As Kaiser partners with Renown, as well as opening or acquiring facilities throughout the Northern Nevada area this and next year and offering plans in the next plan year, has PEBP considering looking at them as a replacement for UMR?

They are very good at cost containment without making the patient care and support experience a Byzantine and frustrating slog. They also pay providers on time. All unlike UMR.

PEBP issues an annual letter to beneficiaries, explaining Consumer Driven Health Plan Prescription Drug Coverage is comparable to drug coverage provided under Medicare Part D. The letter explains we have the right to choose between the two drug coverages. However, PEBP's plan is no longer comparable to Medicare Part D. Weight loss drugs such as Zepbound are now covered under Medicare part D but are not covered under PEBP. This makes a difference of anywhere from $800.00 to over $1000.00 per refill. Why doesn't the Consumer Driven Heath Plan cover Zepbound when Medicare Part D does cover it? PEBP needs to amend the letters they keep sending since they are no longer correct. PEBP is behind the times. I am pre-diabetic as are many other beneficiaries. Maintaining a healthy weight is a key part of avoiding becoming diabetic. I am requesting a fresh review of weight loss drug coverage, especially for patients who are pre-diabetic.

Derek Vogel

PUBLIC COMMENT TO THE PEBP BOARD

Subject: Lack of In-Network Emergency Ambulance Coverage and Inadequate Member Disclosure in Washoe County

Date: August 5, 2026

Dear Members of the PEBP Board:

I am submitting this public comment regarding a serious gap in emergency ground-ambulance coverage for PEBP members in Washoe County, together with the way that coverage is described to members through the UMR app.

On July 16, 2025, my husband, Derek Vogel, required emergency transportation by REMSA. REMSA is the exclusive 911 ground-ambulance provider in our area. He had no ability to select another provider, verify network participation, negotiate the charge, or choose an in-network alternative.

REMSA billed $2,162.50. UMR processed the claim and paid $782.54, leaving a REMSA balance of $1,379.96. Our family had already met the plan's annual out-of-pocket maximum. Nevertheless, because REMSA is treated as out of network and does not accept the plan payment as payment in full, we remain responsible for a substantial balance bill for an emergency service we had no choice but to use.

REMSA has confirmed in writing that the health plan does not maintain an in-network ground-ambulance provider in our service area and that patients have little or no ability to select an alternative provider. REMSA has also now advised us in writing that it attempted to contract with our insurance in the past without receiving a response and is currently attempting to contact the insurance side again. This makes it especially important for PEBP to determine which entity is responsible for responding to and completing ambulance-network negotiations.

I have also located relevant member-facing information in the UMR app. Under the coverage type "Medical - In-Network," the app lists:

"Ambulance ground - yes, benefits included in this plan."

The app does not clearly disclose on that benefits screen that REMSA, the exclusive 911 provider in Washoe County, may be out of network; that no practical in-network alternative may exist; or that a member may face substantial balance billing after the claim is processed.

The UMR app also states that out-of-network ambulance services are covered at "80% after deductible." However, UMR paid $782.54 toward REMSA's $2,162.50 charge — approximately 36% of the billed amount. Based on the claim figures, it appears that the stated 80% was applied

only to UMR's internally determined allowed amount, not to REMSA's actual charge. The app does not clearly explain that distinction or warn members that the exclusive ambulance provider may bill them for the difference between UMR's allowed amount and the provider's charge.

A general disclaimer states that the plan terms prevail and that final coverage and patient responsibility are determined when the claim is processed. However, that disclaimer does not explain the specific and unavoidable REMSA network gap facing Northern Nevada members, nor does it explain that an advertised 80% out-of-network benefit may still leave the member responsible for more than half of the provider's bill.

A reasonable member reviewing the app could understandably believe that emergency ground-ambulance transportation is meaningfully covered without exposure to a large balance bill — particularly where the in-network screen says ground-ambulance benefits are included and the out-of-network screen says ambulance services are covered at 80% after deductible.

The consequences are more serious than financial inconvenience. During a later [redacted] episode involving repeated [redacted], my husband did not call 911 because he feared that our family would receive another large REMSA balance bill. His [redacted] later expressed concern that he should have received emergency evaluation and ordered a [redacted].

No Nevadan with comprehensive state-sponsored health coverage should be afraid to call 911 because the only available ambulance provider is out of network.

I respectfully ask the PEBP Board to:

• Determine which entity is responsible for negotiating and maintaining an adequate emergency ground-ambulance network for PEBP members.

• Investigate why REMSA remains out of network when it is the exclusive 911 provider in Washoe County, including REMSA's written statement that prior contracting efforts did not receive a response.

• Establish a network-gap exception, single-case agreement, special reimbursement arrangement, or other protection for unavoidable emergency ambulance services.

• Review whether UMR and PEBP member materials clearly explain that the stated 80% out-of-network benefit is based on an allowed amount rather than the provider's actual charge, and that members may be balance billed for the difference.

• Review whether members are adequately warned that the only available 911 provider may be out of network and that the annual out-of-pocket maximum may not protect them from the provider's balance bill.

• Consider an additional payment or administrative remedy for Derek Vogel's unresolved $1,379.96 REMSA balance.

• Take action to prevent other members from delaying or avoiding emergency care because of predictable ambulance balance billing.

A formal complaint is currently pending with the Nevada Division of Insurance concerning claim administration, network adequacy, reimbursement, member disclosures, and the absence of an in-network emergency ground-ambulance option.

Screenshots of the UMR app benefit information and REMSA's written statement regarding its contracting attempts are available and can be provided upon request.

Thank you for reviewing this issue and for protecting the health and financial security of Nevada public employees, retirees, and their families.

Sincerely,

Derek Vogel
PEBP Member
Date of Service: [redacted]
UMR Claim No.: [redacted]
REMSA Account No.: [redacted]

Kelly Vogel
Authorized representative and primary contact
[redacted]
[redacted]

Brandy Cox

[redacted]

[redacted]

[redacted]

August 14, 2026

To: PEBP Board **Re:** Accredo Medication Handling Concerns

Dear Board Members,

I am writing to report a serious and potentially dangerous issue involving Accredo's handling and shipment of temperature-sensitive medication.

My husband takes [redacted] **twice daily** for a [redacted] disorder. This medication is a **critical, life-saving** [redacted] that prevents [redacted] which can travel to his [redacted]. It must remain **at or below 76°F**, with only a very short allowable exposure up to 86°F. For this reason, Accredo has always shipped it in a **styrofoam cooler with ice packs**.

On **August 10**, his medication arrived **in a plain cardboard box**, left on our driveway, with **no cooler and no ice packs**. The outdoor temperature was **100°F**, and the concrete was **120°F**. When we brought the box inside and opened it approximately ten minutes later, the medication inside measured **106°F**. According to manufacturer specifications, exposure to this temperature **renders the medication ineffective**.

My husband contacted Accredo immediately. After **three hours on the phone**, he was told an investigation would be opened, a return label would be sent, and a replacement shipment would be issued.

On **August 13**, the replacement medication arrived **packaged the exact same way**—a cardboard box with no cooler or ice. The temperature inside the box was **110°F**.

This morning, after another **three hours and five different representatives**, Accredo stated they would finally send the medication overnight in the correct packaging.

My concern extends beyond our household. Many PEBP members rely on temperature-controlled medications. If this is happening to us, it is almost certain it is happening to others—many of whom may not realize their medication has been compromised. Ineffective medication could lead to **life-threatening consequences**.

I am also deeply concerned that Accredo may be placing returned, heat-damaged medication back into inventory instead of destroying it.

The difficulty of navigating Accredo's automated systems, repeated transfers, and inconsistent handling practices makes resolving these issues extremely challenging. Yet the stakes—people's lives—could not be higher.

I respectfully request that the Board investigate Accredo's shipping practices and take action to ensure all temperature-sensitive medications are handled safely and consistently.

Thank you for your attention to this urgent matter.

Sincerely,

Brandy Cox

TO: Jim Wells, Chair; and Public Employee Benefits Program Board

FROM: Douglas Unger, Past President, UNLV Chapter, Nevada Faculty Alliance; & Member, UNLV Employee Benefits Advisory Committee

PEBP BOARD MEETING – 8-20-26 – PUBLIC COMMENT

Doug Unger, Past President, UNLV Chapter, Nevada Faculty Alliance; and Member, UNLV Employee Benefits Advisory Committee.

Please note that we still don't see crucial budget numbers in time to write and submit Public Comment. Nor do we yet have any comprehensive explanation for the PEBP budget accounting mess that showed more than $100 million in discrepancies between PEBP reports in 2025 and 2026. Both these issues need to be addressed to restore trust in PEBP's numbers.

Speaking to Agenda item #7, this year's increases in plan premiums paired with cuts in benefits are causing unacceptable financial stress for state employees. Further phased-in three-year and two-year increases will be unaffordable. Last Spring, the Board agreed to discuss these plans again, and I hope you will do so. Board members should push back against any suggestion by the Chair or others that PEBP cannot ask for increases in employer (and state) contributions in the next biennial budget. If PEBP's numbers last Spring can be trusted, a one year increase of $90 per month for all PEBP members would have stabilized plan costs without increases and cuts. For this first year of the new biennium, at least consider asking the Governor's budget to meet state employees halfway with a one-year contribution of half this "hold harmless" amount—or $45 per month per member—to reduce the stress and harm already being done to state workers.

Speaking to matters discussed at the July 23rd Strategic Planning meeting, it is NOT wise for PEBP to separate active employee and retiree employee risk pools so as to raise premiums for non-Medicare retirees disproportionately by possibly more than 30%. And even worse effects would result if non-Medicare retirees would be separated from PEBP and dumped onto the ever eroding and increasingly expensive Silver State Exchange. To inflict on non-Medicare retirees radical increases in healthcare premiums or for PEBP to dump them would be both punitive and wrong. Especially this would single out state employees covered under the Police/Fire statutes for PERS, our Nevada Department of Corrections, Highway Patrol, State Police and Fire Marshall Officers, whose jobs are physically and psychologically demanding, and for whom PERS rules suggest our state should accommodate early retirements. The NDOC has a staffing crisis—many of you may have read about the millions in overtime charges to the state budget needed to keep our correctional institutions staffed. This staffing crisis will get worse if officers are punished by cuts in anticipated retirement benefits. The approximately 3,900 non-Medicare retirees across our state have earned and deserve comfortable retirements. PEBP should NOT break this promise to state retirees and, in effect, disparage and devalue their decades of service.

Employee advocates will once again seek of the Legislature and Governor the restoration of the monthly subsidy for post-2011 hired retirees to match those hired earlier, and to add to the $13 contribution per month per year of service up to 20 years for ALL state retirees because it has not kept pace with inflation since the last $1 increase in 2019. Dumping state workers completely unsupported onto the shifting, uncertain terrain of an ever more besieged Medicare system is not enough to be able to hire and retain the high quality workforce needed to serve the citizens of Nevada into the future. Thank you.

Kent Ervin

I currently serve as chair of RPEN's Legislative/Insurance Committee. The Retired Public Employees of Nevada has nearly 7000 members statewide including many state employees and retirees who are participants in PEBP.

We have been hearing complaints from PEBP Medicare retirees about the Senior Care Plus Medicare Advantage Plan, which they joined through Via Benefits.

Kaiser Permanente recently acquired majority ownership of Hometown Health, Renown's insurance arm, and is operating it as Kaiser Permanente Nevada. Senior Care Plus was part of Hometown Health. Kaiser is advertising increased access to healthcare in Northern Nevada. But in July, Senior Care Plus (SCP) cancelled contracts with several providers in its network in Northern Nevada. The primary care providers of hundreds of patients will no longer be in-network. SCP patients were notified in the middle of the plan year, before open enrollment is available, and told to go to a new Kaiser clinic in Reno. However, patients who have attempted to make appointments with Kaiser have found they are not available any time soon. As of 8/1/2026, SCP listed only one physician and six other practitioners at Kaiser in its network in Reno. Enrollees in Carson City and other outlying areas would have to drive or arrange transportation to Reno to see a Kaiser provider, if one is available. Retirees in their 70s, 80s or 90s are being asked to change their primary care provider with whom they have had a relationship for decades.

Our question is: What is PEBP and Via Benefits doing to assist its Senior Care Plus enrollees? What are their options to keep seeing their long-time primary physicians in-network? Given the significant changes to Senior Care Plus's network and coverage area, is a Special Enrollment Period for changing Medicare Advantage Plans outside of open enrollment being allowed? We respectfully ask the Executive Officer and Willis Towers Watson to address these concerns and provide guidance to the over 400 PEBP Retires who have enrolled in Senior Care Plus through Via Benefits.

Thank you.

Kent Ervin, regarding Item 7D, Duties, Policies, and Procedures amendments on 8/20/2026 agenda

Rate Formulas. The specification on page 21 of the existing formulas and practice for rates for the various plan options and dependent tiers is an important addition to the Duties, Policies, and Procedures manual.

To give some historical background: at one time PEBP rated the four dependent tiers separately rather than using these formulas. That created inequities. For example, in FY2011 the unsubsidized CDHP rate for Employee+Spouse was $1502/month but the rate for Employee+Family was $1190. That is, if a couple added a child, their rate and premium actually significantly decreased. The reason was that couples with children were, on average, younger and healthier with lower expenses than couples without children. That was unfair to younger couples without children. That situation was fixed in FY2012 and onward by using the formula whereby each adult has the same rate and children have the same additional rate for either a single employee or a married employee.

However, the chart on page 21 of the **draft is incomplete and should be amended** to clarify exactly how rates are set for children and for plan options.

1) The table does not indicate how the rates for Children are determined. Since FY2022, the additional amount for Children has been fixed at 37.5% of the Adult rate. That is, there is an algebraic relationship:

   $A = 0.375 \times X$ $B = 0.375 \times Y$ $C = 0.375 \times Z$

   Prior to FY2022, the percentage for children versus adults varied from 30.9% to 41.4%. Whatever the value, it is important that the percentages be uniform across the three plan options to avoid inequities due to different enrollment demographics by plan option and subsequent adverse selection.

   Suggested amendment: (a) Insert a provision that "The rate for Children shall be 37.5% of the rate for an Adult in the same plan option." and (b) direct staff and the actuary to bring back information on the average costs for Children for possible revision of the percentage.

2) The table does not indicate how to implement the directive "Rates will be adjusted by plan to reflect the actuarial value and costs associated with the plan to avoid any one plan subsidizing the rates of any other plan." A formula should be specified to prevent the recent mis-pricing of plan options from being repeated.
   Suggested amendment: Insert "The rates for the richer plan options as determined follows:

   $Y = X \times$ (Actuarial value of LDPPO / Actuarial value of CDHP)

   $Z = X \times$ (Actuarial value of EPO-HMO / Actuarial value of CDHP)"

3) The value of G should include the cost of employee-only expenses:
   Suggested amendment: Revise "G = General Overhead Costs" to "G = General Overhead Costs plus basic life insurance and other employee-only expenses"

Employer Contribution Policy

The table below provides the history of employer contribution (aka "subsidy") percentages for employees, retirees, and dependents. The employee percentage is simply 100% minus the employer contribution percentage. The employee-only percentages have been adjusted year-to-year based on projected rates and funding, often with little or no Board discussion of dependent or retiree rates.

1) Over the past 15 years, the employer contribution percentages for active employee dependents has been decreased from 73% to 68.5%, while the retiree percentage has increased from 64% to 70%. Why**? These percentages are a reflection of values toward dependents vs actives and retirees, and they deserve a full Board discussion.**

2) Although the proposed percentages seem similar to the values in the recent past, small changes for the Employee percentage translate to large changes in the monthly premium. For example, a 0.5 percentage point change from 6.5% to 7.0% represents a 7.7% increase in the employee's premium. This leveraging effect could be eliminated by **increasing the Employer Contribution to 100% of the Employee-Only CDHP rate,** with necessary adjustments of the dependent and retiree percentages phased in. Note that most competing cities and counties provide 100% of healthcare insurance cost for their employees.

CDHP - Employer Contribution Percentages							
	Active Employees				Pre-Medicare Retiree 15YOS		Active Employee-Only Percentage
	employee	spouse	children	spouse+ children	retiree	spouse	
FY12	92.8%	72.8%	72.8%	72.8%	63.8%	(n/a)	7.2%
FY13	93.0%	73.0%	73.0%	73.0%	64.0%	(n/a)	7.0%
FY14	93.0%	73.0%	73.0%	73.0%	64.0%	(n/a)	7.0%
FY15	93.0%	73.0%	73.0%	73.0%	64.0%	(n/a)	7.0%
FY16	93.0%	73.0%	73.0%	73.0%	64.0%	(n/a)	7.0%
FY17	93.0%	73.0%	73.0%	73.0%	64.0%	56.0%	7.0%
FY18	93.0%	73.4%	73.8%	73.6%	64.1%	55.4%	7.0%
FY19	94.5%	74.5%	74.5%	74.5%	64.5%	55.5%	5.5%
FY20	95.0%	75.0%	75.0%	75.0%	66.0%	54.0%	5.0%
FY21	93.1%	68.9%	69.8%	69.2%	62.8%	56.9%	6.9%
FY22	92.9%	68.5%	68.5%	68.5%	62.7%	54.1%	7.1%
FY23	93.0%	69.3%	69.3%	69.3%	64.0%	52.3%	7.0%
FY24	92.8%	68.3%	68.3%	68.3%	64.7%	56.0%	7.2%
FY25	92.3%	69.0%	69.2%	69.1%	61.6%	51.9%	7.7%
FY26	93.5%	69.0%	69.0%	69.0%	67.0%	51.5%	6.5%
FY27	93.3%	67.9%	67.9%	67.9%	69.9%	52.8%	6.7%
proposed	**93.5%**	**68.5%**	**68.5%**	**68.5%**	**70.0%**	**55.0%**	**6.5%**