1,561	*-69.8%*	$471
Services										
Radiology Svcs per 1000	8,163.4	*-58.7%*	3,370.7	*6.7%*	3,595.5	40,500.0	*-88.1%*	4,800.0	*-30.0%*	3,360.0
Radiology Paid PMPY	$829	*-60.6%*	$327	*13.1%*	$370	$4,617	*-33.0%*	$3,092	*-51.0%*	$1,516
Lab Services per 1000	24,844.2	*-61.4%*	9,591.3	*12.5%*	10,791.3	105,000.0	*-81.0%*	20,000.0	*-25.6%*	14,880.0
Labs Paid PMPY	$548	*-58.1%*	$230	*16.2%*	$267	$580	*-73.0%*	$157	*-14.3%*	$134

Utilization Summary – YTD Trend

Retired Members

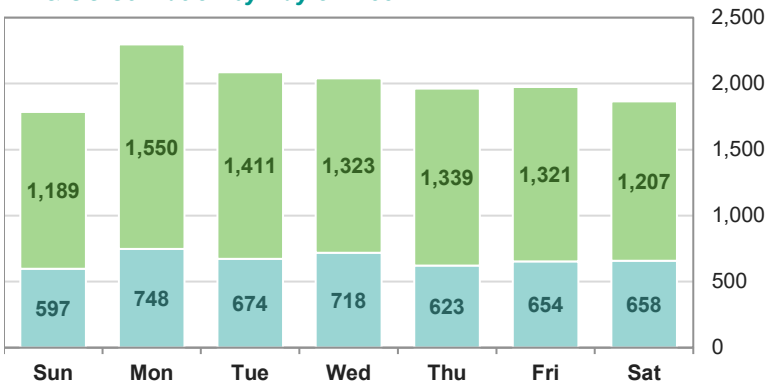
Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	47	*29.8%*	61	*-6.6%*	57	1	*0.0%*	1	*0.0%*	1
# of Admit Days	210	*92.9%*	405	*-13.8%*	349	3	*266.7%*	11	*-81.8%*	2
Paid per Admit	$40,808	*10.9%*	$45,263	*-28.8%*	$32,234	$55,310	*37.3%*	$75,918	*-89.0%*	$8,343
Paid per Admit Day	$9,133	*-25.4%*	$6,817	*-22.8%*	$5,265	$18,437	*-62.6%*	$6,902	*-39.6%*	$4,172
Admits per 1000	125.9	*-65.0%*	44.0	*-16.7%*	36.7	75.0	*-68.0%*	24.0	*16.3%*	27.9
Average LOS	4.5	*48.6%*	6.6	*-7.8%*	6.1	3.0	*266.7%*	11.0	*-81.8%*	2.0
Emergency Room Visits										
# of ER Visits	179	*52.0%*	272	*12.5%*	306	5	*160.0%*	13	*-53.8%*	6
~ % resulting in Admit	16.8%	*-3.2 pts*	13.6%	*0.1 pts*	13.7%	0.0%	*7.7 pts*	7.7%	*9.0 pts*	16.7%
ER Visits per Patient	1.3	*24.3%*	1.6	*-12.4%*	1.4	1.3	*4.0%*	1.3	*15.4%*	1.5
ER Visits per 1000	479.5	*-59.0%*	196.4	*0.3%*	196.9	375.0	*-16.8%*	312.0	*-46.3%*	167.4
Paid per ER Visit	$2,781	*7.1%*	$2,977	*32.6%*	$3,949	$1,131	*218.1%*	$3,597	*-43.7%*	$2,027
Urgent Care Visits										
# of UC Visits	264	*53.8%*	406	*15.0%*	467	9	*22.2%*	11	*9.1%*	12
UC Visits per Patient	1.4	*8.1%*	1.5	*0.8%*	1.5	1.8	*-12.7%*	1.6	*-23.6%*	1.2
UC Visits per 1000	707.2	*-58.6%*	293.1	*2.5%*	300.5	675.0	*-60.9%*	264.0	*26.8%*	334.9
Paid per UC Visit	$86	*15.0%*	$99	*6.4%*	$105	$52	*-5.4%*	$49	*9.0%*	$53
Office Visits										
Off Visits per Patient	5.6	*10.8%*	6.2	*2.1%*	6.4	7.0	*9.5%*	7.7	*22.2%*	9.4
Paid per Office Visit	$89	*9.5%*	$98	*1.1%*	$99	$60	*11.5%*	$67	*15.6%*	$78
Office Visits Paid PMPY	$1,330	*-57.5%*	$565	*5.1%*	$594	$1,272	*-56.1%*	$559	*38.7%*	$775
Services										
Radiology Svcs per 1000	14,818.4	*-55.9%*	6,535.3	*3.5%*	6,761.8	47,025.0	*-77.5%*	10,560.0	*-1.4%*	10,409.3
Radiology Paid PMPY	$1,553	*-54.3%*	$709	*7.1%*	$760	$2,347	*-76.6%*	$549	*17.7%*	$647
Lab Services per 1000	36,537.0	*-65.7%*	12,544.4	*13.4%*	14,231.5	45,300.0	*-53.6%*	21,024.0	*-16.5%*	17,553.5
Labs Paid PMPY	$707	*-55.1%*	$318	*18.5%*	$376	$1,502	*-90.4%*	$145	*-9.4%*	$131

On Demand Care Summary

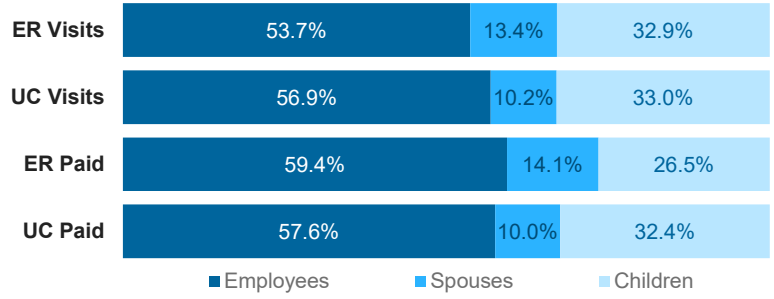
Emergency Room & Urgent Care

Measure	2024-4Q	2025-4Q	*Change*	UMR Norm	*Variance*
Emergency Room					
# of Visits	3,584	4,672	*30.4%*		
# of Patients	2,548	3,269	*28.3%*		
Total Plan Paid	$10,720,746	$14,878,349	*38.8%*		
Total Mem Paid	$2,221,714	$2,828,036	*27.3%*		
Visits per 1000	186.3	199.2	*6.9%*	233.5	*-14.7%*
Paid per Visit	$2,991	$3,185	*6.5%*	$2,114	*50.6%*
Paid PMPM	$46	$53	*13.8%*	$41	*28.5%*
% ER Patients w/ Office Visit*	91.8%	93.9%	*2.1 pts*		
% Potentially Avoidable**	15.0%	15.6%	*0.7 pts*	16.9%	*-1.3 pts*
Urgent Care					
# of Visits	7,444	9,340	*25.5%*		
# of Patients	4,894	6,084	*24.3%*		
Total Plan Paid	$759,792	$1,024,954	*34.9%*		
Total Mem Paid	$544,772	$675,892	*24.1%*		
Visits per 1000	387.0	398.3	*2.9%*	263.2	*51.3%*
Paid per Visit	$102	$110	*7.5%*	$112	*-1.7%*
Paid PMPM	$3	$4	*10.6%*	$2	*48.7%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	**Total**	ER	UC	Total
Employee	2,509	5,311	**7,820**	$8,832,792	$589,895	**$9,422,686**
Spouse	625	951	**1,576**	$2,103,591	$102,802	**$2,206,392**
Child	1,538	3,078	**4,616**	$3,941,967	$332,258	**$4,274,224**
Total	**4,672**	**9,340**	**14,012**	**$14,878,349**	**$1,024,954**	**$15,903,303**

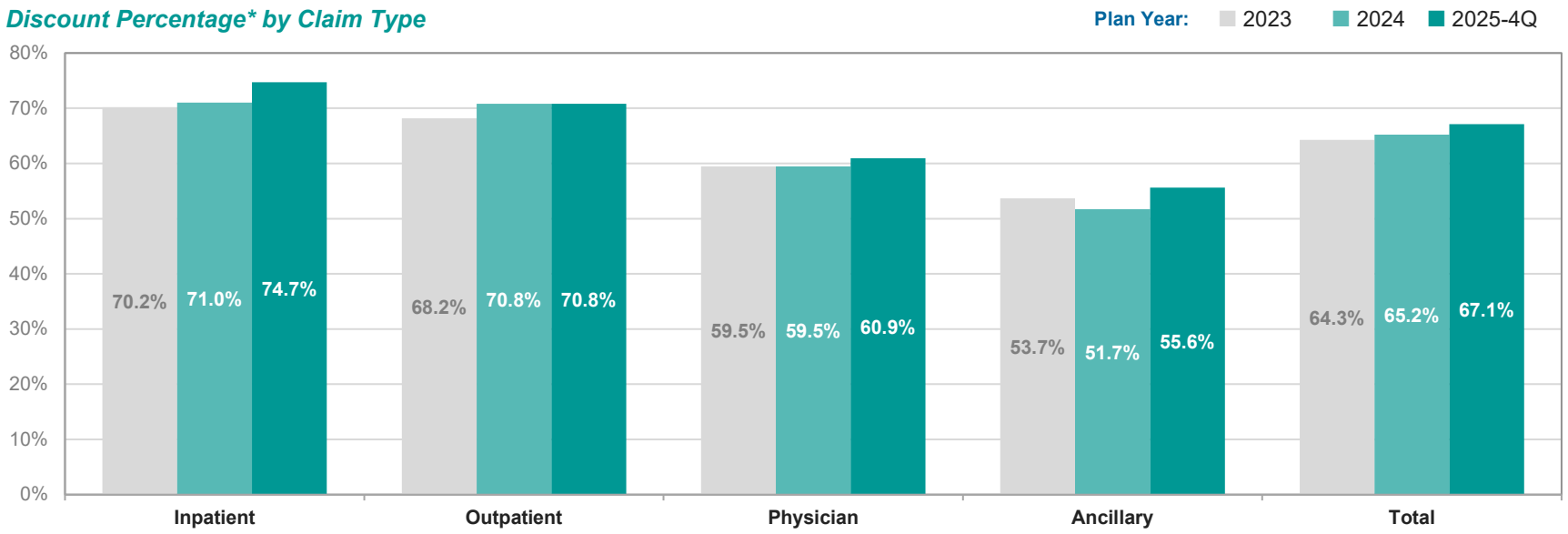
* Office Visit within prior 12 months..

** ER Visits are categorized as potentially avoidable based on primary and secondary diagnosis and do not necessarily indicate misuse of the ER for the patient's specific circumstances.

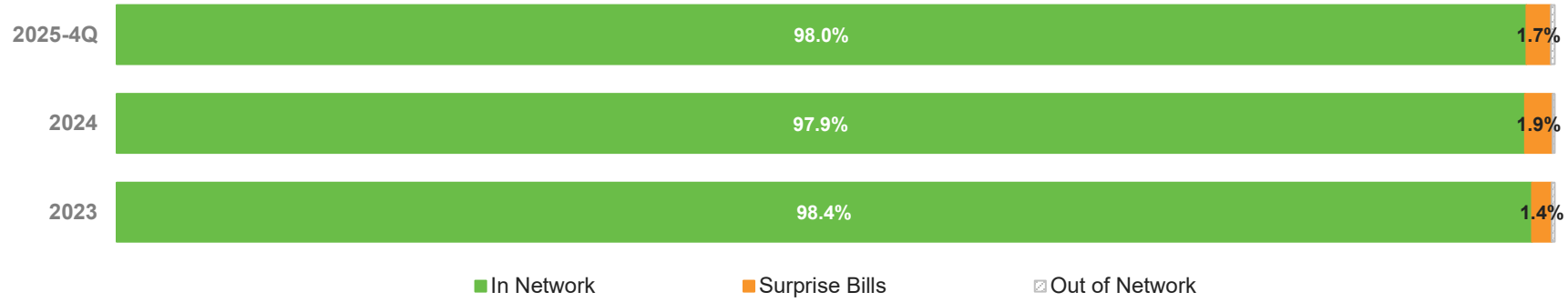
Network Summary

Discount Percentage & Network Utilization

Discount Percentage by Claim Type*



*Network Utilization**



* Network Discounts and Utilization exclude COB Claims, and Network Discounts additionally exclude Surprise Bills.

Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2024 (Full Year)		2025-4Q		CYTD Paid by Relationship			CYTD Paid by Sex	
	Patients	Total Paid	Patients	Total Paid	Employee	Spouse	Child	Male	Female
Health Status & Health Services	12,860	$9,799,414	15,933	$13,125,849	$7,534,734	$2,852,717	$2,738,398	$4,206,613	$8,919,236
Neoplasms	2,400	$5,750,257	3,006	$10,454,135	$8,550,800	$1,660,651	$242,684	$3,352,373	$7,101,762
Musculoskeletal System	5,252	$8,247,149	6,392	$9,971,815	$6,963,651	$2,013,737	$994,428	$4,249,839	$5,721,977
Circulatory System	2,897	$6,856,254	3,700	$9,265,567	$6,505,478	$2,470,502	$289,587	$5,925,962	$3,339,605
Mental, Behavioral & Neurodevelopmental	4,161	$6,596,135	5,403	$9,148,979	$4,076,929	$874,535	$4,197,515	$3,591,994	$5,556,985
Injury, Poisoning & External Causes	2,586	$5,001,111	3,374	$8,521,617	$5,510,842	$936,148	$2,074,627	$4,076,327	$4,445,290
Symptoms, Signs & Findings, NEC	8,003	$5,392,767	10,316	$7,524,028	$4,658,430	$1,230,278	$1,635,319	$2,529,020	$4,995,008
Digestive System	2,577	$4,958,096	3,369	$6,835,609	$4,621,129	$1,206,804	$1,007,677	$2,853,384	$3,982,225
Nervous System	2,751	$5,952,179	3,485	$5,995,432	$4,575,875	$836,794	$582,763	$1,874,321	$4,121,110
Genitourinary System	3,804	$4,801,920	5,020	$5,876,996	$4,273,425	$1,016,535	$587,036	$1,586,486	$4,290,510
Endocrine, Nutritional & Metabolic	5,290	$3,869,576	6,742	$5,668,698	$4,502,892	$808,414	$357,392	$2,189,707	$3,478,991
Respiratory System	5,652	$3,772,490	6,826	$5,610,487	$2,675,583	$944,049	$1,990,854	$2,665,850	$2,944,637
Pregnancy, Childbirth & the Puerperium	476	$3,930,375	643	$5,490,502	$3,612,954	$1,267,116	$610,432	$8,271	$5,482,231
Perinatal Originating Conditions	226	$3,322,086	312	$4,049,899	$1,768	$0	$4,048,131	$2,588,083	$1,461,816
Blood & Immune Disorders	718	$416,460	1,041	$2,739,481	$1,440,520	$146,902	$1,152,059	$2,296,139	$443,342
Infectious & Parasitic Diseases	1,650	$1,677,923	1,937	$1,811,338	$1,004,138	$393,834	$413,366	$876,431	$934,907
Eye and Adnexa	4,615	$1,199,451	5,230	$1,509,643	$952,125	$247,078	$310,440	$625,713	$883,930
Skin & Subcutaneous Tissue	3,978	$941,344	5,109	$1,235,100	$661,755	$234,771	$338,574	$507,810	$727,290
Ear and Mastoid Process	1,597	$644,319	2,008	$974,018	$415,419	$90,801	$467,798	$389,484	$584,534
Congenital Malformations & Abnormalities	311	$611,052	435	$581,437	$106,015	$21,177	$454,245	$289,832	$291,604
External Causes of Morbidity	6	$1,053	11	$22,660	$21,222	$579	$859	$557	$22,103
Total	**18,957**	**$83,741,413**	**23,085**	**$116,413,291**	**$72,665,683**	**$19,253,422**	**$24,494,186**	**$46,684,198**	**$69,729,093**

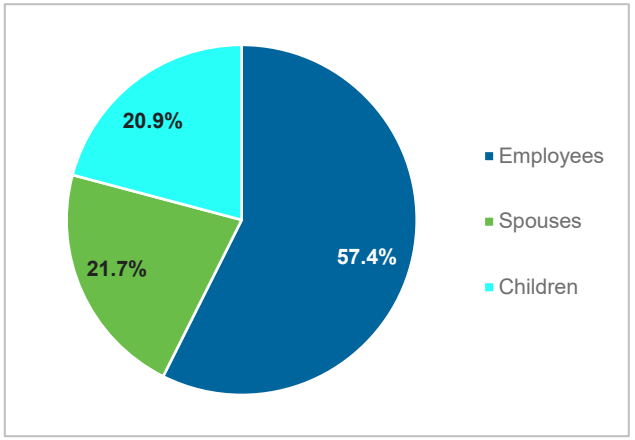
#1 Top Dx Chapter

Health Status & Health Services

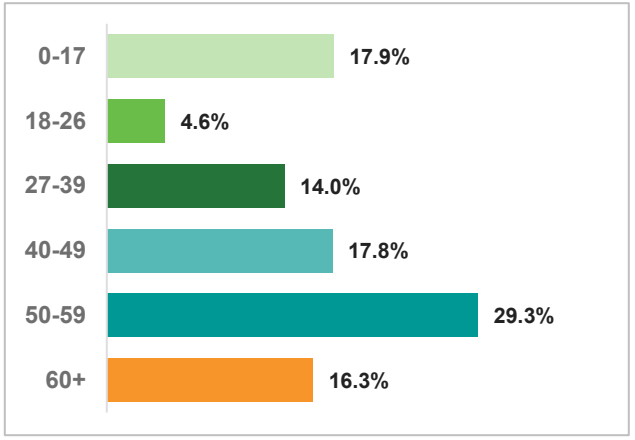
Breakout by Diagnostic Grouping & Demographics

#	Health Status & Services Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Encounter for antineoplastic therapies	59	368	$3,901,570	29.7%
2	Medical examination/evaluation	11,963	21,557	$2,771,774	21.1%
3	Neoplasm-related encounters	4,334	7,949	$2,164,218	16.5%
4	Exposure, enc, screen or contact w infectious dz	5,752	8,654	$1,719,378	13.1%
5	Contraceptive & procreative management	995	1,905	$743,759	5.7%
6	Other aftercare encounter	569	1,128	$316,744	2.4%
7	Implant, device or graft related encounter	435	1,170	$232,940	1.8%
8	Encount for obs & exam for conds ruled out	2,196	2,856	$210,680	1.6%
9	Family history of disease	197	276	$209,425	1.6%
10	Personal history of other disease	534	713	$155,398	1.2%
11	Other specified status	896	1,680	$147,533	1.1%
12	Other specified encounters & counseling	455	1,480	$111,914	0.9%
13	Organ transplant status	30	149	$85,080	0.6%
14	Acquired absence of limb or organ	40	87	$72,909	0.6%
15	Encounter for prophylactic or oth procedures	74	86	$70,685	0.5%
16	Personal history of malignant neoplasm	105	163	$64,343	0.5%
17	Enc for prophylactic measures (ex immuniz)	124	184	$47,143	0.4%
18	Genetic susceptibility to disease	16	25	$27,807	0.2%
19	Encounter for administrative purposes	51	65	$23,606	0.2%
20	Lifestyle/life management factors	76	153	$16,924	0.1%
...	*All Others*	*1,604*	*2,104*	*$32,018*	*0.2%*
=	**Total**	**15,933**	**52,945**	**$13,125,849**	**100.0%**

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



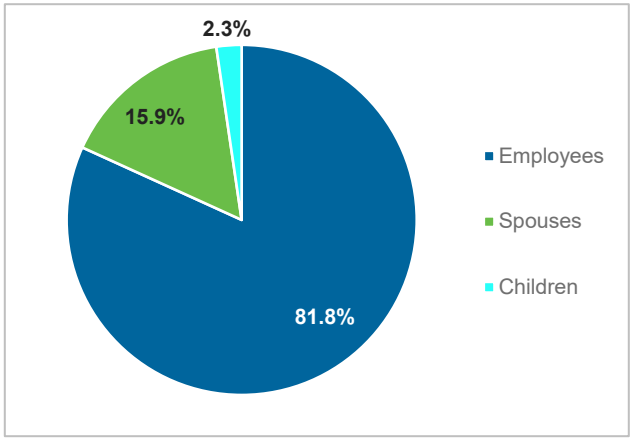
#2 Top Dx Chapter

Neoplasms (Cancer)

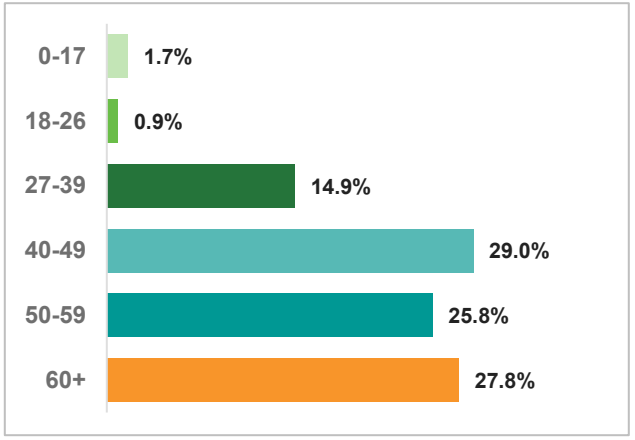
Breakout by Diagnostic Grouping & Demographics

#	Neoplasms (Cancer) Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Breast cancer	150	2,108	$2,509,692	24.0%
2	Benign neoplasms	2,178	3,508	$1,514,508	14.5%
3	Secondary malignancies	46	260	$870,899	8.3%
4	Lymphoma	35	433	$628,480	6.0%
5	Skin cancer	217	656	$605,923	5.8%
6	Colorectal cancer	35	484	$583,286	5.6%
7	Other cancer	50	465	$488,775	4.7%
8	Other gastrointestinal cancers	20	435	$441,868	4.2%
9	Leukemia	18	358	$441,651	4.2%
10	Multiple myeloma	5	86	$425,206	4.1%
11	Neoplasms of unspec nature	1,082	1,638	$374,935	3.6%
12	Prostate cancer	58	531	$369,263	3.5%
13	Thyroid cancer	60	308	$258,112	2.5%
14	Brain cancer	11	151	$253,355	2.4%
15	Respiratory cancers	13	268	$222,366	2.1%
16	Head & neck cancers	19	151	$118,644	1.1%
17	Pancreatic cancer	8	125	$79,834	0.8%
18	Cervical cancer	16	62	$67,843	0.6%
19	Endometrial cancer	16	67	$64,548	0.6%
20	Kidney Cancer	18	47	$45,458	0.4%
...	*All Others*	*35*	*151*	*$89,489*	*0.9%*
=	**Total**	**3,006**	**13,187**	**$10,454,135**	**100.0%**

Neoplasms (Cancer) Paid by Relationship



Neoplasms (Cancer) Paid by Age Range



Note: there are additional cancer-related costs for encounters and therapy, totaling $6,065,788 – see Health Status for more details

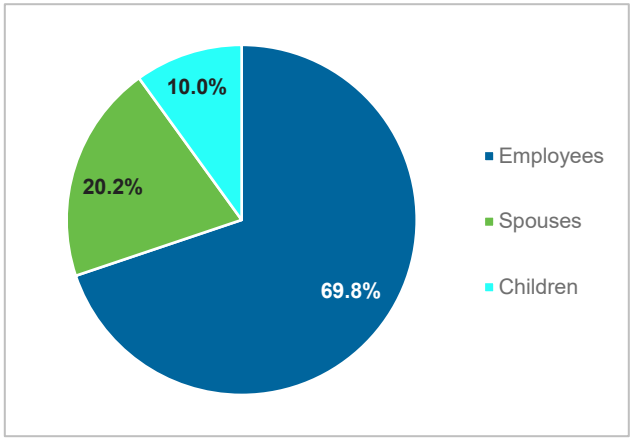
#3 Top Dx Chapter

Musculoskeletal System

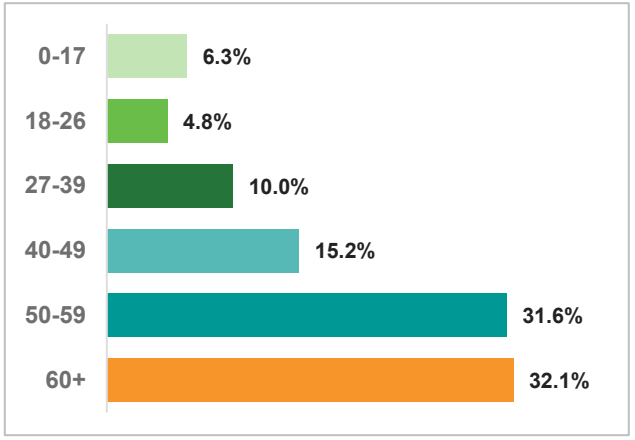
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	1,808	7,940	$2,764,716	27.7%
2	Osteoarthritis & osteoporosis	816	2,365	$1,863,004	18.7%
3	Other musculoskeletal pain	3,717	12,100	$1,639,847	16.4%
4	Tendon, tissue, muscle disorders	1,465	3,936	$1,137,584	11.4%
5	Scoliosis & oth deformities	595	1,257	$794,396	8.0%
6	Other MSK	124	468	$553,284	5.5%
7	Joint disorders & fractures	543	1,234	$455,480	4.6%
8	Low back pain	936	3,022	$339,651	3.4%
9	Rheumatoid arthritis & related disease	161	736	$272,247	2.7%
10	Lupus	128	523	$77,919	0.8%
11	Gout & crystal arthropathies	123	203	$41,195	0.4%
12	Biomechanical lesions	507	2,365	$32,494	0.3%
=	**Total**	**6,392**	**38,014**	**$9,971,815**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2023 (Full Year)		2024 (Full Year)		2025-4Q		2025-4Q Paid by Claim Type			
	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Inpatient	Outpatient	Physician	Ancillary
Depressive disorders	809	$816,779	1,312	$1,765,217	1,657	$2,195,970	$412,556	$35,529	$1,745,321	$2,564
Neurodevelopmental disorders	475	$333,190	839	$967,358	1,117	$2,005,009	$48,155	$5,302	$1,951,429	$124
Anxiety & related Disorders	1,022	$497,830	1,659	$914,955	2,234	$1,366,176	$0	$45,161	$1,318,515	$2,500
Trauma & stressor disorders	656	$443,281	1,151	$777,003	1,462	$1,169,043	$694	$15,742	$1,152,459	$149
Alcohol-related disorders	68	$264,765	100	$479,637	129	$614,122	$429,381	$57,206	$127,534	$0
Other mental health	222	$81,092	359	$444,148	475	$484,670	$30,467	$160,623	$292,385	$1,195
Obsessive compulsive disorders	35	$95,327	82	$67,055	113	$292,390	$35,487	$0	$256,904	$0
Bipolar & related Disorders	142	$184,393	220	$270,639	285	$252,131	$35,001	$10,665	$206,465	$0
Eating disorders	38	$115,900	53	$266,949	67	$215,695	$51,311	$0	$164,384	$0
Suicidal ideation, attempt or self-harm	40	$168,577	61	$408,763	59	$212,799	$14,569	$170,551	$27,678	$0
Schizophrenia spectrum disorders	23	$59,238	29	$162,208	40	$204,689	$139,978	$22,559	$42,152	$0
Opiod disorders	20	$18,095	23	$40,867	30	$70,004	$40,573	$5,491	$23,940	$0
Cannabis-related disorders	12	$2,064	19	$5,535	26	$42,633	$3,360	$27,000	$12,272	$0
Other substance use	44	$8,435	96	$10,587	94	$16,449	$0	$3,659	$12,791	$0
Stimulant disorders	7	$6,429	11	$15,213	10	$7,200	$0	$0	$7,200	$0
Total	**2,630**	**$3,095,394**	**4,161**	**$6,596,135**	**5,403**	**$9,148,979**	**$1,241,531**	**$559,488**	**$7,341,428**	**$6,531**

Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	62	2.8	*31.9%*	41	1.8	*41.4%*	$7,349	96.8	129.0
Asthma	799	35.5	*20.0%*	319	14.2	*29.1%*	$4,380	53.8	220.3
Atrial Fibrillation	158	7.0	*35.0%*	110	4.9	*46.7%*	$41,586	360.8	569.6
Blood Disorders	938	41.7	*43.2%*	412	18.3	*48.7%*	$18,061	165.2	327.3
CAD	255	11.3	*34.2%*	119	5.3	*38.4%*	$22,851	266.7	356.9
COPD	68	3.0	*83.8%*	32	1.4	*23.1%*	$24,995	441.2	602.9
Cancer	1,458	64.8	*29.1%*	695	30.9	*38.7%*	$14,789	65.8	163.9
Chronic Pain	132	5.9	*0.8%*	53	2.4	*3.9%*	$21,548	257.6	393.9
CHF	58	2.6	*48.7%*	35	1.6	*59.1%*	$68,142	689.7	879.3
Demyelinating Diseases	69	3.1	*21.1%*	51	2.3	*27.5%*	$30,398	101.4	289.9
Depression	1,554	69.0	*28.9%*	1,135	50.4	*31.7%*	$8,392	79.8	228.4
Diabetes	1,439	63.9	*32.7%*	999	44.4	*34.6%*	$7,695	73.7	230.0
ESRD	62	2.8	*51.2%*	43	1.9	*87.0%*	$57,628	951.6	1,274.2
Eating Disorders	61	2.7	*41.9%*	44	2.0	*29.4%*	$13,634	65.6	245.9
HIV/AIDS	39	1.7	*30.0%*	27	1.2	*12.5%*	$3,247	51.3	51.3
Hyperlipidemia	797	35.4	*37.4%*	263	11.7	*39.2%*	$2,727	17.6	59.0
Hypertension	1,933	85.9	*30.2%*	953	42.3	*39.1%*	$7,534	80.7	227.6
Immune Disorders	72	3.2	*20.0%*	31	1.4	*10.7%*	$27,210	111.1	222.2
IBD	86	3.8	*-3.4%*	24	1.1	*-27.3%*	$3,579	11.6	151.2
Liver Disease	4	0.2	*100.0%*	3	0.1	*50.0%*	$131,460	2,000.0	3,000.0
Morbid Obesity	367	16.3	*57.5%*	184	8.2	*76.9%*	$6,008	76.3	147.1
Osteoarthritis	667	29.6	*21.7%*	291	12.9	*23.8%*	$8,266	31.5	133.4
Peripheral Vascular Disease	86	3.8	*50.9%*	24	1.1	*118.2%*	$6,756	81.4	209.3
Rheumatoid Arthritis	137	6.1	*19.1%*	102	4.5	*22.9%*	$9,930	58.4	219.0

- *Most prevalent chronic condition is Hypertension, with 1,933 members*
- *Depression is the condition with the most moderate/high risk members (1,135)*
- *Members with mod/high risk Cancer have the highest combined cost: 695 members totaling $10.3M*

Date Range: Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

With Condition members are identified by having any covered claim with a diagnosis for the condition in Dx position 1.

Moderate/High-Risk Condition members had either multiple provider visits for the condition (based on Dx position 1) during the date range or at least one ER Visit or Admission for the condition in the range.

Cost & Utilization for All Members:

- **Allowed PMPY:** $5,773
- **Admits per 1000:** 44.6
- **ER Visits per 1000:** 201.1

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2023 - Mar 2024 Eligible	Apr 2023 - Mar 2024 Actual	Apr 2023 - Mar 2024 Rate	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	*Rate Change*	UMR Norm Rate	UMR Norm *Variance*
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	224.4	1,208	**5,383.1**	284.3	1,591	**5,595.3**	*3.9%*	**5,378.5**	*4.0%*
Well Child Visit	3 - 6 years	911.7	720	**789.7**	1,121.0	917	**818.0**	*3.6%*	**796.4**	*2.7%*
Adults w/ Well Visit	Adults 18+	13,498	5,852	**43.4%**	17,002	7,523	**44.2%**	*0.9 pts*	**38.7%**	*5.6 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	4,168	1,955	**46.9%**	5,173	2,521	**48.7%**	*1.8 pts*	**45.0%**	*3.7 pts*
Cervical Cancer	Females 21 - 64	7,153	2,071	**29.0%**	8,965	2,631	**29.3%**	*0.4 pts*	**22.4%**	*7.0 pts*
Prostate Cancer	Males 50 - 70	1,833	793	**43.3%**	2,306	1,066	**46.2%**	*3.0 pts*	**40.2%**	*6.1 pts*
Colorectal Cancer	Members 45 - 75	5,740	993	**17.3%**	7,187	1,388	**19.3%**	*2.0 pts*	**15.8%**	*3.5 pts*
Cholesterol	Female 45+ Male 35+	7,061	4,048	**57.3%**	8,859	5,180	**58.5%**	*1.1 pts*	**44.6%**	*13.9 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	666	532	**79.9%**	799	648	**81.1%**	*1.2 pts*		
COPD	Spirometry Test	37	6	**16.2%**	68	11	**16.2%**	*0.0 pts*		
Type 2 Diabetes	A1c Test	997	898	**90.1%**	1,316	1,217	**92.5%**	*2.4 pts*	**83.1%**	*9.3 pts*
	Eye Exam	997	211	**21.2%**	1,316	281	**21.4%**	*0.2 pts*	**25.4%**	*-4.0 pts*
	Lipid Panel	997	792	**79.4%**	1,316	1,083	**82.3%**	*2.9 pts*	**69.6%**	*12.6 pts*
	Urine Protein Test	997	653	**65.5%**	1,316	929	**70.6%**	*5.1 pts*	**61.7%**	*8.9 pts*
	Any Diabetes Screen	997	940	**94.3%**	1,316	1,266	**96.2%**	*1.9 pts*	**91.7%**	*4.5 pts*
Hyperlipidemia	Lipid Profile	580	318	**54.8%**	797	381	**47.8%**	*-7.0 pts*		
Hypertension	Creatinine Test	1,485	287	**19.3%**	1,933	377	**19.5%**	*0.2 pts*		
	Lipid Profile	1,485	414	**27.9%**	1,933	475	**24.6%**	*-3.3 pts*		

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.

18.1.5

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report
        18.1.3 Q4 CDHP Performance Review
        18.1.4 Q4 LD PPO Performance Review
        18.1.5 Q4 EPO Performance Review

Quarterly Plan Performance Review

EPO Plan • 2025-4Q

UMR
A UnitedHealthcare Company

RPG 4.90 • Run Date: 8/28/2025

Report Criteria & Contents

Experience Periods*

- **2025 Plan Year (Current)**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024
- **2023 Plan Year**
  - 2023-4Q.1st four Quarters: Claims Paid 7/1/2022 - 6/30/2023
  - 2023 Full Year: Claims paid 7/1/2022 - 6/30/2023

Group Data

- Data reported is for the EPO Plan only:
- Contract = 7670-00-414946 or 7670-09-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,077 groups with approximately 7.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2024 - 6/30/2025

* Additional date ranges for specific figures are defined on the page if applicable

Executive Summary

Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: +12.5%
- High-Cost Claimants Paid PMPM trend: +13.7%; Non HCCs trend: +12.8%
- Top Paid Diagnostic Chapters: Musculoskeletal (+23.0% Paid PMPM), Neoplasms (Cancer) (+21.6%), Circulatory System (+12.6%)

Membership & Demographics

- Total membership is 9.7% lower than prior period
- Employees decreased 9.2%, while Dependents were down 10.3%
- 65.2% of members had < $2,500 medical paid, with 8.6% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $37,557, which is 13.0% lower than 2024-4Q
- Paid per ER Visit was $3,391, which is 12.4% higher than 2024-4Q

Network Utilization & Savings

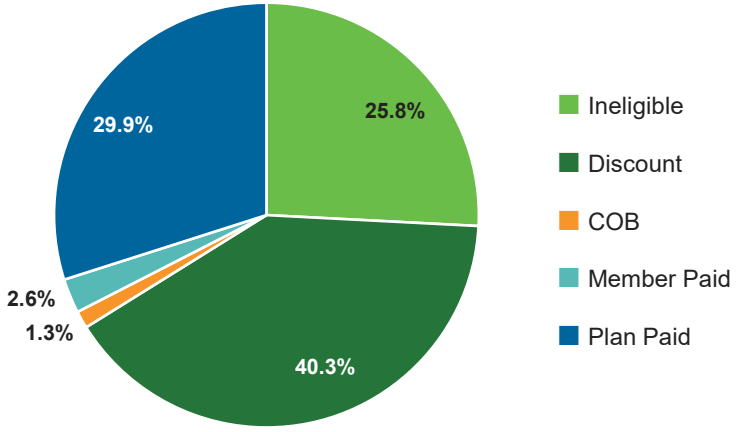
- 96.7% of all Medical spend dollars were to In Network providers
- The average In Network discount was 55.7%, which is somewhat (−0.5 pts) below the 2024 average discount of 56.2%

Medical Total Savings Summary

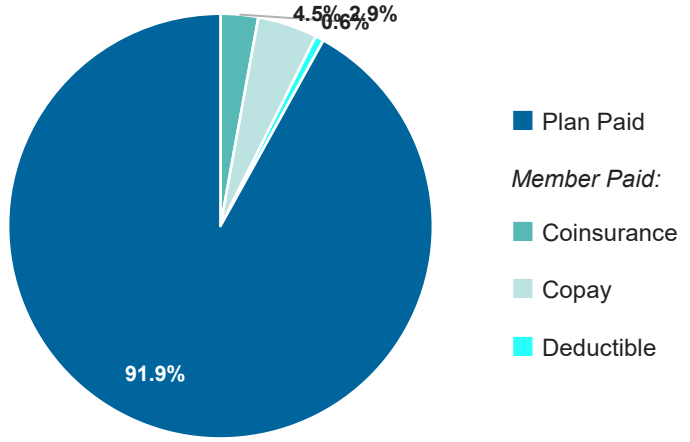
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2025-4Q Total Dollars	2025-4Q PMPM*	2024 PMPM*	*Trend*
Medical Billed	**$151,066,580**	**$2,435**	$2,127	***14.5%***
(-) Ineligible	**$38,976,928**	**$628**	$504	***24.8%***
Medical Covered	**$112,089,652**	**$1,807**	$1,623	***11.3%***
(-) Discount	**$60,858,991**	**$981**	$890	***10.2%***
Medical Allowed	**$51,230,661**	**$826**	$733	***12.6%***
(-) COB	**$2,000,339**	**$32**	$24	***31.6%***
(-) Coinsurance	**$1,404,634**	**$23**	$21	***9.2%***
(-) Copay	**$2,234,415**	**$36**	$34	***6.2%***
(-) Deductible	**$317,401**	**$5**	$6	***-19.7%***
Total Member Paid	**$3,956,451**	**$64**	$61	***4.5%***
Total Plan Paid	**$45,156,705**	**$728**	$643	***13.1%***

Breakout of Billed Dollars



Breakout of Paid Dollars: Plan vs. Member Paid



* PMPM (per member per month): Amount per the average total membership (both primary subscribers and dependents) per month.

Medical & Rx Paid Claims by Age Range

Age	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)						Change	
	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Med Paid	Med Paid PMPM	Rx Paid	Rx Paid PMPM	Total Paid	Tot Paid PMPM	Total Paid	Tot Paid PMPM
<1	$2,243,415	$4,095	$5,026	$9	**$2,248,441**	**$4,104**	$3,482,910	$9,139	$1,530	$4	$3,484,440	**$9,143**	*55.0%*	*122.8%*
1	$259,110	$419	$3,912	$6	**$263,022**	**$425**	$262,186	$580	$3,283	$7	$265,469	**$587**	*0.9%*	*38.1%*
2 - 4	$558,887	$263	$11,458	$5	**$570,345**	**$268**	$222,846	$132	$13,323	$8	$236,169	**$140**	*-58.6%*	*-47.8%*
5 - 9	$467,901	$121	$52,429	$14	**$520,330**	**$134**	$614,866	$165	$58,465	$16	$673,331	**$181**	*29.4%*	*34.3%*
10 - 14	$1,822,331	$361	$147,599	$29	**$1,969,931**	**$391**	$975,930	$218	$155,934	$35	$1,131,864	**$253**	*-42.5%*	*-35.3%*
15 - 19	$1,856,370	$322	$718,022	$124	**$2,574,392**	**$446**	$1,642,999	$314	$641,876	$123	$2,284,875	**$436**	*-11.2%*	*-2.2%*
20 - 24	$1,115,868	$193	$281,503	$49	**$1,397,370**	**$242**	$1,291,273	$247	$522,167	$100	$1,813,440	**$347**	*29.8%*	*43.3%*
25 - 29	$839,263	$403	$370,036	$178	**$1,209,299**	**$581**	$567,203	$309	$285,001	$155	$852,204	**$464**	*-29.5%*	*-20.1%*
30 - 34	$1,438,456	$512	$1,484,983	$529	**$2,923,439**	**$1,041**	$1,290,590	$535	$675,745	$280	$1,966,335	**$816**	*-32.7%*	*-21.6%*
35 - 39	$2,479,017	$582	$682,927	$160	**$3,161,944**	**$742**	$1,872,927	$528	$545,746	$154	$2,418,673	**$682**	*-23.5%*	*-8.1%*
40 - 44	$2,177,899	$459	$1,592,301	$336	**$3,770,200**	**$795**	$2,095,410	$488	$1,927,250	$449	$4,022,659	**$938**	*6.7%*	*18.0%*
45 - 49	$4,911,767	$955	$2,120,928	$412	**$7,032,695**	**$1,367**	$6,258,133	$1,417	$1,465,014	$332	$7,723,147	**$1,749**	*9.8%*	*27.9%*
50 - 54	$4,314,362	$644	$1,697,122	$253	**$6,011,484**	**$898**	$4,051,960	$684	$2,126,508	$359	$6,178,468	**$1,043**	*2.8%*	*16.2%*
55 - 59	$6,260,425	$893	$3,019,573	$431	**$9,279,998**	**$1,324**	$6,477,200	$938	$3,221,683	$466	$9,698,882	**$1,404**	*4.5%*	*6.0%*
60 - 64	$9,476,428	$1,184	$3,992,556	$499	**$13,468,984**	**$1,683**	$8,314,397	$1,162	$3,597,700	$503	$11,912,098	**$1,665**	*-11.6%*	*-1.1%*
65+	$3,991,623	$944	$1,901,357	$450	**$5,892,980**	**$1,393**	$5,735,874	$1,312	$2,593,144	$593	$8,329,018	**$1,905**	*41.3%*	*36.7%*
Total	**$44,213,123**	**$643**	**$18,081,730**	**$263**	$62,294,854	$906	**$45,156,705**	**$728**	**$17,834,368**	**$287**	**$62,991,072**	$1,015	***1.1%***	***12.0%***

Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Average Enrollment							
Employees	1,122	*175.3%*	3,089	*-9.2%*	2,805		
Spouses	217	*177.7%*	602	*-10.4%*	539		
Children	751	*171.1%*	2,037	*-10.3%*	1,826		
Tot. Members	**2,090**	***174.0%***	**5,727**	***-9.7%***	**5,170**		
Avg. Family Size	1.9	*-0.5%*	1.9	*-0.6%*	1.8	1.9	*-4.0%*
Financial Summary							
Allowed	$20,075,479	*151.0%*	$50,382,246	*1.7%*	$51,230,661		
Plan Paid	$18,041,437	*145.1%*	$44,213,123	*2.1%*	$45,156,705		
Member Paid (OOP)	$1,557,989	*169.2%*	$4,194,135	*-5.7%*	$3,956,451		
Paid PEPY	$16,080	*-11.0%*	$14,315	*12.5%*	$16,102	$10,136	*58.9%*
Paid PMPY	$8,632	*-10.6%*	$7,720	*13.1%*	$8,734	$5,280	*65.4%*
Paid PEPM	$1,340	*-11.0%*	$1,193	*12.5%*	$1,342	$845	*58.9%*
Paid PMPM	$719	*-10.6%*	$643	*13.1%*	$728	$440	*65.4%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	50	*24.0%*	62	*-4.8%*	59		
HCCs per 1000	23.9	*-54.7%*	10.8	*5.4%*	11.4	6.9	*66.3%*
Paid per HCC	$256,471	*4.8%*	$268,731	*7.9%*	$289,942	$230,655	*25.7%*
HCC Paid % of Tot	71.1%	*-33.4 pts*	37.7%	*0.2 pts*	37.9%	30.1%	*7.8 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$2,314	*-0.1%*	$2,312	*20.7%*	$2,789	$1,318	*111.6%*
Outpatient	$2,601	*-16.3%*	$2,177	*12.7%*	$2,453	$1,552	*58.1%*
Physician	$3,611	*-13.2%*	$3,134	*7.9%*	$3,383	$2,299	*47.1%*
Ancillary	$106	*-8.0%*	$98	*10.8%*	$108	$110	*-1.5%*

- *With $38.3M paid, the State Active population is 84.8% of total 2025-4Q med spend*
- *On a Paid PMPM basis, State Actives are up 11.9% compared to prior year*
- *Total EPO Plan Paid PMPM trend is +13.1%*

PEPY (per employee per year) and **PEPM** (per employee per month) represent amounts per the primary subscriber (employee or retiree).

PMPY (per member per year) and **PMPM** (per member per month) represent amounts per all covered members, including dependents.

Amounts **Per Year** (**PEPY** and **PMPY**) have been annualized.

HCCs (High-cost Claimants) are based on patients with $100,000+ paid medical in the period.

Claim Type: Ancillary includes Durable Medical Equipment, prosthetics, some drugs paid on the medical plan, et al.

Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	936	*172.6%*	2,551	*-10.2%*	2,291	1	*266.7%*	2	*-18.2%*	2
Spouses	187	*174.2%*	512	*-10.6%*	457	0	-	0	-	0
Children	701	*170.2%*	1,896	*-10.6%*	1,694	0	-	0	-	0
Tot. Members	**1,824**	***171.9%***	**4,959**	***-10.4%***	**4,442**	**1**	***266.7%***	**2**	***-18.2%***	**2**
Avg. Family Size	1.9	*-0.3%*	1.9	*-0.2%*	1.9	1.0	*0.0%*	1.0	*0.0%*	1.0
Financial Summary										
Allowed	$16,067,260	*160.9%*	$41,912,359	*0.2%*	$42,008,318	$1,985	*127.5%*	$4,517	*24.4%*	$5,618
Plan Paid	$14,706,304	*159.8%*	$38,203,284	*0.3%*	$38,309,548	$1,583	*124.1%*	$3,547	*22.7%*	$4,354
Member Paid (OOP)	$1,280,446	*170.3%*	$3,460,814	*-7.4%*	$3,203,983	$402	*141.2%*	$970	*30.3%*	$1,264
Paid PEPY	$15,714	*-4.7%*	$14,974	*11.7%*	$16,722	$3,166	*-38.9%*	$1,935	*50.0%*	$2,903
Paid PMPY	$8,063	*-4.4%*	$7,704	*11.9%*	$8,624	$3,166	*-38.9%*	$1,935	*50.0%*	$2,903
Paid PEPM	$1,309	*-4.7%*	$1,248	*11.7%*	$1,394	$264	*-38.9%*	$161	*50.0%*	$242
Paid PMPM	$672	*-4.4%*	$642	*11.9%*	$719	$264	*-38.9%*	$161	*50.0%*	$242
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	39	*38.5%*	54	*-11.1%*	48	0	-	0	-	0
HCCs per 1000	21.4	*-49.1%*	10.9	*-0.8%*	10.8	0.0	-	0.0	-	0.0
Paid per HCC	$260,607	*6.8%*	$278,222	*10.8%*	$308,200	$0	-	$0	-	$0
HCC Paid % of Tot	69.1%	*-29.8 pts*	39.3%	*-0.7 pts*	38.6%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$2,181	*13.5%*	$2,476	*17.1%*	$2,899	$0	-	$0	-	$0
Outpatient	$2,355	*-12.1%*	$2,071	*11.9%*	$2,317	$0	-	$0	-	$0
Physician	$3,427	*-10.5%*	$3,067	*7.7%*	$3,304	$2,439	*-26.1%*	$1,804	*39.5%*	$2,516
Ancillary	$100	*-8.6%*	$92	*13.6%*	$104	$727	*-81.9%*	$131	*194.7%*	$387

Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Average Enrollment										
Employees	167	*190.6%*	486	*-3.6%*	468	18	*170.1%*	50	*-11.7%*	44
Spouses	26	*204.0%*	80	*-7.4%*	74	4	*165.9%*	10	*-21.4%*	8
Children	46	*184.0%*	130	*-4.0%*	124	4	*165.4%*	12	*-27.5%*	8
Tot. Members	**239**	***190.8%***	**695**	***-4.1%***	**667**	**26**	***168.8%***	**71**	***-15.6%***	**60**
Avg. Family Size	1.4	*0.1%*	1.4	*-0.5%*	1.4	1.4	*-0.5%*	1.4	*-4.4%*	1.4
Financial Summary										
Allowed	$3,827,598	*103.4%*	$7,783,435	*11.8%*	$8,705,026	$178,636	*281.7%*	$681,934	*-25.0%*	$511,699
Plan Paid	$3,269,482	*72.9%*	$5,652,251	*16.6%*	$6,587,906	$64,069	*452.6%*	$354,041	*-28.0%*	$254,897
Member Paid (OOP)	$252,803	*159.3%*	$655,475	*5.2%*	$689,806	$24,338	*215.9%*	$76,876	*-20.1%*	$61,398
Paid PEPY	$19,560	*-40.5%*	$11,637	*20.9%*	$14,073	$3,479	*104.6%*	$7,116	*-18.4%*	$5,804
Paid PMPY	$13,673	*-40.5%*	$8,129	*21.6%*	$9,882	$2,425	*105.6%*	$4,986	*-14.7%*	$4,254
Paid PEPM	$1,630	*-40.5%*	$970	*20.9%*	$1,173	$290	*104.6%*	$593	*-18.4%*	$484
Paid PMPM	$1,139	*-40.5%*	$677	*21.6%*	$823	$202	*105.6%*	$416	*-14.7%*	$355
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	12	*-41.7%*	7	*57.1%*	11	0	-	1	*-100.0%*	0
HCCs per 1000	50.2	*-79.9%*	10.1	*63.9%*	16.5	0.0	-	14.1	*-100.0%*	0.0
Paid per HCC	$221,656	*-9.1%*	$201,561	*2.5%*	$206,510	$0	-	$132,680	*-100.0%*	$0
HCC Paid % of Tot	*81.4%*	*-56.4 pts*	*25.0%*	*9.5 pts*	*34.5%*	*0.0%*	-	*37.5%*	*-37.5 pts*	*0.0%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$3,593	*-64.3%*	$1,283	*72.7%*	$2,216	$0	-	$1,007	*10.5%*	$1,113
Outpatient	$4,671	*-38.0%*	$2,898	*19.4%*	$3,459	$850	*203.1%*	$2,576	*-44.4%*	$1,432
Physician	$5,255	*-27.5%*	$3,812	*6.4%*	$4,058	$1,467	*-16.3%*	$1,228	*40.7%*	$1,727
Ancillary	$153	*-11.7%*	$135	*10.4%*	$149	$108	*62.2%*	$175	*-109.8%*	-$17

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2024-4Q (7/1/2023 - 6/30/2024) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Inpatient	$12,275,760	$766,419	$125,804	**$13,167,983**	$12,877,660	$1,199,662	$277,347	**$14,354,669**	*9.0%*
Outpatient	$10,267,227	$1,881,555	$133,439	**$12,282,221**	$10,292,163	$2,141,444	$164,429	**$12,598,036**	*2.6%*
Physician	$15,206,511	$2,391,811	$259,145	**$17,857,467**	$14,677,973	$2,443,126	$262,328	**$17,383,427**	*-2.7%*
Ancillary	$453,786	$74,740	$19,337	**$547,863**	$461,751	$78,244	$21,326	**$561,321**	*2.5%*
Total	**$38,203,284**	**$5,114,525**	**$537,726**	$43,855,535	**$38,309,548**	**$5,862,477**	**$725,429**	$44,897,454	***2.4%***
PMPM	**$642.04**	**$734.02**	**$390.65**	$646.38	**$718.70**	**$882.14**	**$535.67**	$732.37	***13.3%***
Non-State Members									
Inpatient	$0	$0	$71,527	**$71,527**	$0	$60,333	$6,337	**$66,670**	*-6.8%*
Outpatient	$0	$5,422	$177,496	**$182,917**	$0	$4,108	$81,672	**$85,780**	*-53.1%*
Physician	$3,306	$12,786	$74,367	**$90,459**	$3,773	$19,203	$84,277	**$107,253**	*18.6%*
Ancillary	$241	$0	$12,444	**$12,685**	$581	$0	-$1,033	**-$452**	*-103.6%*
Total	**$3,547**	**$18,207**	**$335,834**	$357,588	**$4,354**	**$83,643**	**$171,253**	$259,251	***-27.5%***
PMPM	**$161.25**	**$178.27**	**$447.86**	$409.14	**$241.90**	**$1,394.05**	**$259.87**	$351.76	***-14.0%***
All Members									
Inpatient	$12,275,760	$766,419	$197,331	**$13,239,510**	$12,877,660	$1,259,995	$283,684	**$14,421,339**	*8.9%*
Outpatient	$10,267,227	$1,886,977	$310,935	**$12,465,139**	$10,292,163	$2,145,552	$246,101	**$12,683,816**	*1.8%*
Physician	$15,209,817	$2,404,597	$333,512	**$17,947,926**	$14,681,747	$2,462,329	$346,605	**$17,490,680**	*-2.5%*
Ancillary	$454,027	$74,740	$31,782	**$560,548**	$462,332	$78,244	$20,293	**$560,869**	*0.1%*
Total	**$38,206,831**	**$5,132,732**	**$873,560**	$44,213,123	**$38,313,903**	**$5,946,120**	**$896,682**	$45,156,705	***2.1%***
PMPM	**$641.86**	**$725.99**	**$410.83**	$643.37	**$718.53**	**$886.72**	**$445.39**	$727.85	***13.1%***

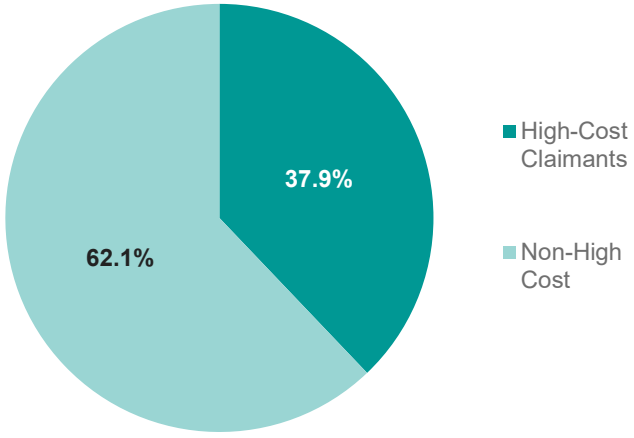
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2024-4Q (7/1/2023 - 6/30/2024)						2025-4Q (7/1/2024 - 6/30/2025)					
	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Member Paid)	OOP % of Tot
No Claims	570	8.7%	$0	0.0%	$0	0.0%	510	8.6%	$0	0.0%	$0	0.0%
< $0 - $0	167	2.6%	-$44,214	-0.1%	-$597	0.0%	189	3.2%	-$95,218	-0.2%	$6,017	0.2%
> $0 - $2,500	3,579	54.8%	$2,922,121	6.6%	$808,382	19.3%	3,153	53.4%	$2,654,130	5.9%	$745,717	18.8%
> $2,500 - $5,000	866	13.2%	$3,062,392	6.9%	$701,046	16.7%	745	12.6%	$2,657,120	5.9%	$612,651	15.5%
> $5,000 - $10,000	656	10.0%	$4,586,835	10.4%	$922,001	22.0%	556	9.4%	$3,841,377	8.5%	$762,798	19.3%
> $10,000 - $25,000	404	6.2%	$6,306,623	14.3%	$830,543	19.8%	411	7.0%	$6,416,535	14.2%	$823,391	20.8%
> $25,000 - $50,000	161	2.5%	$5,633,699	12.7%	$423,998	10.1%	197	3.3%	$6,759,361	15.0%	$523,866	13.2%
> $50,000 - $100,000	71	1.1%	$5,084,357	11.5%	$260,880	6.2%	84	1.4%	$5,816,835	12.9%	$269,061	6.8%
> $100,000	62	0.9%	$16,661,311	37.7%	$247,882	5.9%	59	1.0%	$17,106,564	37.9%	$212,950	5.4%
Total	**6,536**	**100.0%**	**$44,213,123**	**100.0%**	**$4,194,135**	**100.0%**	**5,904**	**100.0%**	**$45,156,705**	**100.0%**	**$3,956,451**	**100.0%**

* Unique Members are counted equally regardless of length of coverage. Note that because data is on a paid basis, member counts may also include those not active in the period.

Cost Distribution: HCCs vs. Non-HCCs



HCC Cost Breakout by Diagnostic Chapter

#	Diagnostic Chapter	Patients	Total Paid	% of Tot
1	Neoplasms	28	$3,188,011	18.6%
2	Perinatal Originating Conditions	3	$3,096,833	18.1%
3	Circulatory System	40	$2,234,299	13.1%
4	Injury, Poisoning & External Causes	33	$1,641,343	9.6%
5	Digestive System	25	$1,359,350	7.9%
6	Health Status & Health Services	51	$1,263,969	7.4%
7	Musculoskeletal System	35	$798,975	4.7%
8	Symptoms, Signs & Findings, NEC	53	$584,088	3.4%
9	Infectious & Parasitic Diseases	13	$561,227	3.3%
10	Respiratory System	27	$522,482	3.1%
...	*All Others*		*$1,855,988*	*10.8%*
=	**Total**	**59**	**$17,106,564**	**100.0%**

Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2025-4Q	*Variance*
Inpatient Admissions							
# of Admits	386	*-9.3%*	350	*-11.4%*	310		
# of Admit Days	1,744	*11.5%*	1,945	*-3.0%*	1,886		
Paid per Admit	$48,941	*-11.9%*	$43,139	*-12.9%*	$37,558	$28,787	*30.5%*
Paid per Admit Day	$10,832	*-28.3%*	$7,763	*-20.5%*	$6,173	$5,622	*9.8%*
Admits per 1000	184.7	*-66.9%*	61.1	*-1.9%*	60.0	47.9	*25.2%*
Average LOS	4.5	*23.0%*	5.6	*9.5%*	6.1	5.1	*18.8%*
Emergency Room Visits							
# of ER Visits	1,305	*6.3%*	1,387	*-13.2%*	1,204		
~ % resulting in Admit	12.8%	*1.8 pts*	14.6%	*1.6 pts*	16.2%	11.1%	*5.0 pts*
ER Visits per Patient	1.4	*6.5%*	1.5	*-4.5%*	1.4		
ER Visits per 1000	624.4	*-61.2%*	242.2	*-3.8%*	232.9	233.5	*-0.3%*
Paid per ER Visit	$2,700	*11.7%*	$3,016	*12.4%*	$3,391	$2,114	*60.4%*
Urgent Care Visits							
# of UC Visits	2,635	*4.3%*	2,749	*-2.1%*	2,692		
UC Visits per Patient	1.6	*2.5%*	1.7	*3.9%*	1.7		-
UC Visits per 1000	1,260.8	*-61.9%*	480.0	*8.5%*	520.7	263.2	*97.8%*
Paid per UC Visit	$111	*16.0%*	$129	*4.4%*	$134	$112	*20.4%*
Office Visits							
Off Visits per Patient	5.1	*14.6%*	5.9	*3.8%*	6.1		
Paid per Office Visit	$109	*4.3%*	$114	*4.0%*	$118	$89	*33.2%*
Office Visits Paid PMPY	$1,467	*-58.4%*	$611	*7.0%*	$654	$350	*87.0%*
Services							
Radiology Svcs per 1000	9,238.0	*-63.6%*	3,364.5	*13.3%*	3,811.3	3,999.8	*-4.7%*
Radiology Paid PMPY	$1,293	*-56.3%*	$565	*9.4%*	$618		
Lab Services per 1000	27,462.4	*-61.0%*	10,697.1	*6.7%*	11,411.4	11,047.4	*3.3%*
Labs Paid PMPY	$565	*-58.8%*	$233	*23.7%*	$288		

- *Inpatient Admission rate per 1000 decreased 1.9%, and amount paid per Admission is 12.9% lower than prior period*
- *ER utilization decreased 3.8%, but amount paid per ER visit is 12.4% higher than prior period*

Admissions and all other **Visits** are counted for utilization if the *initial Paid Date* for the first primary claim (facility claim for non-Office Visits) fell within the time period. For cost purposes, however, all visit costs paid within the time period are included.

Counts **per 1000** and amounts **PMPY** (per member per year) have been annualized.

Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	325	*-8.0%*	299	*-19.1%*	242	0	-	0	-	0
# of Admit Days	1,387	*22.9%*	1,705	*-10.8%*	1,521	0	-	0	-	0
Paid per Admit	$50,909	*-8.8%*	$46,425	*-12.5%*	$40,619	$0	-	$0	-	$0
Paid per Admit Day	$11,929	*-31.8%*	$8,141	*-20.6%*	$6,463	$0	-	$0	-	$0
Admits per 1000	178.2	*-66.2%*	60.3	*-9.7%*	54.5	0.0	-	0.0	-	0.0
Average LOS	4.3	*33.6%*	5.7	*10.2%*	6.3	0.0	-	0.0	-	0.0
Emergency Room Visits										
# of ER Visits	1,105	*7.6%*	1,189	*-17.3%*	983	0	-	0	-	1
~ % resulting in Admit	12.3%	*1.2 pts*	13.5%	*-0.4 pts*	13.1%	0.0%	-	0.0%	-	0.0%
ER Visits per Patient	1.4	*5.7%*	1.5	*-4.1%*	1.4	0.0	-	0.0	-	1.0
ER Visits per 1000	605.8	*-60.4%*	239.8	*-7.7%*	221.3	0.0	-	0.0	-	666.7
Paid per ER Visit	$2,764	*10.5%*	$3,055	*14.6%*	$3,502	$0	-	$0	-	$369
Urgent Care Visits										
# of UC Visits	2,379	*4.2%*	2,478	*-3.7%*	2,386	0	-	0	-	0
UC Visits per Patient	1.6	*2.6%*	1.7	*3.3%*	1.7	0.0	-	0.0	-	0.0
UC Visits per 1000	1,304.3	*-61.7%*	499.7	*7.5%*	537.1	0.0	-	0.0	-	0.0
Paid per UC Visit	$113	*16.4%*	$131	*3.8%*	$136	$0	-	$0	-	$0
Office Visits										
Off Visits per Patient	4.9	*14.0%*	5.6	*3.0%*	5.8	10.0	*10.0%*	11.0	*-27.3%*	8.0
Paid per Office Visit	$111	*5.4%*	$117	*4.7%*	$123	$113	*14.6%*	$129	*15.6%*	$149
Office Visits Paid PMPY	$1,428	*-58.0%*	$600	*6.4%*	$639	$2,253	*-65.6%*	$775	*2.7%*	$796
Services										
Radiology Svcs per 1000	8,379.8	*-61.8%*	3,201.3	*9.4%*	3,502.9	8,000.0	*-72.7%*	2,181.8	*22.2%*	2,666.7
Radiology Paid PMPY	$1,251	*-56.1%*	$549	*8.8%*	$597	$694	*-74.7%*	$176	*43.0%*	$251
Lab Services per 1000	26,396.1	*-61.1%*	10,268.4	*5.8%*	10,867.4	80,000.0	*-80.9%*	15,272.7	*-12.7%*	13,333.3
Labs Paid PMPY	$545	*-57.8%*	$230	*23.7%*	$285	$845	*-60.5%*	$334	*25.9%*	$421

Utilization Summary – YTD Trend

Retired Members

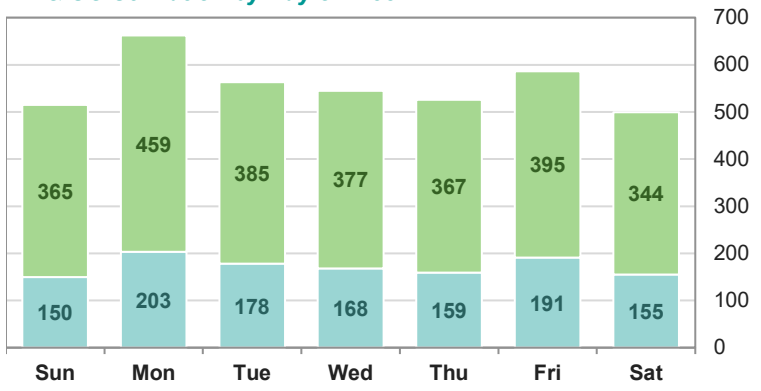
Measure	State Retirees					Non-State Retirees				
	2023-4Q	⇨	2024-4Q	⇨	2025-4Q	2023-4Q	⇨	2024-4Q	⇨	2025-4Q
Inpatient Admissions										
# of Admits	59	*-27.1%*	43	*48.8%*	64	2	*300.0%*	8	*-50.0%*	4
# of Admit Days	350	*-36.9%*	221	*58.4%*	350	7	*171.4%*	19	*-21.1%*	15
Paid per Admit	$39,461	*-38.4%*	$24,305	*11.1%*	$27,014	$8,833	*166.7%*	$23,557	*-10.7%*	$21,034
Paid per Admit Day	$6,652	*-28.9%*	$4,729	*4.5%*	$4,940	$2,524	*293.0%*	$9,919	*-43.5%*	$5,609
Admits per 1000	246.7	*-74.9%*	61.8	*55.2%*	96.0	75.7	*48.8%*	112.7	*-40.8%*	66.8
Average LOS	5.9	*-13.4%*	5.1	*6.4%*	5.5	3.5	*-32.1%*	2.4	*57.9%*	3.8
Emergency Room Visits										
# of ER Visits	175	*5.7%*	185	*8.1%*	200	25	*-48.0%*	13	*53.8%*	20
~ % resulting in Admit	17.1%	*1.2 pts*	18.4%	*12.6 pts*	31.0%	4.0%	*49.8 pts*	53.8%	*-33.8 pts*	20.0%
ER Visits per Patient	1.5	*18.8%*	1.8	*-11.3%*	1.6	1.8	*-27.2%*	1.3	*9.9%*	1.4
ER Visits per 1000	731.8	*-63.6%*	266.1	*12.8%*	300.0	946.4	*-80.7%*	183.1	*82.3%*	333.8
Paid per ER Visit	$2,517	*11.7%*	$2,812	*10.2%*	$3,098	$1,177	*97.8%*	$2,329	*-55.9%*	$1,028
Urgent Care Visits										
# of UC Visits	229	*7.0%*	245	*17.6%*	288	27	*-3.7%*	26	*-30.8%*	18
UC Visits per Patient	1.5	*2.9%*	1.5	*8.0%*	1.7	1.7	*-3.7%*	1.6	*10.8%*	1.8
UC Visits per 1000	957.7	*-63.2%*	352.3	*22.6%*	432.0	1,022.1	*-64.2%*	366.2	*-18.0%*	300.4
Paid per UC Visit	$101	*13.3%*	$114	*11.6%*	$127	$62	*-19.2%*	$50	*-28.3%*	$36
Office Visits										
Off Visits per Patient	6.3	*14.2%*	7.2	*7.8%*	7.8	6.1	*18.4%*	7.2	*7.1%*	7.7
Paid per Office Visit	$102	*-0.7%*	$101	*1.6%*	$102	$58	*-19.6%*	$47	*8.1%*	$51
Office Visits Paid PMPY	$1,799	*-60.1%*	$718	*8.1%*	$776	$1,128	*-73.0%*	$305	*20.0%*	$365
Services										
Radiology Svcs per 1000	15,456.5	*-70.8%*	4,515.7	*26.5%*	5,712.0	12,227.1	*-71.2%*	3,521.1	*57.8%*	5,557.7
Radiology Paid PMPY	$1,670	*-56.4%*	$728	*7.2%*	$781	$747	*-84.5%*	$116	*220.6%*	$373
Lab Services per 1000	35,617.7	*-61.1%*	13,872.0	*10.9%*	15,381.0	26,271.3	*-64.1%*	9,422.5	*-20.1%*	7,527.1
Labs Paid PMPY	$729	*-64.5%*	$259	*24.9%*	$323	$476	*-64.0%*	$171	*-14.6%*	$146

On Demand Care Summary

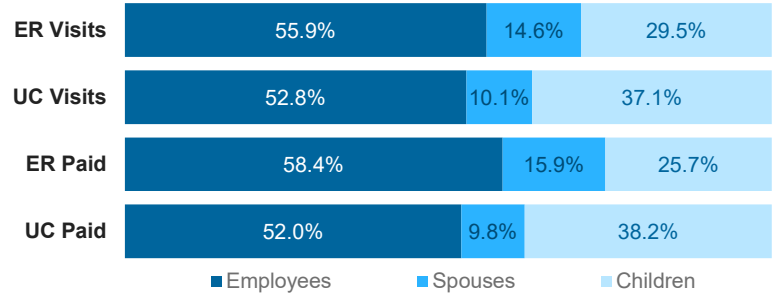
Emergency Room & Urgent Care

Measure	2024-4Q	2025-4Q	*Change*	UMR Norm	*Variance*
Emergency Room					
# of Visits	1,387	1,204	*-13.2%*		
# of Patients	925	841	*-9.1%*		
Total Plan Paid	$4,182,972	$4,082,842	*-2.4%*		
Total Mem Paid	$651,431	$570,269	*-12.5%*		
Visits per 1000	242.2	232.9	*-3.8%*	233.5	*-0.3%*
Paid per Visit	$3,016	$3,391	*12.4%*	$2,114	*60.4%*
Paid PMPM	$61	$66	*8.1%*	$41	*60.0%*
% ER Patients w/ Office Visit*	95.5%	97.3%	*1.8 pts*		
% Potentially Avoidable**	13.4%	12.8%	*-0.6 pts*	16.9%	*-4.2 pts*
Urgent Care					
# of Visits	2,749	2,692	*-2.1%*		
# of Patients	1,655	1,560	*-5.7%*		
Total Plan Paid	$353,966	$361,901	*2.2%*		
Total Mem Paid	$126,498	$121,454	*-4.0%*		
Visits per 1000	480.0	520.7	*8.5%*	263.2	*97.8%*
Paid per Visit	$129	$134	*4.4%*	$112	*20.4%*
Paid PMPM	$5	$6	*13.3%*	$2	*138.2%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	**Total**	ER	UC	Total
Employee	673	1,421	**2,094**	$2,383,205	$188,305	**$2,571,510**
Spouse	176	273	**449**	$648,557	$35,339	**$683,896**
Child	355	998	**1,353**	$1,051,080	$138,257	**$1,189,337**
Total	**1,204**	**2,692**	**3,896**	**$4,082,842**	**$361,901**	**$4,444,742**

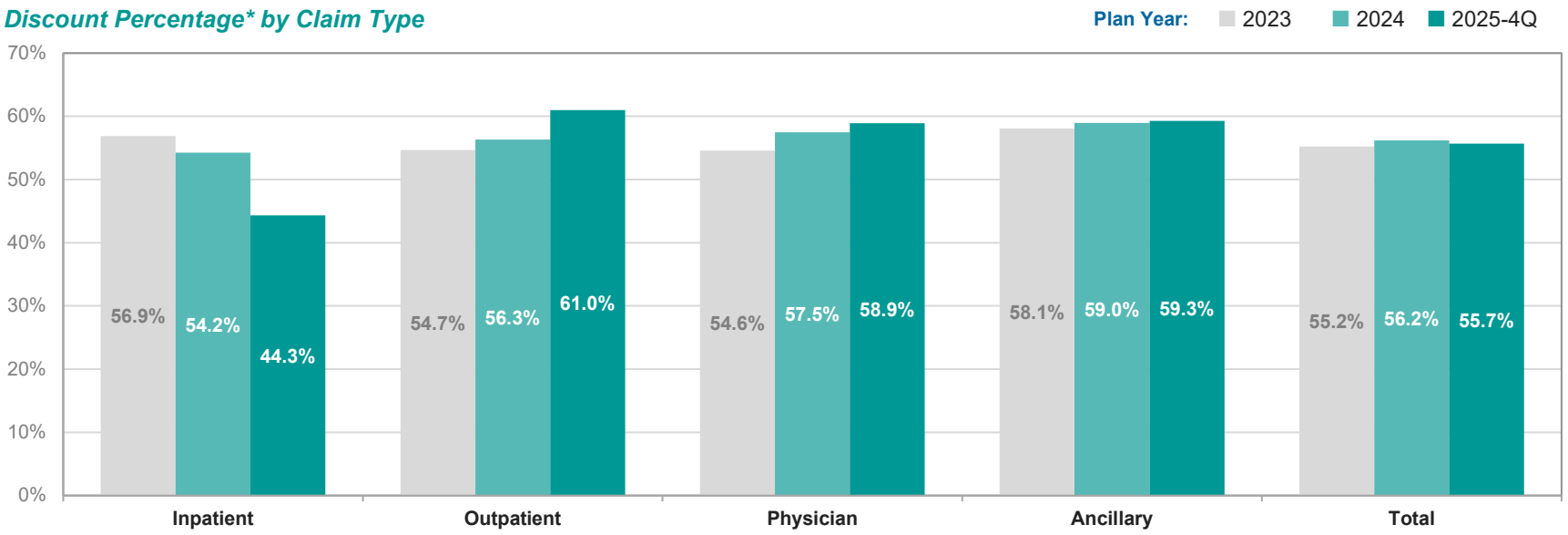
* Office Visit within prior 12 months..

** ER Visits are categorized as potentially avoidable based on primary and secondary diagnosis and do not necessarily indicate misuse of the ER for the patient's specific circumstances.

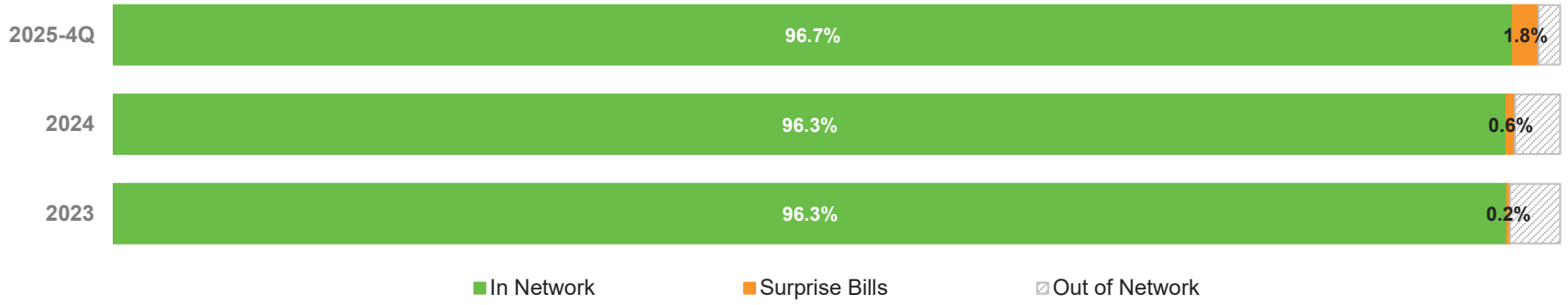
Network Summary

Discount Percentage & Network Utilization

Discount Percentage by Claim Type*



*Network Utilization**



* Network Discounts and Utilization exclude COB Claims, and Network Discounts additionally exclude Surprise Bills.

Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2024 (Full Year)		2025-4Q		CYTD Paid by Relationship			CYTD Paid by Sex	
	Patients	Total Paid	Patients	Total Paid	Employee	Spouse	Child	Male	Female
Musculoskeletal System	2,070	$4,602,332	1,916	$5,111,750	$3,815,375	$1,058,864	$237,511	$2,003,636	$3,108,114
Neoplasms	956	$4,619,242	948	$5,069,259	$3,176,960	$1,806,631	$85,668	$1,059,088	$4,010,171
Circulatory System	1,084	$4,487,845	1,057	$4,561,417	$3,615,330	$844,703	$101,383	$1,888,055	$2,673,361
Digestive System	848	$2,625,472	839	$3,833,453	$3,118,556	$410,831	$304,066	$1,325,590	$2,507,863
Health Status & Health Services	4,187	$4,675,804	3,709	$3,578,036	$2,360,413	$555,522	$662,101	$1,283,277	$2,294,759
Perinatal Originating Conditions	76	$1,990,280	60	$3,326,874	$738	$115	$3,326,021	$511,532	$2,815,342
Injury, Poisoning & External Causes	987	$3,319,950	954	$3,217,301	$2,077,447	$486,829	$653,025	$1,281,926	$1,935,375
Symptoms, Signs & Findings, NEC	2,600	$2,268,545	2,460	$2,751,576	$1,554,222	$789,248	$408,106	$1,154,614	$1,596,962
Mental, Behavioral & Neurodevelopmental	1,352	$2,322,608	1,305	$2,232,030	$945,866	$282,957	$1,003,207	$739,291	$1,492,739
Genitourinary System	1,208	$2,173,973	1,125	$2,141,134	$1,755,830	$179,519	$205,785	$584,058	$1,557,076
Respiratory System	1,820	$1,973,123	1,683	$1,989,295	$1,039,397	$401,414	$548,484	$699,485	$1,289,811
Nervous System	1,174	$1,812,222	1,081	$1,684,188	$1,088,644	$380,677	$214,867	$704,271	$979,917
Endocrine, Nutritional & Metabolic	1,892	$2,071,739	1,718	$1,519,332	$1,220,005	$169,940	$129,387	$733,272	$786,060
Pregnancy, Childbirth & the Puerperium	117	$1,094,523	100	$1,125,245	$760,636	$219,511	$145,098	$125	$1,125,121
Infectious & Parasitic Diseases	519	$1,452,642	496	$868,889	$769,708	$50,743	$48,437	$203,551	$665,338
Blood & Immune Disorders	252	$886,310	216	$504,817	$335,163	$49,324	$120,329	$289,479	$215,338
Skin & Subcutaneous Tissue	1,429	$854,655	1,389	$471,294	$351,616	$46,949	$72,730	$172,362	$298,932
Ear and Mastoid Process	573	$333,384	513	$468,197	$295,970	$55,407	$116,820	$174,640	$293,557
Eye and Adnexa	1,733	$533,279	1,537	$443,366	$315,156	$53,922	$74,289	$189,416	$253,950
Congenital Malformations & Abnormalities	93	$115,196	97	$259,127	$72,598	$5,166	$181,364	$138,747	$120,380
External Causes of Morbidity	1	$0	1	$124	$0	$0	$124	$0	$124
Total	**5,860**	**$44,213,123**	**5,279**	**$45,156,705**	**$28,669,631**	**$7,848,273**	**$8,638,801**	**$15,136,416**	**$30,020,289**

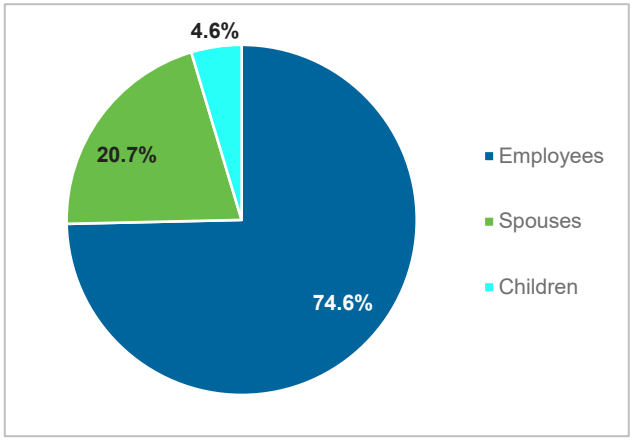
#1 Top Dx Chapter

Musculoskeletal System

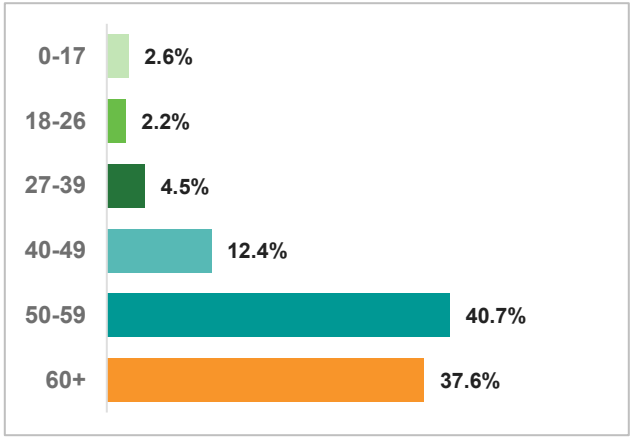
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	582	3,084	$1,928,163	37.7%
2	Osteoarthritis & osteoporosis	337	963	$865,383	16.9%
3	Tendon, tissue, muscle disorders	487	1,368	$655,930	12.8%
4	Other musculoskeletal pain	1,223	4,314	$535,579	10.5%
5	Lupus	44	194	$290,860	5.7%
6	Scoliosis & oth deformities	185	453	$224,960	4.4%
7	Joint disorders & fractures	157	359	$180,907	3.5%
8	Other MSK	46	165	$162,947	3.2%
9	Rheumatoid arthritis & related disease	62	250	$146,955	2.9%
10	Low back pain	300	871	$59,250	1.2%
11	Biomechanical lesions	124	547	$50,242	1.0%
12	Gout & crystal arthropathies	41	97	$10,575	0.2%
=	**Total**	**1,916**	**13,315**	**$5,111,750**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



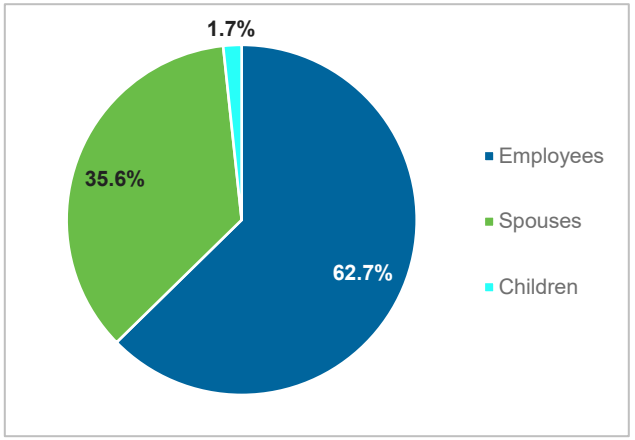
#2 Top Dx Chapter

Neoplasms (Cancer)

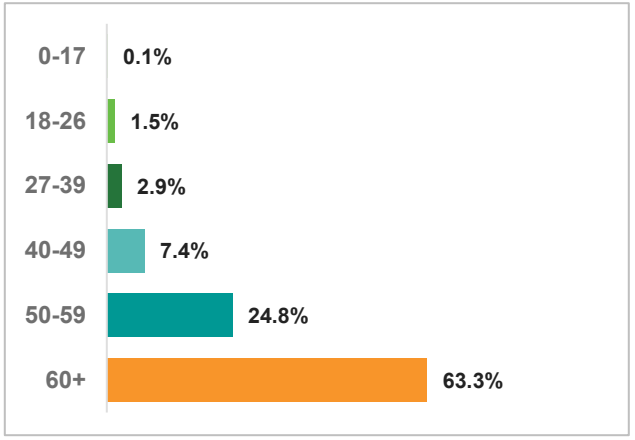
Breakout by Diagnostic Grouping & Demographics

#	Neoplasms (Cancer) Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Other gastrointestinal cancers	7	59	$1,307,925	25.8%
2	Breast cancer	47	557	$988,987	19.5%
3	Benign neoplasms	662	1,080	$488,078	9.6%
4	Respiratory cancers	6	113	$346,626	6.8%
5	Kidney Cancer	7	49	$294,629	5.8%
6	Lymphoma	17	226	$281,454	5.6%
7	Prostate cancer	26	289	$198,948	3.9%
8	Skin cancer	100	311	$159,083	3.1%
9	Ovarian cancer	5	40	$139,879	2.8%
10	Leukemia	9	91	$134,601	2.7%
11	Colorectal cancer	8	88	$121,484	2.4%
12	Pancreatic cancer	3	61	$117,950	2.3%
13	Secondary malignancies	16	116	$116,493	2.3%
14	Other cancer	16	52	$95,935	1.9%
15	Endometrial cancer	9	67	$82,577	1.6%
16	Neoplasms of unspec nature	376	524	$77,881	1.5%
17	Head & neck cancers	5	48	$74,087	1.5%
18	Thyroid cancer	7	20	$22,657	0.4%
19	Oral cancer	2	10	$14,842	0.3%
20	Brain cancer	5	19	$2,388	0.0%
...	*All Others*	*7*	*12*	*$2,752*	*0.1%*
=	**Total**	**948**	**4,085**	**$5,069,259**	**100.0%**

Neoplasms (Cancer) Paid by Relationship



Neoplasms (Cancer) Paid by Age Range



Note: there are additional cancer-related costs for encounters and therapy, totaling $1,933,232 – these costs are categorized under Health Status

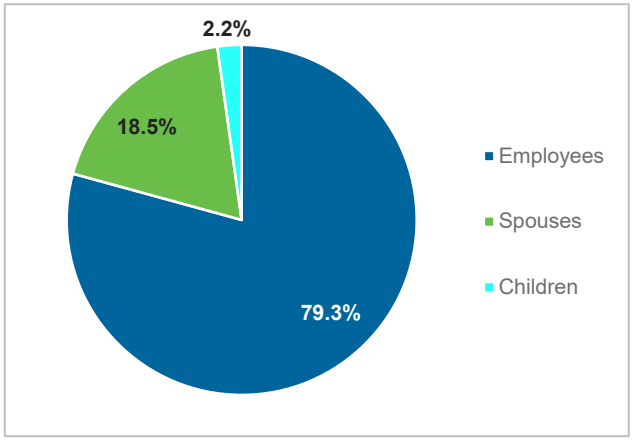
#3 Top Dx Chapter

Circulatory System

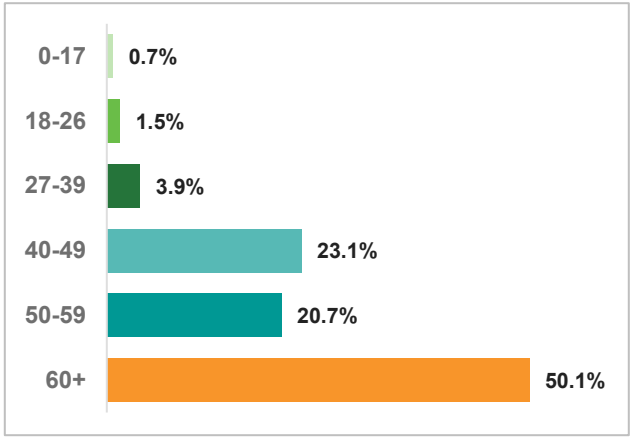
Breakout by Diagnostic Grouping & Demographics

#	Circulatory System Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Cerebrovascular disease	49	180	$1,099,302	24.1%
2	Cardiac dysrhythmias	188	689	$914,155	20.0%
3	Coronary atherosclerosis & oth heart disease	146	447	$512,510	11.2%
4	Heart failure	44	179	$419,706	9.2%
5	Myocardial infarction	16	59	$358,246	7.9%
6	Nonspecific chest pain	233	530	$332,058	7.3%
7	Nonrheumatic & unspecified valve disorders	60	97	$256,781	5.6%
8	Hypertension	586	1,160	$216,723	4.8%
9	Vascular disease	77	221	$165,103	3.6%
10	Other circulatory	56	117	$141,217	3.1%
11	Acute pulmonary embolism, DVT	42	185	$140,019	3.1%
12	Myocarditis & cardiomyopathy	13	25	$5,598	0.1%
=	**Total**	**1,057**	**4,289**	**$4,561,417**	**100.0%**

Circulatory System Paid by Relationship



Circulatory System Paid by Age Range



Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2023 (Full Year)		2024 (Full Year)		2025-4Q		2025-4Q Paid by Claim Type			
	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Inpatient	Outpatient	Physician	Ancillary
Depressive disorders	394	$484,494	424	$531,931	410	$621,974	$172,397	$12,197	$435,965	$1,416
Anxiety & related Disorders	521	$279,609	512	$337,685	490	$381,768	$0	$12,198	$369,357	$213
Trauma & stressor disorders	294	$210,733	338	$370,626	332	$297,354	$0	$3,126	$294,228	$0
Neurodevelopmental disorders	225	$140,318	253	$292,459	260	$259,148	$0	$4,231	$254,917	$0
Alcohol-related disorders	29	$154,326	45	$307,936	30	$150,432	$101,077	$13,616	$35,740	$0
Suicidal ideation, attempt or self-harm	21	$78,998	23	$42,788	24	$141,882	$76,795	$52,401	$12,685	$0
Other mental health	142	$47,033	141	$117,944	133	$99,065	$0	$18,470	$80,241	$354
Eating disorders	17	$31,584	15	$51,171	13	$88,845	$0	$0	$88,845	$0
Bipolar & related Disorders	82	$64,002	79	$92,390	66	$83,919	$24,396	$0	$59,523	$0
Schizophrenia spectrum disorders	14	$17,003	16	$33,159	13	$68,703	$33,179	$13,502	$22,013	$8
Opiod disorders	15	$8,462	13	$38,318	8	$13,737	$2,040	$0	$11,697	$0
Obsessive compulsive disorders	20	$19,073	22	$60,775	20	$9,774	$0	$0	$9,709	$65
Other substance use	38	$3,558	40	$10,408	37	$7,180	$0	$2,573	$4,607	$0
Stimulant disorders	5	$31,458	6	$31,146	1	$5,296	$2,656	$0	$2,640	$0
Cannabis-related disorders	10	$5,823	5	$3,870	10	$2,953	$0	$199	$2,754	$0
Total	**1,310**	**$1,576,476**	**1,352**	**$2,322,608**	**1,305**	**$2,232,030**	**$412,539**	**$132,512**	**$1,684,921**	**$2,057**

Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	9	1.7	*-10.0%*	4	0.8	*-50.0%*	$13,875	444.4	555.6
Asthma	234	44.1	*-11.4%*	110	20.7	*-0.9%*	$6,527	68.4	226.5
Atrial Fibrillation	66	12.4	*8.2%*	45	8.5	*9.8%*	$41,235	469.7	924.2
Blood Disorders	198	37.3	*-20.2%*	98	18.5	*-15.5%*	$30,972	252.5	474.7
CAD	90	17.0	*4.7%*	50	9.4	*56.3%*	$20,014	166.7	388.9
COPD	40	7.5	*14.3%*	25	4.7	*0.0%*	$22,192	300.0	550.0
Cancer	548	103.3	*-1.4%*	270	50.9	*3.8%*	$18,538	125.9	235.4
Chronic Pain	39	7.4	*-13.3%*	15	2.8	*-40.0%*	$71,870	256.4	282.1
CHF	27	5.1	*-10.0%*	17	3.2	*6.3%*	$165,810	629.6	703.7
Demyelinating Diseases	19	3.6	*-13.6%*	15	2.8	*-6.3%*	$33,491	52.6	315.8
Depression	408	76.9	*-2.6%*	304	57.3	*9.0%*	$13,877	159.3	321.1
Diabetes	509	95.9	*1.2%*	379	71.4	*-4.8%*	$13,029	60.9	188.6
ESRD	16	3.0	*-36.0%*	8	1.5	*-63.6%*	$236,363	937.5	1,312.5
Eating Disorders	15	2.8	*15.4%*	10	1.9	*42.9%*	$15,508	0.0	533.3
HIV/AIDS	5	0.9	*-44.4%*	5	0.9	*0.0%*	$4,161	0.0	0.0
Hyperlipidemia	200	37.7	*0.0%*	69	13.0	*11.3%*	$4,286	15.0	95.0
Hypertension	567	106.9	*-5.0%*	241	45.4	*-6.9%*	$6,521	58.2	194.0
Immune Disorders	21	4.0	*-22.2%*	10	1.9	*-16.7%*	$31,535	95.2	142.9
IBD	22	4.1	*-26.7%*	5	0.9	*-28.6%*	$1,235	0.0	0.0
Liver Disease	1	0.2	*-75.0%*	1	0.2	*0.0%*	$1,396,175	1,000.0	0.0
Morbid Obesity	99	18.7	*-13.9%*	53	10.0	*-15.9%*	$22,934	90.9	141.4
Osteoarthritis	279	52.6	*-3.1%*	125	23.6	*-10.1%*	$12,365	78.9	240.1
Peripheral Vascular Disease	23	4.3	*-32.4%*	6	1.1	*-33.3%*	$13,999	217.4	217.4
Rheumatoid Arthritis	56	10.6	*-16.4%*	46	8.7	*-6.1%*	$11,727	53.6	250.0

- *Most prevalent chronic condition is Hypertension, with 567 members*
- *Diabetes is the condition with the most moderate/high risk members (379)*
- *Members with mod/high risk Cancer have the highest combined cost: 270 members totaling $5.01M*

Date Range: Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

With Condition members are identified by having any covered claim with a diagnosis for the condition in Dx position 1.

Moderate/High-Risk Condition members had either multiple provider visits for the condition (based on Dx position 1) during the date range or at least one ER Visit or Admission for the condition in the range.

Cost & Utilization for All Members:

- **Allowed PMPY:** $8,471
- **Admits per 1000:** 56.5
- **ER Visits per 1000:** 235.2

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2023 - Mar 2024 Eligible	Apr 2023 - Mar 2024 Actual	Apr 2023 - Mar 2024 Rate	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	*Rate Change*	UMR Norm Rate	UMR Norm *Variance*
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	66.8	371	**5,550.2**	42.8	237	**5,538.1**	*-0.2%*	**5,378.5**	*3.0%*
Well Child Visit	3 - 6 years	257.1	212	**824.5**	217.0	179	**824.9**	*0.0%*	**796.4**	*3.6%*
Adults w/ Well Visit	Adults 18+	4,553	1,979	**43.5%**	4,129	1,798	**43.5%**	*0.1 pts*	**38.7%**	*4.9 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	1,635	779	**47.6%**	1,488	795	**53.4%**	*5.8 pts*	**45.0%**	*8.4 pts*
Cervical Cancer	Females 21 - 64	2,216	551	**24.9%**	1,966	463	**23.6%**	*-1.3 pts*	**22.4%**	*1.2 pts*
Prostate Cancer	Males 50 - 70	932	426	**45.7%**	883	438	**49.6%**	*3.9 pts*	**40.2%**	*9.4 pts*
Colorectal Cancer	Members 45 - 75	2,614	438	**16.8%**	2,408	433	**18.0%**	*1.2 pts*	**15.8%**	*2.1 pts*
Cholesterol	Female 45+ Male 35+	2,946	1,647	**55.9%**	2,717	1,557	**57.3%**	*1.4 pts*	**44.6%**	*12.7 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	264	214	**81.1%**	234	189	**80.8%**	*-0.3 pts*		
COPD	Spirometry Test	35	8	**22.9%**	40	5	**12.5%**	*-10.4 pts*		
Type 2 Diabetes	A1c Test	455	410	**90.1%**	467	415	**88.9%**	*-1.2 pts*	**83.1%**	*5.7 pts*
	Eye Exam	455	127	**27.9%**	467	129	**27.6%**	*-0.3 pts*	**25.4%**	*2.2 pts*
	Lipid Panel	455	345	**75.8%**	467	349	**74.7%**	*-1.1 pts*	**69.6%**	*5.1 pts*
	Urine Protein Test	455	304	**66.8%**	467	307	**65.7%**	*-1.1 pts*	**61.7%**	*4.1 pts*
	Any Diabetes Screen	455	435	**95.6%**	467	445	**95.3%**	*-0.3 pts*	**91.7%**	*3.6 pts*
Hyperlipidemia	Lipid Profile	200	108	**54.0%**	200	99	**49.5%**	*-4.5 pts*		
Hypertension	Creatinine Test	597	155	**26.0%**	567	117	**20.6%**	*-5.3 pts*		
	Lipid Profile	597	160	**26.8%**	567	153	**27.0%**	*0.2 pts*		

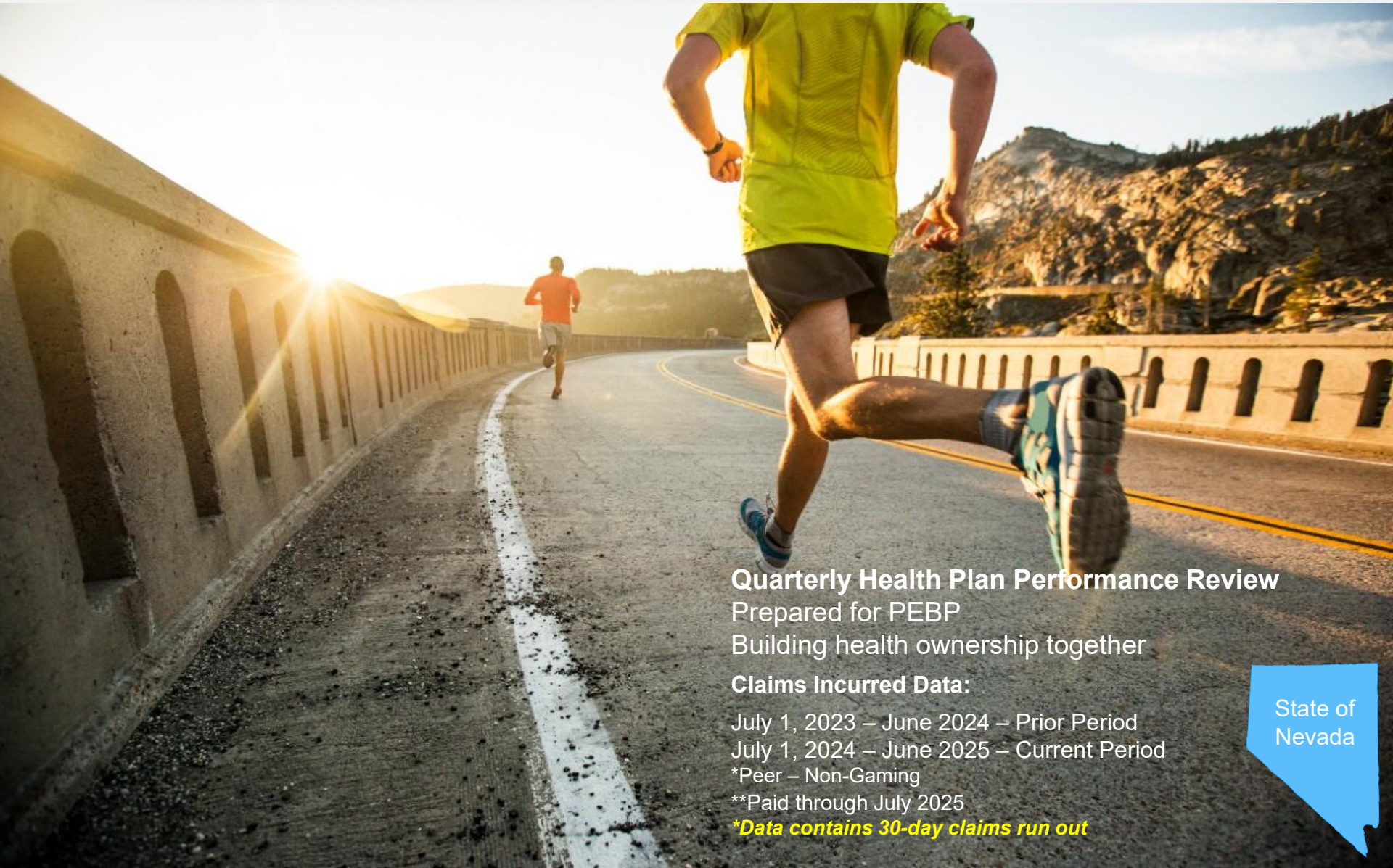
Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2024 - 3/31/2025, Paid through 6/30/2025

Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.

18.1.6

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report
        18.1.3 Q4 CDHP Performance Review
        18.1.4 Q4 LD PPO Performance Review
        18.1.5 Q4 EPO Performance Review
        18.1.6 Q4 HPN Performance Review

Power Of Partnership.



Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2023 – June 2024 – Prior Period
July 1, 2024 – June 2025 – Current Period
*Peer – Non-Gaming
**Paid through July 2025
Data contains 30-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -1.3% decrease for employees
- -1.5% decrease for members

Medical Paid PMPM

- 8.5% increase in overall medical paid PMPM
- 10.4% increase in non-Catastrophic spend on a PMPM basis
- 1.8% increase in Catastrophic spend on a PMPM basis

High-Cost Claimants

- 84 High-Cost Claimants accounted for 29.4% of medical spend
- 18.3% increase in HCC from prior period
- Avg. Paid per case decreased -12.9%

Emergency Room

- ER Visits Per 1,000 members increased 0.9%
- Avg. paid per ER Visit increased 18.6%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -2.4%
- Avg. paid per Urgent care visit increased 6.5%

Rx Drivers

- Rx Net Paid PMPM increased 16.0%
- Specialty Spend increased 15.7%
- Specialty Rx driving 38.2% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx PMPM increased 11.1% through Q4 2025

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	July - June 2024 Q4						July - June 2025 Q4						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$637,063	$1,387	$1,234	$3	$638,296	$1,390	$777,719	$1,633	$11,322	$24	$789,041	$1,656	23.6%	784.6%
01	$148,997	$265	$2,599	$5	$151,596	$269	$105,349	$271	$650	$2	$105,999	$273	2.5%	-63.7%
02-04	$803,862	$417	$13,400	$7	$817,262	$424	$757,832	$390	$5,772	$3	$763,604	$393	-6.5%	-57.3%
05-09	$707,818	$186	$73,345	$19	$781,163	$205	$799,324	$216	$31,413	$8	$830,737	$225	16.4%	-55.8%
10-14	$1,000,107	$188	$164,984	$31	$1,165,090	$219	$855,442	$163	$85,373	$16	$940,815	$179	-13.3%	-47.6%
15-19	$1,160,138	$187	$248,590	$40	$1,408,728	$227	$1,135,995	$187	$211,155	$35	$1,347,150	$222	0.2%	-13.1%
20-24	$1,130,225	$196	$109,139	$19	$1,239,365	$215	$1,191,224	$203	$269,012	$46	$1,460,236	$249	3.5%	142.1%
25-29	$1,212,953	$382	$201,762	$63	$1,414,716	$445	$1,034,378	$305	$333,236	$98	$1,367,614	$404	-20.0%	55.0%
30-34	$1,122,693	$308	$522,253	$143	$1,644,946	$452	$1,518,898	$427	$524,647	$147	$2,043,545	$574	38.3%	2.7%
35-39	$1,545,284	$330	$1,186,862	$254	$2,732,146	$584	$1,552,373	$360	$942,435	$218	$2,494,808	$578	8.9%	-14.0%
40-44	$2,111,769	$419	$755,584	$150	$2,867,353	$569	$1,795,170	$349	$982,338	$191	$2,777,509	$540	-16.6%	27.5%
45-49	$2,125,279	$333	$1,603,795	$251	$3,729,074	$584	$3,153,754	$522	$1,853,513	$307	$5,007,267	$829	56.9%	22.2%
50-54	$2,309,484	$310	$2,189,037	$293	$4,498,521	$603	$3,538,082	$474	$2,804,295	$376	$6,342,377	$850	53.1%	28.0%
55-59	$2,716,519	$364	$2,683,175	$360	$5,399,694	$724	$2,942,066	$402	$2,889,163	$395	$5,831,230	$798	10.4%	9.8%
60-64	$3,722,988	$521	$2,076,601	$291	$5,799,589	$812	$3,013,890	$442	$2,461,748	$361	$5,475,638	$803	-15.2%	24.2%
65+	$3,727,424	$735	$1,940,632	$383	$5,668,056	$1,117	$3,801,323	$722	$2,334,073	$443	$6,135,396	$1,165	-1.8%	15.8%
Total	$26,182,602	$353	$13,772,993	$186	$39,955,595	$539	$27,972,820	$383	$15,740,146	$216	$43,712,967	$599	9.4%	11.1%

Financial Summary

UnitedHealthcare

Financial and Demographic (*July 2024 thru June 2025 Q4*)												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲
Avg. # Employees	3,618	3,540	3,494	-1.3%	3,199	3,106	3,097	-0.3%	419	434	396	-8.7%
Avg. # Members	6,370	6,175	6,083	-1.5%	5,804	5,582	5,539	-0.8%	566	594	543	-8.5%
Ratio	1.8	1.7	1.7	-0.2%	1.8	1.8	1.8	-0.5%	1.4	1.4	1.4	0.1%
Financial												
Medical Paid	$27,057,503	$26,182,602	$27,972,820	6.8%	$12,571,555	$10,880,065	$12,078,769	11.0%	$14,485,948	$15,302,537	$15,894,051	3.9%
Member Paid	$2,000,760	$2,251,487	$2,780,882	23.5%	$1,365,537	$1,606,622	$1,899,105	18.2%	$635,223	$644,865	$881,777	36.7%
Net Paid PEPY	$7,479	$7,396	$8,007	8.3%	$7,477	$7,261	$8,048	10.8%	$7,498	$8,358	$7,683	-8.1%
Net Paid PMPY	$4,248	$4,240	$4,599	8.5%	$4,121	$4,041	$4,500	11.4%	$5,549	$6,109	$5,608	-8.2%
Net Paid PEPM	$623	$616	$667	8.3%	$623	$605	$671	10.8%	$625	$696	$640	-8.1%
Net Paid PMPM	$354	$353	$383	8.5%	$343	$337	$375	11.4%	$462	$509	$467	-8.2%
High Cost Claimants												
# of HCC's > $50k	73	71	84	18.3%	64	54	72	33.3%	9	17	12	-29.4%
Avg. paid per claimant	$124,533	$113,809	$99,177	-12.9%	$121,471	$117,719	$99,605	-15.4%	$146,307	$101,387	$96,613	-4.7%
HCC % of Spend	33.6%	30.6%	29.4%	-4.0%	32.5%	28.1%	28.7%	2.3%	41.9%	46.2%	34.5%	-25.5%
Spend by Location (PMPY)												
Inpatient	$1,147	$1,222	$1,265	3.5%	$568	$506	$648	28.1%	$552	$1,388	$731	-47.3%
Outpatient	$1,134	$994	$1,182	18.9%	$605	$441	$594	34.6%	$598	$821	$719	-12.3%
Professional	$1,533	$1,599	$1,695	6.0%	$993	$612	$761	24.2%	$1,095	$1,248	$1,357	8.7%
Total	$3,814	$3,816	$4,142	8.6%	$2,166	$1,949	$2,181	11.9%	$2,245	$3,456	$2,807	-18.8%

Paid Claims by Claim Type

UnitedHealthcare

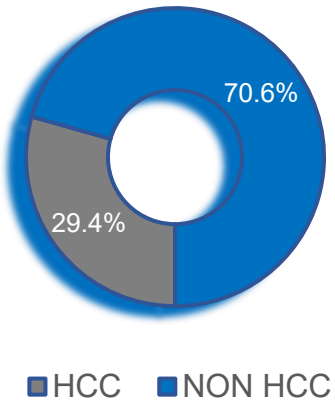
Net Paid Claims - Total Total Participants	July - June 2024 Q4				July - June 2025 Q4				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$5,383,521	$323,042	$1,842,718	$7,549,282	$5,685,556	$231,282	$1,777,953	$7,694,791	1.9%
OutPatient	$16,230,132	$552,126	$1,851,062	$18,633,320	$17,920,795	$379,040	$1,978,194	$20,278,029	8.8%
Total - Medical	$21,613,653	$875,168	$3,693,781	$26,182,602	$23,606,351	$610,322	$3,756,147	$27,972,820	6.8%

Net Paid Claims - Total Total Participants	July - June 2024 Q4				July - June 2025 Q4				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$320	$570	$2,404	$353	$356	$452	$713	$383	8.5%

Cost Distribution – Medical Claims > $50K

July - June 4Q24							July - June 4Q25					
# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid
10	0.2%	$1,597,252	6.1%	$277,407	17.4%	> $100k	7	0.1%	$1,228,632	4.4%	$980,843	79.8%
25	0.4%	$2,024,880	7.7%	$944,682	46.7%	$50k- $100k	31	0.5%	$2,226,230	8.0%	$1,222,487	54.9%
66	1.1%	$2,533,420	9.7%	$1,662,471	65.6%	$25k - $50k	96	1.6%	$3,438,893	12.3%	$1,385,084	40.3%
238	3.9%	$5,018,038	19.2%	$1,722,771	34.3%	$10k - $25k	233	3.8%	$4,896,897	17.5%	$2,383,390	48.7%
344	5.6%	$3,121,660	11.9%	$2,047,155	65.6%	$5k - $10k	490	8.1%	$4,295,836	15.4%	$2,687,747	62.6%

% Paid Attributed to Catastrophic Cases



HCC > $50k - CCSR Chapter Conditions - Thru 4Q25			
Top 5 CCSR Category Conditions	# of Patients	Total Paid	% of Med Paid
Neoplasms	13	$1,311,920	4.6%
Diseases of the circulatory system	11	$833,673	2.9%
Injury, poisoning	8	$801,768	2.8%
Diseases of the digestive system	5	$712,329	2.5%
Mental, behavioral and neurodevelopmental	9	$650,738	2.3%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	July - June 4Q24	July - June 4Q25	▲	July - June 4Q24	July - June 4Q25	▲	July - June 4Q24	July - June 4Q25	▲
Inpatient									
# of Admits	407	408	0.2%	332	358	7.8%	75	50	-33.5%
# of Bedays	2,480	2,595	4.6%	1,850	2,087	12.8%	630	508	-19.4%
Avg. Paid per Admit	$18,938	$19,119	1.0%	$19,278	$19,093	-1.0%	$17,438	$19,306	10.7%
Avg. Paid per Day	$3,110	$3,006	-3.3%	$3,460	$3,275	-5.4%	$2,083	$1,903	-8.7%
Admits Per K	66.0	67.1	1.7%	59.5	64.6	8.6%	126.7	92.1	-27.3%
Days Per K	401.5	426.6	6.2%	331.5	376.8	13.7%	1,060.1	934.4	-11.9%
ALOS	6.1	6.4	4.5%	5.6	5.8	4.6%	5.5	5.9	7.3%
Admits from ER	210	175	-16.7%	168	149	-11.3%	42	26	-38.1%
Physician Office Visits									
Per Member Per Year	2.3	2.2	-3.6%	2.3	2.2	-3.8%	2.6	2.6	-0.9%
Paid Per Visit	$149	$158	6.1%	$154	$163	6.1%	$104	$107	2.9%
Net Paid PMPM	$28	$29	2.2%	$29	$30	2.1%	$22	$23	2.0%
Emergency Room									
# of Visits	793	800	0.9%	722	725	0.4%	71	75	5.6%
Visits Per K	128.4	131.5	2.4%	129.4	130.9	1.2%	119.5	138.1	15.5%
Avg Paid Per Visit	$2,802	$3,323	18.6%	$2,856	$3,353	17.4%	$2,248	$3,040	35.2%
Urgent Care									
# of Visits	4,005	3,909	-2.4%	3,603	3,544	-1.6%	402	365	-9.2%
Visits Per K	648.5	642.7	-0.9%	645.5	639.8	-0.9%	676.9	672.0	-0.7%
Avg Paid Per Visit	$124	$132	6.5%	$93	$92	-1.2%	$87	$77	-10.9%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Neurodevelopmental disorders	$748,456	3.3%	$34,164	$1,673	$712,619	$502,742	$245,714	$0
Spondylopathies/spondyloarthropathy	$599,331	2.7%	$483,709	$105,727	$9,895	$165,371	$433,959	$0
Septicemia	$523,130	2.3%	$379,282	$143,848		$214,209	$308,921	$0
Liveborn	$514,065	2.3%			$514,065	$498,247	$15,817	$0
Osteoarthritis	$423,032	1.9%	$283,485	$139,328	$219	$183,460	$239,572	$0
Encounter for antineoplastic therapies	$407,921	1.8%	$350,626	$57,295		$40,480	$367,441	$0
Depressive disorders	$396,106	1.8%	$174,643	$28,471	$192,992	$144,781	$251,325	$0
Sleep wake disorders	$392,402	1.8%	$336,168	$36,726	$19,508	$159,333	$233,068	$0
Abdominal pain and other digestive/abdomen	$384,741	1.7%	$255,309	$59,989	$69,443	$107,252	$277,489	$0
Nonspecific chest pain	$328,438	1.5%	$200,313	$56,662	$71,463	$132,165	$196,274	$0
Breast cancer - all other types	$326,179	1.5%	$171,016	$155,163		$4,542	$321,636	$0
Diabetes mellitus with complication	$323,225	1.4%	$259,783	$33,342	$30,101	$175,105	$148,120	$0
Neoplasm-related encounters	$315,766	1.4%	$270,922	$44,523	$321	$128,890	$186,876	$0
Hearing loss	$309,437	1.4%	$228,247	$35,910	$45,279	$86,628	$222,809	$0
Pneumonia (except that caused by tuberculosis)	$302,504	1.4%	$228,989	$61,234	$12,281	$149,155	$153,349	$0
Medical examination/evaluation	$283,251	1.3%	$64,738	$51,302	$167,210	$135,074	$148,176	$0
Sprains and strains, initial encounter	$276,519	1.2%	$217,515	$32,404	$26,600	$85,718	$190,800	$0
Benign neoplasms	$267,398	1.2%	$230,504	$32,829	$4,065	$17,472	$249,926	$0
Multiple myeloma	$265,940	1.2%	$265,940			$6,203	$259,736	$0
Urinary tract infections	$265,598	1.2%	$99,705	$122,952	$42,941	$39,062	$226,536	$0
Cardiac dysrhythmias	$256,418	1.1%	$177,588	$77,166	$1,664	$123,304	$133,115	$0
Other specified and unspecified	$247,423	1.1%	$96,092	$151,245	$87	$95,953	$151,471	$0
Asthma	$244,165	1.1%	$212,695	$3,571	$27,899	$21,674	$222,491	$0
Anxiety and fear-related disorders	$241,897	1.1%	$157,487	$27,985	$56,425	$67,795	$174,102	$0
Coronary atherosclerosis and other heart disease	$241,644	1.1%	$216,354	$25,289		$166,468	$75,175	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health diagnosis by Spend				
CCSR Category Description	July - June 4Q24		July - June 4Q25	
	Patients	Total Paid	Patients	Total Paid
Neurodevelopmental disorders	227	$583,229	224	$748,456
Depressive disorders	360	$300,526	372	$396,106
Anxiety and fear-related disorders	441	$199,835	463	$241,897
Trauma- and stressor-related disorders	254	$133,943	271	$168,744
Alcohol-related disorders	29	$106,442	26	$69,311
Bipolar and related disorders	89	$65,293	83	$99,462
Suicidal ideation/attempt/intentional self-harm	16	$47,193	12	$36,626
Schizophrenia spectrum and other psychotic disorders	17	$48,260	11	$20,717
Other specified and unspecified mood disorders	28	$19,758	17	$14,248
Stimulant-related disorders	2	$10,140	3	$22,674

**Not Representative of all utilization*

**Data based on medical spend only*

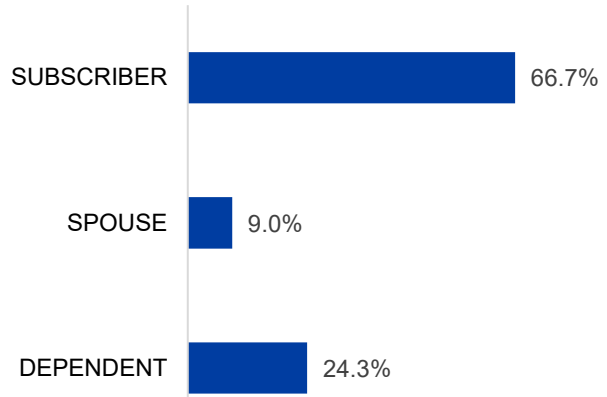
Respiratory Disorders

Top 10 Respiratory Disorders				
CCSR Category Description	Patients	Claims	Total Paid	% Paid
Pneumonia (except that caused by tuberculosis)	43	159	$302,504	20.5%
Asthma	244	547	$244,165	16.5%
Other specified upper respiratory infections	706	987	$186,993	12.7%
Respiratory failure; insufficiency; arrest	31	296	$160,881	10.9%
Sinusitis	361	502	$130,578	8.8%
Other specified and unspecified upper respiratory disease	337	1,219	$121,651	8.2%
Acute and chronic tonsillitis	69	146	$91,462	6.2%
Pneumothorax	9	133	$68,413	4.6%
Other specified and unspecified lower respiratory disease	61	103	$55,984	3.8%
Acute bronchitis	255	322	$38,209	2.6%

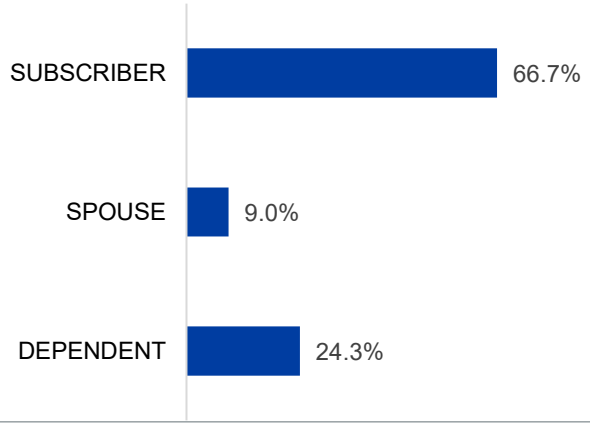
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Relationship



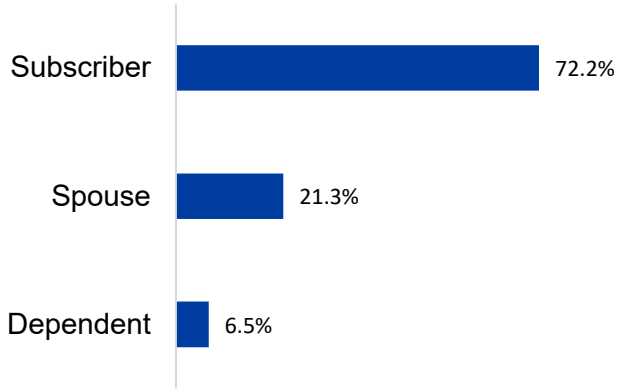
Infections

Top 10 Infectious and Parasitic Diseases				
CCSR Description	Patients	Claims	Total Paid	% Paid
Septicemia	22	77	$523,130	69.6%
COVID-19	144	268	$104,934	14.0%
Viral infection	185	273	$66,014	8.8%
HIV infection	30	136	$37,888	5.0%
Tuberculosis	1	19	$9,011	1.2%
Foodborne intoxications	2	3	$2,457	0.3%
Sexually transmitted infections (excluding HIV)	26	38	$2,078	0.3%
Bacterial infections	20	29	$1,817	0.2%
Hepatitis	9	32	$1,694	0.2%
Fungal infections	88	119	$1,614	0.2%

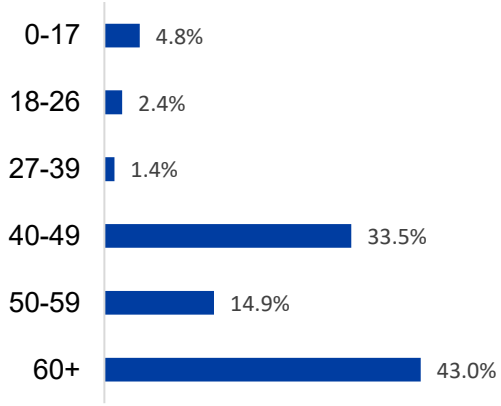
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



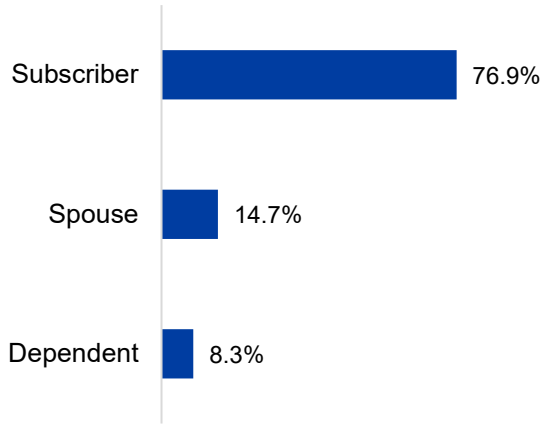
Pregnancy Related Disorders

Top 10 Complications of Pregnancy by Spend				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Complications specified during childbirth	21	32	$144,117	14.1%
Uncomplicated pregnancy, delivery or puerperium	73	342	$127,266	12.5%
Hypertension and hypertensive-related conditions pregnancy	13	75	$106,405	10.4%
Other specified complications in pregnancy	48	172	$100,849	9.9%
Previous C-section	8	20	$77,441	7.6%
Malposition, disproportion or other labor complications	11	32	$77,056	7.6%
Maternal care related to fetal conditions	26	52	$64,460	6.3%
Diabetes or abnormal glucose tolerance complicating pregnancy	11	58	$47,816	4.7%
Maternal care related to disorders of the placenta	8	14	$43,989	4.3%
Early or threatened labor	15	28	$35,571	3.5%

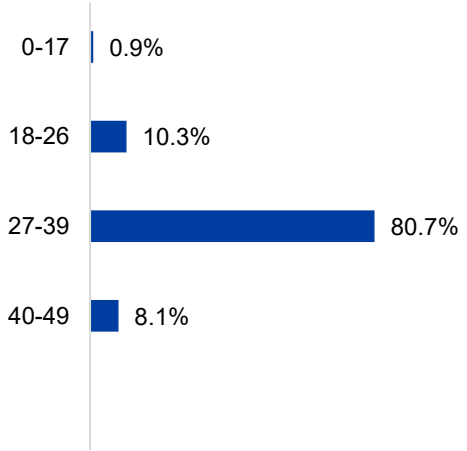
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



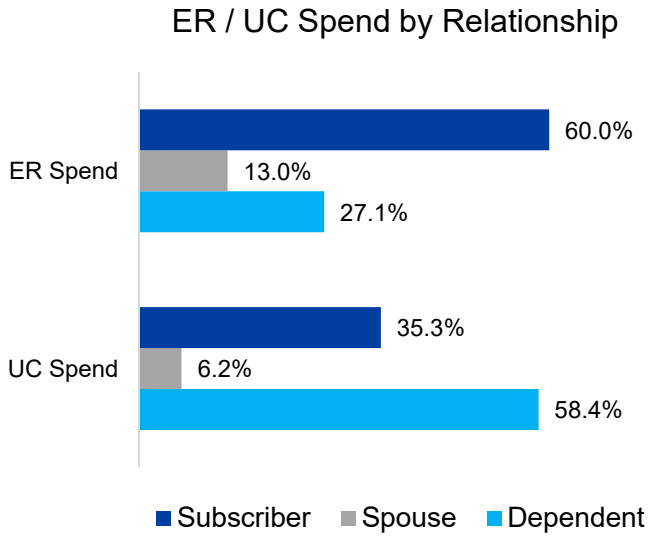
Emergency Room and Urgent Care

	July - June 4Q24		July - June 4Q25		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	793	4,005	800	3,909		
Visits Per Member	0.13	0.65	0.13	0.64	0.08	0.31
Visits Per K	128.4	648.5	131.5	642.7	101.5	484.32
Avg. Paid Per Visit	$2,802	$124	$3,323	$132	$2,882	$129

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - 4Q25				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	458	75.3	1,107	182.0
Spouse	97	15.9	380	62.5
Dependent	245	40.3	2,422	398.2
Total	800	131.5	3,909	642.7



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	1,622	26.7%	266.7	$26.40
Hypertension	759	12.5%	124.8	$1.18
Intervertebral Disc Disorders	539	8.9%	88.6	$8.25
Diabetes with complications	394	6.5%	64.7	$5.88
Asthma	234	3.9%	38.5	$3.37
Coronary Atherosclerosis	138	2.3%	22.7	$3.34
Chronic Renal Failure	104	1.7%	17.1	$3.23
Normal Pregnancy/Delivery	72	1.2%	11.8	$1.53
COPD	69	1.1%	11.3	$0.22
Breast Cancer	65	1.1%	10.7	$4.58
Congestive Heart Failure (CHF)	55	0.9%	9.0	$2.42
Prostate Cancer	28	0.5%	4.6	$1.79
Colon Cancer	15	0.3%	2.5	$1.16
Acute Myocardial Infarction	12	0.2%	2.0	$1.02
Cervical Cancer	3	0.1%	0.5	$0.01

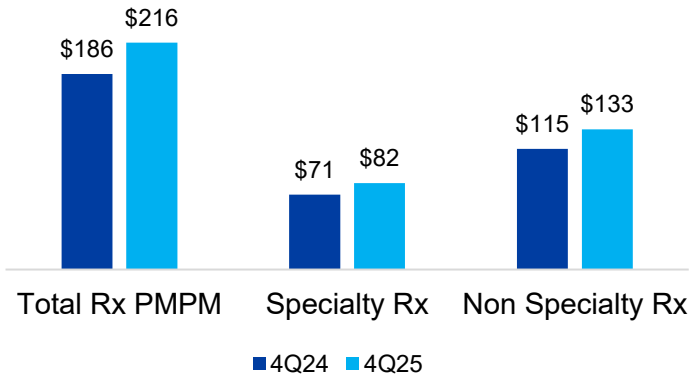
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	July - June 4Q24	July - June 4Q25	Δ
Enrolled Members	8,234	8,110	-1.5%
Average Prescriptions PMPY	17.2	17.5	1.5%
Formulary Rate	88.6%	89.2%	0.7%
Generic Use Rate	85.8%	85.4%	-0.5%
Generic Substitution Rate	98.4%	98.9%	0.5%
Avg Net Paid per Prescription	$130	$148	14.3%
Net Paid PMPM	$186	$216	16.0%

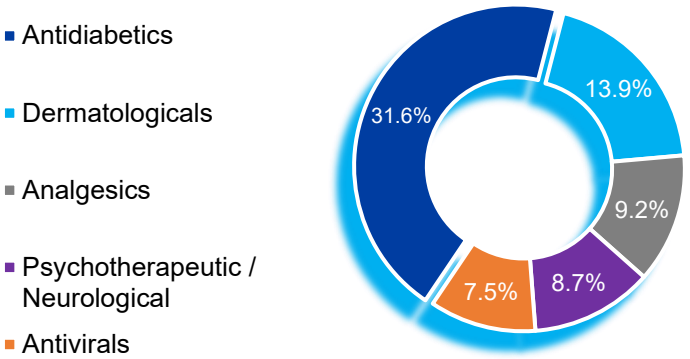
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **16.0%**, (**$30 PMPM**) from prior period
- Avg. paid per Script increased **14.3%** (**$18 PMPM**) year over year
- Specialty Rx spend driving **38.2%** of Rx Spend
- Specialty Rx spend increased **15%** from prior period
  Specialty Rx Drivers:
  Mounjaro (Antidiabetic) Spend up **115.3%**
  Ozempic (Antidiabetic) Spend up **15.8%**
- Tier 1 Rx drove **75.1%** of total claim volume, but only accounts for **5.8%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



18.1.7

18. Quarter 4 Vendor Reports. (Information/Discussion)
    18.1 Receipt of quarterly vendor reports for the period ending June 30, 2025:
        18.1.1 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
        18.1.2 Q4 Doctor on Demand Engagement Report
        18.1.3 Q4 CDHP Performance Review
        18.1.4 Q4 LD PPO Performance Review
        18.1.5 Q4 EPO Performance Review
        18.1.6 Q4 HPN Performance Review
        18.1.7 Q4 Dental Performance Review

NEVADA PEBP

Public Employees' Benefits Program

Quarterly Plan Performance Review

Dental • 2025-4Q

Claims Paid 7/1/2024 - 6/30/2025

UMR℠

A UnitedHealthcare Company

RPG 4.90 • Run Date: 8/28/2025

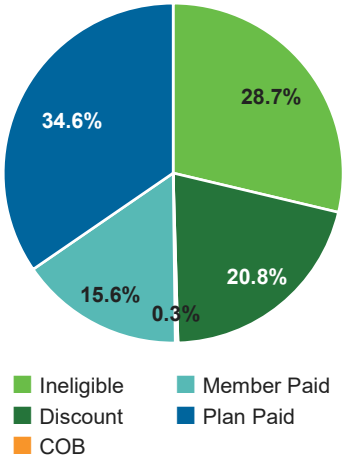
Dental Total Savings Summary

Breakouts & Network Performance

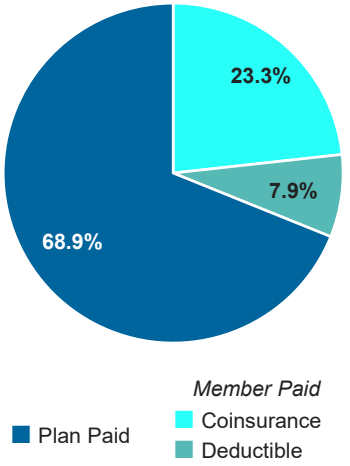
Dental Dollar Chain: Billed to Paid Dollars

Dollar Amount	Total Dollars	PMPM
Dental Billed	$83,261,874	$101.98
(-) Ineligible	$23,994,952	$29.39
Dental Covered	$59,266,922	$72.59
(-) Discount	$17,411,154	$21.33
Dental Allowed	$41,855,768	$51.27
(-) COB	$217,833	$0.27
(-) Coinsurance	$9,753,456	$11.95
(-) Deductible	$3,294,054	$4.03
Total Member Paid	$13,047,510	$15.98
Total Plan Paid	$28,899,293	$35.40

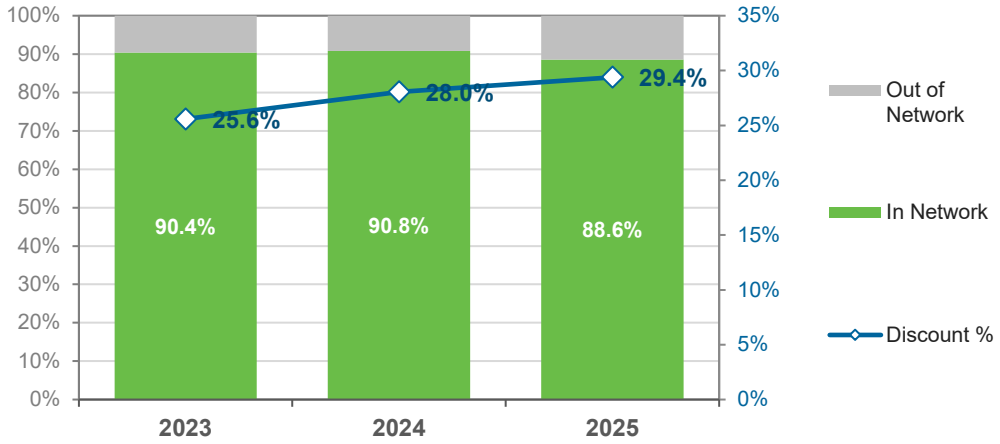
Breakout of Billed Dollars



Breakout of Paid Dollars



Dental Network Performance



Dental Claims Breakouts

Age Range, Member Cost, and Dental Category

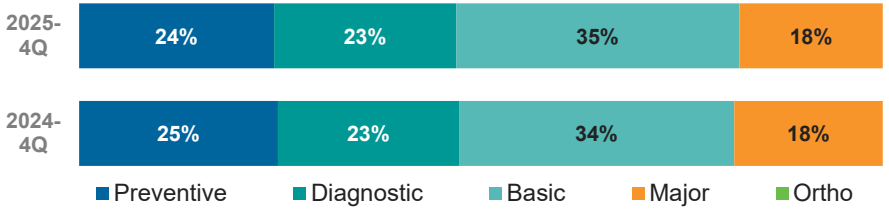
Dental Paid Claims by Age Range

Age	2024-4Q		2025-4Q		Change	
	Total Paid	Paid PMPM	Total Paid	Paid PMPM	Total	PMPM
< 01	$11,292	$2.56	$9,093	$1.90	-19.5%	-25.7%
01	$51,530	$10.07	$51,362	$10.09	-0.3%	0.3%
02 - 04	$425,708	$22.85	$454,129	$23.53	6.7%	3.0%
05 - 09	$1,252,969	$34.45	$1,325,075	$34.15	5.8%	-0.9%
10 - 14	$1,355,867	$31.09	$1,447,535	$31.75	6.8%	2.1%
15 - 19	$1,890,567	$37.05	$1,903,140	$35.97	0.7%	-2.9%
20 - 24	$1,101,254	$20.68	$1,208,259	$21.34	9.7%	3.2%
25 - 29	$936,306	$25.59	$1,026,138	$25.16	9.6%	-1.7%
30 - 34	$1,195,874	$27.15	$1,246,859	$26.63	4.3%	-1.9%
35 - 39	$1,457,274	$29.06	$1,618,466	$30.55	11.1%	5.1%
40 - 44	$1,639,038	$30.95	$1,736,362	$30.86	5.9%	-0.3%
45 - 49	$1,671,296	$33.12	$1,747,128	$33.27	4.5%	0.4%
50 - 54	$1,980,881	$33.98	$2,114,876	$35.63	6.8%	4.9%
55 - 59	$2,227,465	$38.15	$2,274,126	$37.76	2.1%	-1.0%
60 - 64	$2,635,831	$42.08	$2,672,565	$43.14	1.4%	2.5%
65+	$7,823,594	$48.41	$8,064,181	$49.65	3.1%	2.6%
Total	**$27,656,744**	**$35.12**	**$28,899,293**	**$35.40**	**4.5%**	**0.8%**

Dental Cost Distribution

Member Total Paid Range	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Mem Paid)	OOP % of Tot
No Claims	27,651	36.7%	$0	0.0%	$0	0.0%
< $0 - $0	950	1.3%	-$4,347	0.0%	$37,681	0.3%
> $0 - $250	12,783	17.0%	$2,032,945	7.0%	$804,839	6.2%
> $250 - $500	16,166	21.5%	$5,862,095	20.3%	$1,461,094	11.2%
> $500 - $750	6,021	8.0%	$3,649,805	12.6%	$1,316,920	10.1%
> $750 - $1000	3,280	4.4%	$2,842,388	9.8%	$1,357,980	10.4%
> $1000	8,443	11.2%	$14,516,409	50.2%	$8,068,996	61.8%
Total	**75,294**	**100.0%**	**$28,899,293**	**100.0%**	$13,047,510	100.0%

Paid Breakout by Dental Category



Dental Category	2024-4Q		2025-4Q		Change
	Patients	Total Paid	Patients	Total Paid	Total Paid
Preventive	36,300	$6,842,663	36,983	$7,009,776	2.4%
Diagnostic	42,361	$6,228,020	43,549	$6,546,983	5.1%
Basic	21,019	$9,475,074	22,141	$10,180,735	7.4%
Major	7,396	$5,110,988	7,410	$5,161,799	1.0%
Orthodontia	5	$0	2	$0	-
Total Dental	**45,896**	**$27,656,744**	**47,223**	**$28,899,293**	**4.5%**

Dental Paid by Member Status

Breakout of State vs. Non-State by Member Status

Program	2024-4Q (7/1/2023 - 6/30/2024) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Dental	$18,370,115	$2,273,050	$607,814	**$21,250,978**	$19,499,955	$2,276,076	$613,322	**$22,389,353**	*5.4%*
Dental Exchange			$4,025,810	**$4,025,810**			$4,265,064	**$4,265,064**	*5.9%*
Total	**$18,370,115**	**$2,273,050**	**$4,633,624**	**$25,276,788**	**$19,499,955**	**$2,276,076**	**$4,878,385**	**$26,654,417**	***5.5%***
PMPM	**$31.53**	**$38.41**	**$48.63**	**$34.29**	**$31.66**	**$40.51**	**$50.64**	**$34.69**	***1.2%***
Non-State Members									
Dental	$3,532	$71,420	$242,337	**$317,289**	$5,138	$58,220	$215,758	**$279,116**	*-12.0%*
Dental Exchange			$2,062,667	**$2,062,667**			$1,965,760	**$1,965,760**	*-4.7%*
Total	**$3,532**	**$71,420**	**$2,305,004**	**$2,379,956**	**$5,138**	**$58,220**	**$2,181,518**	**$2,244,876**	***-5.7%***
PMPM	**$26.54**	**$38.52**	**$47.56**	**$47.17**	**$31.18**	**$44.52**	**$46.84**	**$46.73**	***-0.9%***
All Members									
Dental	$18,373,646	$2,344,470	$850,150	**$21,568,267**	$19,505,093	$2,334,296	$829,080	**$22,668,469**	*5.1%*
Dental Exchange			$6,088,477	**$6,088,477**			$6,230,824	**$6,230,824**	*2.3%*
Total	**$18,373,646**	**$2,344,470**	**$6,938,628**	**$27,656,744**	**$19,505,093**	**$2,334,296**	**$7,059,904**	**$28,899,293**	***4.5%***
PMPM	**$31.53**	**$38.41**	**$48.27**	**$35.12**	**$31.66**	**$40.60**	**$49.40**	**$35.40**	***0.8%***

19.

19. Public Comment.

20.

20. Adjournment.