

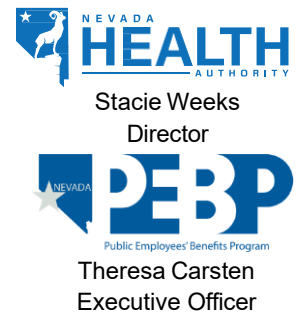


Joe Lombardo
Governor

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: August 20, 2026 9:00 a.m.

Physical Meeting Location: 3427 Goni Road, Suite 117, Carson City, NV 89706

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/1X1Q5uGTn7U>**

To submit written public comment, please upload your document to the Public Comment Upload Form located under Meetings and Events 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/89141150499>
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: 891 4115 0499 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) 684-7020 or email jcrane@nvha.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. At the discretion of the chair, the time for each individual to make comment, as well as the aggregate time for public comment, may be reasonably limited. Any such limitations will be announced at the beginning of the comment period. Additional comment periods, subject to similar limitations as announced by the chair, may be allowed on individual agenda items at the discretion of the chair. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. 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 or who wish to make comments not subject to a potential time limit may submit their public comment in writing by uploading a document to the [Public Comment Upload Form](#) located under [Meetings and Events](#) on the PEBP website, <https://www.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. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)

4. Approval of Action Minutes from the July 23, 2026 Strategic Planning Meeting. (Jim Wells, Board Chair) **(For Possible Action)**

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

6. Q4 Budget Report. (Monica McJoy, Chief Financial Officer) (Information/Discussion)

7. Discussion and possible action regarding framework for submission of Agency Budget Request for the 2028-2029 biennium. (Monica McJoy, Chief Financial Officer and Theresa Carsten, Executive Officer) **(For Possible Action)**

Topics addressed will include, but not be limited to:

- A. Administrative Enhancements;
- B. State Subsidization Policy;
- C. Other items requested by the Board; and
- D. Any Necessary Amendment to PEBP's Board and Agency Duties, Policies and Procedures Resulting from the discussion

8. Report Concerning Costs for Retired State Employees to Obtain Coverage through PEBP Under Medicare and Not Under Medicare for Transmittal to Interim Finance Committee Pursuant to NRS 297.04347. (Brandee Mooneyhan, Lead Insurance Counsel, and Debbie Donaldson, Segal) **(For Possible Action)**
9. Pharmacy Benefit Manager Rebate Changes. (Amy Donahue and Amy Daily, ESI) (Information/Discussion)
 - 9.1 Impact of Rebate Changes to the Biennial Budget and Premiums (Debbie Donaldson, Segal) (Information/Discussion)
10. NVHA Statewide Purchasing Delegation. (Theresa Carsten, Executive Officer) **(For Possible Action)**
 - 10.1 Pharmacy Benefit Manager
 - 10.2 Dental Benefit Network/Manager
 - 10.3 Actuarial Services
11. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) **(For Possible Action)**
 - 11.1 Contract Overview
 - 11.2 New Contracts
 - 11.3 Contract Amendments
 - 11.4 Status of Current Solicitations
12. Q2 & Q3 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by UMR. (Joni Amato, CTI) **(For Possible Action)**
13. Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment & Performance Report. (Chris Garcia, Willis Towers Watson/VIA) (Information/Discussion)
14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)
 - 14.1 Q3 UMR – Obesity & Diabetes Care Management
 - 14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
 - 14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management
 - 14.4 Q3 UnitedHealthcare – Basic Life Insurance
 - 14.5 Q3 Express Scripts – Utilization Report
 - 14.6 Q3 Express Scripts – Summary Report
 - 14.7 Q3 CDHP Performance Report
 - 14.8 Q3 LD PPO Performance Report
 - 14.9 Q3 EPO Performance Report
 - 14.10 Q3 HPN Performance Report
 - 14.11 Q3 Dental Performance Review
 - 14.12 Q3 Doctor on Demand Engagement Report

15. 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.
16. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at <https://www.pebp.nv.gov/meetings-events/current-board-meetings/> (under the Board Meeting date referenced above). For additional information 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://www.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://www.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 e-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. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)

4.

4. Approval of Action Minutes from July 23, 2026 Strategic Planning Meeting. (Jim Wells, Board Chair)
(For Possible Action)

**STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STRATEGIC PLANNING MEETING**

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)

July 23, 2026

**MEMBERS PRESENT
IN PERSON:**

Mr. Jim Wells, Board Chair
Dr. Keiko Duncan, Vice Chair
Mr. Jim Barnes, Member
Dr. Blaine Harper, Member
Ms. Laura Rich, Member
Mr. Christopher Viton, Member
Dr. Paul Davis, Member

**MEMBERS PRESENT VIA
TELECONFERENCE:**

Ms. Joy Grimmer, Member

MEMBERS EXCUSED:

Mr. Tom Zumtobel, Member
Dr. Jennifer McClendon, Member

FOR THE BOARD:

Mr. Jose Rivera, Deputy Attorney General

FOR STAFF:

Ms. Theresa Carsten, Executive Officer
Mr. Nik Proper, Operations Officer
Ms. Monica McJoy, Chief Financial Officer
Ms. Jessica Crane, Executive Assistant

OTHER PRESENTERS:

Andrew Sherman – Segal
Debbie Donaldson – Segal
Maryellen Vargas – Milliman
Kali Schweitzer - Milliman
Amy McClendon - Segal

1. Open Meeting; Roll Call.
 - Board Chair Wells opened the meeting at 9:02 a.m.
2. Public Comment.
 - Kent Ervin, NV Faculty Alliance
3. PEBP Board disclosures for applicable Board meeting agenda items.
(Jose Rivera , Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the May 26, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 4

MOTION: Motion to approve action minutes.

BY: Member, Jim Barnes

SECOND: Member, Paul Davis

VOTE: Unanimous, the motion carried

5. Strategic Planning Session. (Andrew Sherman, Segal) (**For Possible Action**)
Facilitated discussion providing a forum for the Board to examine priorities, goals, and strategies for PEBP to consider pursuing, including no more than one hour of discussion each regarding the following topics:
 - (a) General plan design;
 - (b) Composition of risk pools used to determine rates;
 - (c) Contracting procedures, including current and potential future contracts;
 - (d) Pharmacy benefits offered by PEBP, including potential coordination with the Nevada Health Authority; and
 - (e) Disease management/care coordination;as well as additional discussion topics that arise from the Board's conversation. It is contemplated that this session will result in direction to relevant vendors/staff to prepare presentations for Board consideration and possible action at future meeting(s).

BOARD ACTION ON ITEM 5

MOTION: No action taken.

6. 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.
7. Adjournment.

BOARD ACTION ON ITEM 14

MOTION: Motion to adjourn at 3:02 p.m.

BY: Member, Chris Viton

SECOND: Member, Laura Rich

VOTE: Unanimous, the motion carried

Items for further exploration:

Disease Management and Care Coordination:

Whole Person CC/CM vendor procurement

Carrum services expansion & mandatory participation

Improve contract terms for utilization, care, and disease management through amendments

Pharmacy Benefits:

Specialty drug management solutions

Direct rebate contracting

Plan Design:

Consolidation of plans

Full replacement of HMO

Adjusting CDHP and LD PPO actuarial value

Composition of Risk Pools:

Dependent subsidization

Moving non-Medicare retirees to State Health Exchange

Separating actives and retirees – rate separately

Contracting Procedures:

Expanding Centers of Excellence

Coordination with NV Health Authority/Medicaid

Audits

Additional items for discussion:

- Plan value comparisons
- Number of retirees using out-of-network services
- Risk scores between Northern and Southern Nevada
- Why mental health claims are paid at less than what Medicare is paying and are Doctor on Demand claims included in the analysis
- Pharmacy co-pay changes
- Is a self-funded plan better than an HMO
- What will Kaiser be offering in Northern Nevada

Disease Mgt & Care Coord.

- | | AM DOTS | FM DOTS |
|--|---|---------|
| ① Explore care navigation Carrum-like Vendor | - mandatory network
- possible expansion of Svs. | |
| ② Update Condition-specific care mgt programs | | |
| ③ Require participation to cover GLP-1s or other Benefits Mandatory | | |
| ④ <u>Additional Point Solution Vendors</u> | | |
| ⑤ Improve Contract terms for utilization, care, and disease mgt through procurement amendment | | |
| ⑥ Other: | | |
| Whole person ^{co} /CM vendor Procurement | | |

Pharmacy Benefits

+ PEBP Coordination w/NVHA

	AM DOTS	PM DOTS
① glp1 management solutions	PD	
② Specialty Drug Mgt Solutions	CL, JN, KD	KD, CL, ST, JN, CL, JN, CL, JN
③ Direct Rebate Contracting	CL, JB, KD, F, SB, PD	KD, CL, JB, ST, CL, PD
④ Narrow Formulary	SB	
⑤ Narrow Retail Network		
⑥ Point Solution Utilization Mgt		
⑦ Copay Plan Design Changes		
⑧ Other:		

PLAN DESIGN

	AM DOTS	PM DOTS
Full replacement: single or multiple plan options	BR	BR
Consolidation of existing plan options	JA, JW, BR, JS, JB	BR, JW, CV, JB
Return deductibles to historical levels prior to buydown		
Expand HMO access	CV, BR, JB	
Other (Board members add additional ideas below):		

1

2

3

4

Composition of Risk Pools

① Separate Actives & Retirees from the Risk Pool
(Rate Separately)

• Provide Supplemental \$\$ to mitigate rate increases for Non-Medicare retirees

AM DOTS PM DOTS



② Move Non-Medicare Retirees to the Exchange



③ Dependent Subsidies



④ Other (Board members add additional ideas here):



Contracting Procedures

	AMCOTS	PAIDOTS
① Procurement for Medical Claims administrator		
② Direct Contracting w/ specific hospitals/providers		
③ Direct Contracting for specific SVS (eg Ambulance)	30A	
④ Referenced-based pricing	07 9	20
⑤ Expand Centers of Excellence	30	20 20
⑥ Direct Primary Care	07 20 07	
⑦ Near-site Clinics		
⑧ Coordination w/ NVHA/Medicaid	20 20 30 07 07	20 20 20 20
⑨ Explore available programs through CMS	Combined 8 & 9	
⑩ Additional Point Solution Vendors	30A	
⑪ Audits	20 07 07 07	20 20 20
⑫ Other:		

5.

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



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Stacie Weeks
Director



Theresa Carsten
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: August 20, 2026

Item Number: 5

Title: Executive Officer Report

SUMMARY

The executive officer will provide narrative updates on the following items:

1. Plan Year 2027 Balance Forward – available cash on hand.
 - a. Reserve requirements
 - b. Possible cash flow timing issues
 - c. PEBP reserve requirements for solvency- See attached Segal report
2. Plan Year 25 Look Back Analysis – See attached Segal report.
3. 28/29 Budget Build Enhancements
4. RFP Timeline Review
5. Presentations from Vendors Interested in Future Contracts with PEBP.
 - a. How would the board like these meetings/presentations scheduled for consideration.
 - b. Will the board consider a deadline for all vendor presentations to ensure timely adjustments to RFPs can be made before posting for procurement.
 - c. EXAMPLE: Starling Oncology was referred by board member Zumtobel to meet with PEBP to discuss potential cost savings related to cancer costs.
 - i. Would the board like a presentation from this vendor in September?



Public Employees' Benefit Program Executive Officer Board Report

Theresa Carsten

Executive Officer, PEBP

August 20, 2026

Agenda

-
- 1 **Plan Year 2027 Available Cash on Hand**
 - 2 **Plan Year 2025 Look Back Analysis – See attached Segal report**
 - 3 **Budget Build Enhancements**
 - 4 **RFP Timeline Review**
 - 5 **Presentations from Future Vendors**
-

Where We Should Have Landed the End of PY 26

- \$149 M was the total needed to have operational cash for expenditures in July (PY27) and to have each reserve fully funded.
 - **121 Million for Reserves**
 - **28 Million for Operational Expenses**
- Attached is a version of an EMR report Segal supplies monthly. The attached document is for PY 26 with claims paid through June. This report shows, historically, how revenue is collected and applied to expenditures every month, and how important reserve balances are for cash flow.

Key Takeaway: PEBP's reserve balance has not recovered as needed.

Financial Snapshot of Cash on Hand PY 2027

Our costs could outpace our cashflow.

- Starting Cash: \$ 52M
- July Revenue: \$ 38.6M
- July Medical/Rx Claims: \$61.5M
- PY 27 Rate Revenue Shortfall: \$30M

Cash flow issue: staff are working with employer groups who still have outstanding July contributions to pay; and member premiums have been collected.

2027 Cash	
Revenue and Balance Forward	90.6M
Medical/RX claims	61.5M
Rate revenue shortfall	30M
Available cash	-900k

Reserve Requirements at a Glance

PY 2027	IBNR Reserve	Catastrophic Reserve	HRA Reserve
	\$62,967,000	\$53,000,000	\$5,490,934
Total Reserve Needs	\$121,457,934		
Reserve Needed for Solvency	\$68,457,934		

Plan Year 2025 Look Back Analysis

See Attached Segal Report for Full Details

Total Health Plan Claims

Month	Budget	Actual	Surplus/(Deficit)
Medical	\$243,048,782	\$270,515,232	(\$27,466,450)
CDHP	\$114,522,750	\$101,169,766	\$13,352,985
Copay	\$103,383,104	\$128,043,198	(\$24,660,095)
EPO	\$25,142,928	\$41,302,268	(\$16,159,340)
Prescription Drug	\$61,729,926	\$69,673,031	(\$7,943,105)
CDHP	\$28,601,072	\$24,804,540	\$3,796,532
Copay	\$26,629,227	\$32,462,279	(\$5,833,052)
EPO	\$6,499,627	\$12,406,212	(\$5,906,586)
Dental	\$27,991,073	\$28,522,672	(\$531,599)
Total State	\$332,769,782	\$368,710,935	(\$35,941,153)

28/29 Budget Build Enhancements

Public Employees Benefit Program					
BA 1338 Admin Account					
FY 28-29 Enhancements					
	Number of Primary Participants	45,809		45,809	
		FY 28	PEPM	FY 29	PEPM
E247	This request funds a portion of a contract pharmacist, and two contract management analysts for the oversight and monitoring of the Public Employees Benefit Programs Pharmacy Benefit Manager Vendor. The funding for these positions would be shard with the Nevada Health Authority and be housed in the Department's Pharmacy and PBM Oversight Team.	252,900	0.46	245,886	0.45
E253	This request funds an Agency Manager position to oversee the health performance metrics to be instituted in PEBP to achieve the Department's overall goal of improving the performance on key health indicators across the state; aligning the agency's purchasing strategy with the NVHA; and ensuring better vendor accountability.	161,803	0.29	209,139	0.38
E805	This request reclassifies an Administrative Assistant 1 to Accounting Assistant 3, an Accounting Assistant 2 to an Accounting Assistant 3, and Administrative Assistant 2 to and Administrative Assistant 3 commensurate with the duties of the position.	18,618	0.03	19,573	0.04
E900/E500	This request transfers an IT Professional 2 and an IT Professional 3 to the Director's Office budget account 3158 to be utilized across the department as the Department is centralizing and streamlining IT supports to ensure adequate support for this team. This also saves PEBP money as it splits the cost with the Nevada Health Authority budget for IT staff.	(142,298)	-0.26	(143,834)	-0.26
	Total PEPM		0.53		0.60

Strategic Plan Meeting Recap for RFP Discussion

Disease Management

- Whole Person CC/CM vendor procurement
- Carrum Center for Excellence – explore mandatory network for select services
- Improve current contract terms for utilization management and disease management through contract amendments.

Pharmacy

- Specialty Drug Management Solutions
- Direct Rebate Contracting

Plan Design

- Consolidation of existing plan options.

Risk Pools

- Separate Actives and Retirees
- Move Non-Medicare Retirees to the exchange
- Review Dependent Subsidies

Contracting

- Expand Centers of Excellence services
- Coordinate with NVHA and CMS
- Audit Contracting Revisions

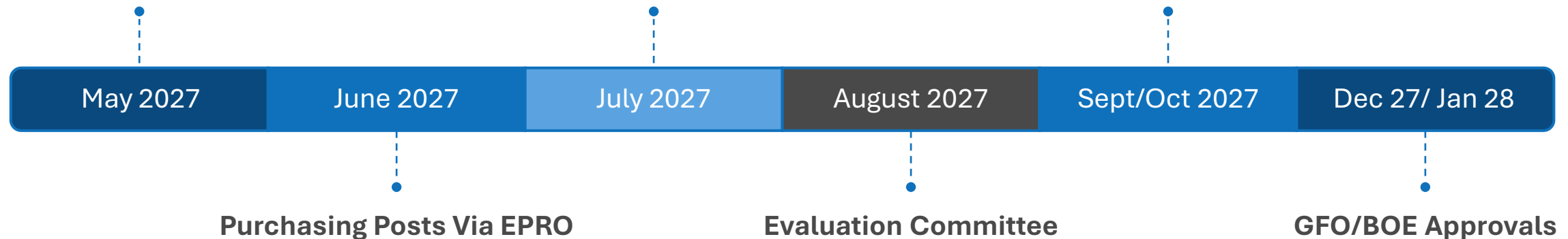
RFP Timelines and Key Milestones

This is a very tight turn around if large scope of work changes are needed for each contract.

TPA/Network/Audits/Basic
Life/Center of
Excellence/Cancer Concierge
to Purchasing

Opening Date

Contract Negotiations



Presentations from Vendors

- Board members may elect to hear from outside vendors on services available for purchase by PEBP. Things to consider:
 - **Will the board be requesting to meet with specific vendors, or are PEBP staff asked to agendaize any vendors that wish to present to the board.**
 - **Timing: presentations should be scheduled in the coming months to ensure scope of work revisions can be made timely and submitted to NVHA for review prior to releasing to Purchasing for procurement.**
 - **Budget: the budget for 28/29 does not account for large cost shifts. Any scope of work revisions, or additional vendors would require selection within our existing budget build.**

Thank You

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Plan YTD	Projected FY2026 Total
Employee/Retiree Count														
Medical/Rx														
Southern NV HMO	3,294	3,261	3,250	3,222	3,212	3,185	3,170	3,148	3,145	3,143	3,133	3,111	3,190	3,190
CDHP, EPO and Copay	29,673	29,643	29,595	29,698	29,831	29,734	29,586	29,571	29,686	29,696	29,689	29,596	29,667	29,667
Total	32,967	32,904	32,845	32,920	33,043	32,919	32,756	32,719	32,831	32,839	32,822	32,707	32,856	32,856
Dental	41,946	41,927	41,886	41,975	42,098	41,966	41,820	41,702	41,825	41,811	41,818	41,698	41,873	41,873
Accruals														
Southern NV HMO														
Participant Contributions	\$234,944	\$422,323	\$2,235,242	\$1,202,376	\$478,669	\$1,442,110	\$1,027,503	\$1,578,274	\$1,054,155	\$1,053,966	\$1,043,477	\$1,048,488	\$12,821,529	\$12,821,529
Employer Contributions	\$3,160,146	\$3,045,660	\$3,210,915	\$3,298,103	\$3,118,834	\$3,052,850	\$3,156,818	\$5,249,593	\$2,753,665	\$3,515,247	\$3,285,521	\$3,201,164	\$40,048,516	\$40,048,516
Sub-total	\$3,395,090	\$3,467,983	\$5,446,158	\$4,500,479	\$3,597,503	\$4,494,960	\$4,184,321	\$6,827,867	\$3,807,820	\$4,569,213	\$4,328,997	\$4,249,653	\$52,870,045	\$52,870,045
CDHP, EPO and Copay														
Participant Contributions	\$1,568,466	\$2,389,885	\$11,142,189	\$6,160,314	\$2,726,312	\$7,298,444	\$5,324,204	\$7,951,172	\$5,445,682	\$5,452,571	\$5,399,058	\$5,454,656	\$66,312,953	\$66,312,953
Employer Contributions	\$28,237,587	\$27,588,373	\$28,583,292	\$28,678,735	\$28,288,009	\$26,186,626	\$28,163,404	\$48,389,620	\$25,048,030	\$30,999,551	\$29,603,313	\$28,276,151	\$358,042,690	\$358,042,690
Sub-total	\$29,806,053	\$29,978,258	\$39,725,481	\$34,839,048	\$31,014,321	\$33,485,070	\$33,487,608	\$56,340,792	\$30,493,712	\$36,452,122	\$35,002,371	\$33,730,807	\$424,355,643	\$424,355,643
Dental														
Participant Contributions	\$537,886	\$553,696	\$1,133,262	\$803,356	\$596,958	\$869,508	\$745,234	\$900,234	\$755,015	\$763,440	\$747,415	\$744,789	\$9,150,994	\$9,150,994
Employer Contributions	\$1,704,877	\$1,664,433	\$1,726,291	\$1,733,787	\$1,706,713	\$1,583,155	\$1,700,561	\$2,917,148	\$1,512,101	\$1,872,753	\$1,786,697	\$1,708,168	\$21,616,683	\$21,616,683
Sub-total	\$2,242,763	\$2,218,329	\$2,859,553	\$2,537,143	\$2,303,672	\$2,452,663	\$2,445,795	\$3,817,382	\$2,267,116	\$2,636,193	\$2,534,112	\$2,452,957	\$30,767,678	\$30,767,678
Total Premium Accrued	\$35,443,906	\$35,664,570	\$48,031,192	\$41,876,671	\$36,915,496	\$40,432,693	\$40,117,724	\$66,986,042	\$36,568,648	\$43,657,529	\$41,865,480	\$40,433,416	\$507,993,366	\$507,993,366
Claims														
Medical/Rx														
Southern NV HMO	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CDHP, EPO and Copay	\$32,358,308	\$17,561,697	\$35,445,356	\$30,847,230	\$21,312,611	\$33,934,510	\$30,513,088	\$26,398,546	\$34,225,343	\$41,511,337	\$28,342,503	\$37,081,783	\$369,532,312	\$369,532,312
COVID Reimbursements	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$32,358,308	\$17,561,697	\$35,445,356	\$30,847,230	\$21,312,611	\$33,934,510	\$30,513,088	\$26,398,546	\$34,225,343	\$41,511,337	\$28,342,503	\$37,081,783	\$369,532,312	\$369,532,312
Dental	\$2,804,056	\$2,635,563	\$2,423,974	\$2,909,010	\$2,005,633	\$2,618,052	\$2,407,815	\$2,324,775	\$2,571,152	\$2,410,013	\$2,149,644	\$2,680,028	\$29,939,715	\$29,939,715
Total Adjusted Claims	\$35,162,364	\$20,197,261	\$37,869,330	\$33,756,240	\$23,318,244	\$36,552,562	\$32,920,903	\$28,723,321	\$36,796,495	\$43,921,351	\$30,492,146	\$39,761,812	\$399,472,027	\$399,472,027
Expenses														
Administrative Expenses1														
Southern NV HMO	\$4,286,013	\$4,249,146	\$4,255,476	\$4,245,600	\$4,205,086	\$4,164,146	\$4,163,908	\$4,130,721	\$4,502,995	\$4,111,784	\$4,109,795	\$4,065,825	\$50,490,495	\$50,490,495
CDHP, EPO and Copay	\$1,932,719	\$1,384,700	\$2,390,668	\$2,737,085	\$2,395,451	\$2,119,171	\$2,264,766	\$2,345,209	\$2,084,618	\$2,525,697	\$2,656,131	\$2,472,772	\$27,308,986	\$27,308,986
Dental	\$87,248	\$87,208	\$87,123	\$87,308	\$87,564	\$87,289	\$86,986	\$86,740	\$86,996	\$86,981	\$86,732	\$86,732	\$1,045,142	\$1,045,142
Sub-total	\$6,305,979	\$5,721,055	\$6,733,267	\$7,069,992	\$6,688,101	\$6,370,606	\$6,515,660	\$6,562,670	\$6,674,609	\$6,724,448	\$6,852,907	\$6,625,329	\$78,844,623	\$78,844,623
HSA Contributions	\$6,656,275	\$102,619	\$50,558	\$63,650	\$33,641	\$32,516	\$0	-\$525	\$0	\$0	\$0	\$0	\$6,938,734	\$6,938,734
HRA Claims	\$573,069	\$527,487	\$470,500	\$485,928	\$351,912	\$386,989	\$356,027	\$324,537	\$353,328	\$337,364	\$295,170	\$342,330	\$4,804,640	\$4,804,640
Total Expenses	\$13,535,323	\$6,351,160	\$7,254,325	\$7,619,570	\$7,073,654	\$6,790,111	\$6,871,687	\$6,886,682	\$7,027,936	\$7,061,812	\$7,148,078	\$6,967,659	\$90,587,997	\$90,587,997
Summary														
Southern NV HMO														
Total Premiums & Expenses	\$4,286,013	\$4,249,146	\$4,255,476	\$4,245,600	\$4,205,086	\$4,164,146	\$4,163,908	\$4,130,721	\$4,502,995	\$4,111,784	\$4,109,795	\$4,065,825	\$50,490,495	\$50,490,495
Surplus Gain/(Loss)	(\$890,923)	(\$781,163)	\$1,190,682	\$254,879	(\$607,583)	\$330,814	\$20,412	\$2,697,147	(\$695,175)	\$457,430	\$219,202	\$183,828	\$2,379,551	\$2,379,551
Loss Ratio	126.2%	122.5%	78.1%	94.3%	116.9%	92.6%	99.5%	60.5%	118.3%	90.0%	94.9%	95.7%	95.5%	95.5%
CDHP, EPO and Copay														
Total Claims & Expenses	\$41,520,371	\$19,576,503	\$38,357,082	\$34,133,692	\$24,093,615	\$36,473,166	\$33,133,880	\$29,087,766	\$38,663,289	\$44,374,398	\$31,293,804	\$39,696,886	\$408,584,673	\$408,584,673
Surplus Gain/(Loss)	(\$11,714,318)	\$10,401,754	\$1,368,399	\$705,156	\$6,920,706	(\$2,988,117)	\$353,728	\$27,273,026	(\$6,169,578)	(\$7,922,276)	\$3,708,567	(\$6,166,079)	\$15,770,970	\$15,770,970
Loss Ratio	139.3%	65.3%	96.6%	98.0%	77.7%	108.9%	98.9%	51.6%	120.2%	121.7%	69.4%	118.3%	96.3%	96.3%
Dental														
Total Claims & Expenses	\$2,891,304	\$2,722,771	\$2,511,097	\$2,996,318	\$2,093,196	\$2,705,341	\$2,494,801	\$2,411,515	\$2,658,148	\$2,496,980	\$2,236,625	\$2,766,760	\$30,984,857	\$30,984,857
Surplus Gain/(Loss)	(\$648,541)	(\$504,443)	\$348,456	(\$459,175)	\$210,475	(\$252,678)	(\$49,006)	\$1,405,667	(\$391,031)	\$139,213	\$297,487	(\$313,803)	(\$217,180)	(\$217,180)
Loss Ratio	128.9%	122.7%	87.7%	118.1%	90.9%	110.3%	102.0%	63.2%	117.2%	94.7%	88.3%	112.8%	100.7%	100.7%
Total														
Total Claims & Expenses	\$48,697,688	\$26,548,421	\$45,123,655	\$41,375,810	\$30,391,697	\$43,342,674	\$39,792,590	\$35,610,003	\$43,824,431	\$50,983,162	\$37,640,224	\$46,729,471	\$490,060,025	\$490,060,025
Surplus Gain/(Loss)	(\$13,253,781)	\$9,116,149	\$2,907,537	\$500,861	\$6,523,598	(\$2,909,981)	\$325,135	\$31,376,039	(\$7,255,784)	(\$7,325,633)	\$4,225,256	(\$6,296,055)	\$17,933,341	\$17,933,341
Loss Ratio	137.4%	74.4%	93.9%	98.8%	82.3%	107.2%	99.2%	63.2%	119.8%	116.8%	89.9%	115.6%	96.5%	96.5%
Accumulated Surplus/(Shortfall)	(\$13,253,781)	(\$4,137,632)	(\$1,230,096)	(\$729,235)	\$5,794,363	\$2,884,383	\$3,209,517	\$34,585,556	\$27,329,773	\$20,004,140	\$24,229,396	\$17,933,341	\$17,933,341	\$17,933,341

Nevada Public Employees' Benefits Program

Plan Year 2025 - Look Back Analysis

Summary of Self-funded Claims, HSA/HRA Contributions, HSA Expense and HRA Claims Experience

State Health Plan Claims

Month	Budget	Actual	Surplus/(Deficit)
Medical	\$239,737,483	\$266,777,908	(\$27,040,425)
CDHP	\$111,922,592	\$98,829,861	\$13,092,731
Copay	\$103,130,776	\$127,402,311	(\$24,271,536)
EPO	\$24,684,115	\$40,545,736	(\$15,861,620)
Prescription Drug	\$60,350,594	\$68,602,399	(\$8,251,805)
CDHP	\$27,523,949	\$24,040,855	\$3,483,094
Copay	\$26,521,059	\$32,245,842	(\$5,724,783)
EPO	\$6,305,586	\$12,315,701	(\$6,010,115)
Dental	\$25,916,420	\$26,338,766	(\$422,347)
Total State	\$326,004,496	\$361,719,073	(\$35,714,577)

Non-State Health Plan Claims

Month	Budget	Actual	Surplus/(Deficit)
Medical	\$3,311,299	\$3,737,324	(\$426,025)
CDHP	\$2,600,158	\$2,339,905	\$260,254
Copay	\$252,328	\$640,887	(\$388,559)
EPO	\$458,813	\$756,532	(\$297,719)
Prescription Drug	\$1,379,332	\$1,070,632	\$308,700
CDHP	\$1,077,123	\$763,684	\$313,439
Copay	\$108,168	\$216,437	(\$108,269)
EPO	\$194,041	\$90,511	\$103,530
Dental	\$2,074,654	\$2,183,906	(\$109,252)
Total State	\$6,765,285	\$6,991,862	(\$226,577)

Total Health Plan Claims

Month	Budget	Actual	Surplus/(Deficit)
Medical	\$243,048,782	\$270,515,232	(\$27,466,450)
CDHP	\$114,522,750	\$101,169,766	\$13,352,985
Copay	\$103,383,104	\$128,043,198	(\$24,660,095)
EPO	\$25,142,928	\$41,302,268	(\$16,159,340)
Prescription Drug	\$61,729,926	\$69,673,031	(\$7,943,105)
CDHP	\$28,601,072	\$24,804,540	\$3,796,532
Copay	\$26,629,227	\$32,462,279	(\$5,833,052)
EPO	\$6,499,627	\$12,406,212	(\$5,906,586)
Dental	\$27,991,073	\$28,522,672	(\$531,599)
Total State	\$332,769,782	\$368,710,935	(\$35,941,153)

Nevada Public Employees' Benefits Program

Plan Year 2025 - Look Back Analysis

Self-funded Medical/HSA and HRA Contributions/HSA Expenses/HRA Claims

State Medical Claims

CDHP						Copay					EPO					Total				
Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	13,626	22,353	\$20,027,871	\$14,277,454	\$5,750,418	11,630	22,241	\$11,667,631	\$10,432,879	\$1,234,751	2,815	5,222	\$2,865,053	\$4,779,064	(\$1,914,011)	28,071	49,817	\$34,560,555	\$29,489,397	\$5,071,158
Aug-24	13,649	22,367	\$8,309,156	\$5,943,211	\$2,365,946	11,715	22,409	\$8,044,887	\$10,061,031	(\$2,016,144)	2,796	5,197	\$2,020,793	\$3,502,355	(\$1,481,562)	28,160	49,972	\$18,374,836	\$19,506,596	(\$1,131,760)
Sep-24	13,604	22,314	\$8,230,187	\$6,366,937	\$1,863,250	11,816	22,596	\$8,084,333	\$9,900,432	(\$1,816,099)	2,772	5,143	\$2,005,436	\$3,200,130	(\$1,194,694)	28,192	50,054	\$18,319,956	\$19,467,500	(\$1,147,544)
Oct-24	13,779	22,494	\$8,399,846	\$7,534,892	\$864,954	11,951	22,822	\$8,173,822	\$9,629,376	(\$1,455,553)	2,766	5,120	\$2,000,298	\$3,104,631	(\$1,104,333)	28,496	50,437	\$18,573,967	\$20,268,899	(\$1,694,932)
Nov-24	13,885	22,641	\$8,414,971	\$6,913,945	\$1,501,026	12,068	23,056	\$8,239,470	\$10,974,229	(\$2,734,759)	2,759	5,119	\$1,995,778	\$2,629,554	(\$633,776)	28,712	50,817	\$18,650,220	\$20,517,729	(\$1,867,509)
Dec-24	13,987	22,720	\$8,409,019	\$7,391,140	\$1,017,880	12,180	23,242	\$8,294,691	\$9,660,658	(\$1,365,967)	2,755	5,107	\$1,993,790	\$2,734,213	(\$740,422)	28,922	51,070	\$18,697,500	\$19,786,010	(\$1,088,510)
Jan-25	13,918	22,659	\$8,338,387	\$8,235,333	\$103,054	12,217	23,255	\$8,319,371	\$11,638,476	(\$3,319,105)	2,747	5,098	\$1,984,367	\$3,225,850	(\$1,241,483)	28,882	51,013	\$18,642,125	\$23,099,659	(\$4,457,534)
Feb-25	13,959	22,688	\$8,342,035	\$6,769,011	\$1,573,024	12,375	23,526	\$8,419,450	\$9,859,970	(\$1,440,520)	2,737	5,086	\$1,978,357	\$3,300,752	(\$1,322,394)	29,071	51,300	\$18,739,842	\$19,929,733	(\$1,189,891)
Mar-25	14,068	22,804	\$8,416,063	\$7,793,321	\$622,742	12,442	23,649	\$8,455,332	\$11,786,348	(\$3,331,017)	2,734	5,064	\$1,975,227	\$3,288,444	(\$1,313,216)	29,244	51,518	\$18,846,622	\$22,868,113	(\$4,021,491)
Apr-25	14,062	22,782	\$8,391,849	\$9,674,612	(\$1,282,763)	12,500	23,756	\$8,461,125	\$12,184,354	(\$3,723,229)	2,722	5,042	\$1,962,889	\$4,838,559	(\$2,875,671)	29,284	51,581	\$18,815,863	\$26,697,526	(\$7,881,663)
May-25	14,064	22,755	\$8,368,273	\$9,395,599	(\$1,027,325)	12,533	23,830	\$8,503,447	\$11,254,796	(\$2,751,349)	2,714	5,034	\$1,957,986	\$3,166,338	(\$1,208,352)	29,311	51,620	\$18,829,707	\$23,816,733	(\$4,987,027)
Jun-25	13,964	22,658	\$8,274,934	\$8,534,408	(\$259,474)	12,509	23,773	\$8,467,217	\$10,019,760	(\$1,552,543)	2,696	4,990	\$1,944,140	\$2,775,845	(\$831,705)	29,169	51,422	\$18,686,291	\$21,330,013	(\$2,643,722)
Total	13,880	22,603	\$111,922,592	\$98,829,861	\$13,092,731	12,161	23,180	\$103,130,776	\$127,402,311	(\$24,271,536)	2,751	5,102	\$24,684,115	\$40,545,736	(\$15,861,620)	28,793	50,885	\$239,737,483	\$266,777,908	(\$27,040,425)
PMPY			\$4,951.62	\$4,372.38	\$579.24			\$4,449.17	\$5,496.27	(\$1,047.10)			\$4,838.14	\$7,947.05	(\$3,108.91)			\$4,711.36	\$5,242.76	(\$531.40)

Non-State Medical Claims

CDHP						Copay					EPO					Total				
Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	304	355	\$390,282	\$133,193	\$257,090	30	45	\$23,364	\$104,155	(\$80,791)	47	67	\$38,995	\$16,888	\$22,107	381	466	\$452,641	\$254,236	\$198,406
Aug-24	302	352	\$205,919	\$112,488	\$93,431	29	44	\$22,585	\$13,880	\$8,705	47	67	\$38,995	\$5,118	\$33,877	378	462	\$267,499	\$131,485	\$136,013
Sep-24	302	352	\$205,919	\$119,384	\$86,535	29	44	\$22,585	\$8,506	\$14,079	47	67	\$38,995	\$16,490	\$22,505	378	462	\$267,499	\$144,380	\$123,119
Oct-24	300	349	\$204,555	\$111,414	\$93,141	27	41	\$21,027	\$15,220	\$5,807	47	65	\$38,995	\$14,381	\$24,614	374	454	\$264,577	\$141,016	\$123,561
Nov-24	298	346	\$203,191	\$251,737	(\$48,546)	26	39	\$20,249	\$20,809	(\$561)	46	64	\$38,165	\$84,310	(\$46,145)	370	448	\$261,605	\$356,856	(\$95,251)
Dec-24	295	342	\$201,146	\$268,898	(\$67,753)	26	39	\$20,249	\$11,974	\$8,274	46	64	\$38,165	\$20,471	\$17,694	367	444	\$259,560	\$301,343	(\$41,784)
Jan-25	295	342	\$201,146	\$145,269	\$55,877	26	39	\$20,249	\$12,810	\$7,439	46	64	\$38,165	\$16,670	\$21,495	367	444	\$259,560	\$174,748	\$84,811
Feb-25	291	338	\$198,418	\$329,166	(\$130,748)	27	41	\$21,027	\$359,460	(\$338,433)	46	64	\$38,165	\$11,713	\$26,452	364	442	\$257,611	\$700,339	(\$442,728)
Mar-25	290	338	\$197,737	\$87,308	\$110,429	26	39	\$20,249	\$49,219	(\$28,970)	46	64	\$38,165	\$47,747	(\$9,582)	362	440	\$256,150	\$184,274	\$71,877
Apr-25	291	338	\$198,418	\$143,940	\$54,478	26	39	\$20,249	\$8,166	\$12,083	45	62	\$37,336	\$13,726	\$23,610	362	438	\$256,002	\$165,832	\$90,171
May-25	290	337	\$197,737	\$170,172	\$27,564	26	39	\$20,249	\$18,043	\$2,205	45	62	\$37,336	\$12,736	\$24,600	361	437	\$255,321	\$200,951	\$54,370
Jun-25	287	333	\$195,691	\$466,935	(\$271,244)	26	39	\$20,249	\$18,645	\$1,603	45	62	\$37,336	\$496,283	(\$458,948)	358	433	\$253,275	\$981,864	(\$728,589)
Total	295	343	\$2,600,158	\$2,339,905	\$260,254	27	40	\$252,328	\$640,887	(\$388,559)	46	64	\$458,813	\$756,532	(\$297,719)	369	448	\$3,311,299	\$3,737,324	(\$426,025)
PMPY			\$7,576.24	\$6,817.92	\$758.32			\$6,243.17	\$15,857.00	(\$9,613.84)			\$7,162.82	\$11,810.71	(\$4,647.89)			\$7,396.73	\$8,348.38	(\$951.65)

Nevada Public Employees' Benefits Program

Plan Year 2025 - Look Back Analysis

Self-funded Prescription Drug Claims and SavOnSP Claims, Net of Rebates

State Rx Claims

CDHP						Copay					EPO					Total				
Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	13,626	22,353	\$2,251,621	\$1,560,325	\$691,296	11,630	22,241	\$2,113,529	\$2,422,760	(\$309,232)	2,815	5,222	\$537,674	\$1,063,576	(\$525,903)	28,071	49,817	\$4,902,824	\$5,046,662	(\$143,838)
Aug-24	13,649	22,367	\$2,255,422	\$1,823,559	\$431,863	11,715	22,409	\$2,128,976	\$2,524,106	(\$395,130)	2,796	5,197	\$534,045	\$1,057,514	(\$523,469)	28,160	49,972	\$4,918,443	\$5,405,179	(\$486,736)
Sep-24	13,604	22,314	\$2,247,986	\$1,898,228	\$349,758	11,816	22,596	\$2,147,331	\$2,706,351	(\$559,020)	2,772	5,143	\$529,461	\$1,113,207	(\$583,746)	28,192	50,054	\$4,924,777	\$5,717,786	(\$793,008)
Oct-24	13,779	22,494	\$2,276,904	\$2,071,935	\$204,969	11,951	22,822	\$2,171,864	\$2,602,355	(\$430,491)	2,766	5,120	\$528,315	\$983,475	(\$455,160)	28,496	50,437	\$4,977,083	\$5,657,765	(\$680,682)
Nov-24	13,885	22,641	\$2,294,420	\$2,009,908	\$284,511	12,068	23,056	\$2,193,127	\$2,872,228	(\$679,102)	2,759	5,119	\$526,978	\$972,904	(\$445,927)	28,712	50,817	\$5,014,524	\$5,855,041	(\$840,517)
Dec-24	13,987	22,720	\$2,311,275	\$1,696,357	\$614,918	12,180	23,242	\$2,213,481	\$2,548,583	(\$335,103)	2,755	5,107	\$526,214	\$990,576	(\$464,362)	28,922	51,070	\$5,050,969	\$5,235,516	(\$184,547)
Jan-25	13,918	22,659	\$2,299,873	\$2,201,406	\$98,467	12,217	23,255	\$2,220,205	\$2,613,674	(\$393,469)	2,747	5,098	\$524,686	\$1,112,721	(\$588,035)	28,882	51,013	\$5,044,763	\$5,927,801	(\$883,038)
Feb-25	13,959	22,688	\$2,306,648	\$1,878,322	\$428,326	12,375	23,526	\$2,248,918	\$2,311,962	(\$63,044)	2,737	5,086	\$522,776	\$772,849	(\$250,073)	29,071	51,300	\$5,078,341	\$4,963,133	\$115,208
Mar-25	14,068	22,804	\$2,324,660	\$2,104,387	\$220,272	12,442	23,649	\$2,261,094	\$2,727,035	(\$465,941)	2,734	5,064	\$522,203	\$932,649	(\$410,446)	29,244	51,518	\$5,107,956	\$5,764,071	(\$656,115)
Apr-25	14,062	22,782	\$2,323,668	\$2,298,355	\$25,313	12,500	23,756	\$2,271,634	\$2,778,829	(\$507,195)	2,722	5,042	\$519,910	\$1,149,938	(\$630,028)	29,284	51,581	\$5,115,213	\$6,227,123	(\$1,111,910)
May-25	14,064	22,755	\$2,323,999	\$2,309,446	\$14,553	12,533	23,830	\$2,277,632	\$2,963,758	(\$686,126)	2,714	5,034	\$518,382	\$1,202,864	(\$684,481)	29,311	51,620	\$5,120,013	\$6,476,067	(\$1,356,055)
Jun-25	13,964	22,658	\$2,307,474	\$2,188,626	\$118,849	12,509	23,773	\$2,273,270	\$3,174,201	(\$900,931)	2,696	4,990	\$514,944	\$963,429	(\$448,485)	29,169	51,422	\$5,095,688	\$6,326,256	(\$1,230,567)
Total	13,880	22,603	\$27,523,949	\$24,040,855	\$3,483,094	12,161	23,180	\$26,521,059	\$32,245,842	(\$5,724,783)	2,751	5,102	\$6,305,586	\$12,315,701	(\$6,010,115)	28,793	50,885	\$60,350,594	\$68,602,399	(\$8,251,805)
PMPY			\$1,217.70	\$1,063.60	\$154.10			\$1,144.15	\$1,391.12	(\$246.97)			\$1,235.91	\$2,413.90	(\$1,177.99)			\$1,186.02	\$1,348.19	(\$162.17)

Non-State Rx Claims

CDHP						Copay					EPO					Total				
Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	304	355	\$92,368	\$33,024	\$59,345	30	45	\$10,016	\$7,816	\$2,200	47	67	\$16,492	\$11,854	\$4,637	381	466	\$118,876	\$52,694	\$66,182
Aug-24	302	352	\$91,761	\$55,075	\$36,685	29	44	\$9,682	\$15,735	(\$6,053)	47	67	\$16,492	\$9,665	\$6,826	378	462	\$117,934	\$80,476	\$37,458
Sep-24	302	352	\$91,761	\$69,038	\$22,722	29	44	\$9,682	\$13,773	(\$4,091)	47	67	\$16,492	\$9,394	\$7,098	378	462	\$117,934	\$92,205	\$25,729
Oct-24	300	349	\$91,153	\$67,866	\$23,287	27	41	\$9,014	\$13,554	(\$4,540)	47	65	\$16,492	\$4,966	\$11,526	374	454	\$116,659	\$86,385	\$30,273
Nov-24	298	346	\$90,545	\$62,845	\$27,700	26	39	\$8,680	\$18,218	(\$9,538)	46	64	\$16,141	\$5,509	\$10,632	370	448	\$115,366	\$86,572	\$28,794
Dec-24	295	342	\$89,634	\$58,779	\$30,855	26	39	\$8,680	\$14,243	(\$5,563)	46	64	\$16,141	\$9,630	\$6,511	367	444	\$114,455	\$82,651	\$31,803
Jan-25	295	342	\$89,634	\$77,310	\$12,323	26	39	\$8,680	\$21,240	(\$12,559)	46	64	\$16,141	\$6,216	\$9,925	367	444	\$114,455	\$104,766	\$9,689
Feb-25	291	338	\$88,418	\$49,368	\$39,050	27	41	\$9,014	\$25,755	(\$16,741)	46	64	\$16,141	\$6,519	\$9,622	364	442	\$113,573	\$81,642	\$31,931
Mar-25	290	338	\$88,114	\$66,039	\$22,075	26	39	\$8,680	\$26,064	(\$17,384)	46	64	\$16,141	\$6,222	\$9,919	362	440	\$112,935	\$98,325	\$14,610
Apr-25	291	338	\$88,418	\$71,876	\$16,542	26	39	\$8,680	\$18,885	(\$10,205)	45	62	\$15,790	\$4,278	\$11,512	362	438	\$112,888	\$95,040	\$17,849
May-25	290	337	\$88,114	\$73,343	\$14,771	26	39	\$8,680	\$23,881	(\$15,201)	45	62	\$15,790	\$7,271	\$8,519	361	437	\$112,585	\$104,496	\$8,089
Jun-25	287	333	\$87,203	\$79,120	\$8,082	26	39	\$8,680	\$17,273	(\$8,593)	45	62	\$15,790	\$8,987	\$6,803	358	433	\$111,673	\$105,380	\$6,293
Total	295	343	\$1,077,123	\$763,684	\$313,439	27	40	\$108,168	\$216,437	(\$108,269)	46	64	\$194,041	\$90,511	\$103,530	369	448	\$1,379,332	\$1,070,632	\$308,700
PMPY			\$3,138.48	\$2,225.19	\$913.29			\$2,676.33	\$5,355.14	(\$2,678.81)			\$3,029.29	\$1,413.02	\$1,616.27			\$3,081.13	\$2,391.56	\$689.57

Nevada Public Employees' Benefits Program

Plan Year 2025 - Look Back Analysis

Self-funded Dental Claims

State Dental Claims

Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	37,301	62,530	\$2,116,832	\$2,440,109	(\$323,277)
Aug-24	37,394	62,692	\$2,122,110	\$2,220,661	(\$98,551)
Sep-24	37,457	62,810	\$2,125,685	\$2,005,764	\$119,920
Oct-24	37,784	63,230	\$2,144,242	\$2,360,184	(\$215,942)
Nov-24	38,018	63,639	\$2,157,522	\$1,968,913	\$188,609
Dec-24	38,233	63,896	\$2,169,723	\$1,913,818	\$255,905
Jan-25	38,191	63,859	\$2,167,339	\$2,332,204	(\$164,865)
Feb-25	38,333	64,075	\$2,175,398	\$2,102,642	\$72,756
Mar-25	38,504	64,270	\$2,185,102	\$2,127,713	\$57,389
Apr-25	38,541	64,340	\$2,187,202	\$2,365,813	(\$178,612)
May-25	38,540	64,330	\$2,187,145	\$2,112,944	\$74,201
Jun-25	38,381	64,114	\$2,178,122	\$2,388,001	(\$209,879)
Total	38,056	63,649	\$25,916,420	\$26,338,766	(\$422,347)
PMPY			\$407.18	\$413.82	(\$6.64)

Non-State Dental Claims

Month	Employee Count	Member Count	Budget	Actual	Surplus/(Deficit)
Jul-24	3,684	4,120	\$176,685	\$211,904	(\$35,219)
Aug-24	3,673	4,107	\$176,157	\$184,009	(\$7,852)
Sep-24	3,662	4,095	\$175,630	\$192,105	(\$16,475)
Oct-24	3,648	4,081	\$174,958	\$211,018	(\$36,059)
Nov-24	3,633	4,062	\$174,239	\$155,135	\$19,104
Dec-24	3,621	4,047	\$173,663	\$146,775	\$26,888
Jan-25	3,606	4,031	\$172,944	\$176,877	(\$3,933)
Feb-25	3,570	3,993	\$171,217	\$173,027	(\$1,810)
Mar-25	3,557	3,978	\$170,594	\$183,691	(\$13,097)
Apr-25	3,541	3,959	\$169,826	\$193,598	(\$23,772)
May-25	3,535	3,952	\$169,539	\$177,101	(\$7,562)
Jun-25	3,528	3,942	\$169,203	\$178,667	(\$9,464)
Total	3,605	4,031	\$2,074,654	\$2,183,906	(\$109,252)
PMPY			\$514.70	\$541.80	(\$27.10)

Nevada Public Employees' Benefits Program

Plan Year 2025 - Look Back Analysis

IBNR - Expected vs. Actual Runout

State

Estimated IBNR at 6/30/2025*							
Plan	IBNR	10% Catastrophic Margin	Expense Margin	Total	Actual Runout as of 6/30/2026	Difference (\$\$) (Claims Only)	Difference (%) (Claims Only)
Medical	\$43,409,000	\$4,341,000	\$0	\$47,750,000	\$44,087,030	\$678,030	1.6%
CDHP	\$15,709,000	\$1,570,000	\$0	\$17,279,000	\$17,432,678	\$1,723,678	11.0%
EPO	\$10,199,000	\$1,021,000	\$0	\$11,220,000	\$4,765,531	(\$5,433,469)	-53.3%
Copay	\$17,501,000	\$1,750,000	\$0	\$19,251,000	\$21,888,821	\$4,387,821	25.1%
Rx	\$4,293,000	\$0	\$0	\$4,293,000	\$4,030,576	(\$262,424)	-6.1%
Dental	\$1,604,000	\$161,000	\$0	\$1,765,000	\$1,276,946	(\$327,054)	-20.4%
State Total	\$49,306,000	\$4,502,000	\$0	\$53,808,000	\$49,394,552	\$88,552	0.2%

Non-State

Estimated IBNR at 6/30/2025*							
Plan	IBNR	10% Catastrophic Margin	Expense Margin	Total	Actual Runout as of 6/30/2026	Difference (\$\$) (Claims Only)	Difference (%) (Claims Only)
Medical	\$519,000	\$51,000	\$0	\$570,000	\$1,845,357	\$1,326,357	255.6%
CDHP	\$444,000	\$44,000	\$0	\$488,000	\$951,821	\$507,821	114.4%
EPO	\$42,000	\$4,000	\$0	\$46,000	\$509,822	\$467,822	1113.9%
Copay	\$33,000	\$3,000	\$0	\$36,000	\$383,714	\$350,714	1062.8%
Rx	\$71,000	\$0	\$0	\$71,000	\$66,314	(\$4,686)	-6.6%
Dental	\$138,000	\$14,000	\$0	\$152,000	\$110,064	(\$27,936)	-20.2%
Non-State Total	\$728,000	\$65,000	\$0	\$793,000	\$2,021,735	\$1,293,735	177.7%

Total

Estimated IBNR at 6/30/2025*							
Plan	IBNR	10% Catastrophic Margin	Expense Margin	Total	Actual Runout as of 6/30/2026	Difference (\$\$) (Claims Only)	Difference (%) (Claims Only)
Medical	\$43,928,000	\$4,392,000	\$0	\$48,320,000	\$45,932,387	\$2,004,387	4.6%
CDHP	\$16,153,000	\$1,614,000	\$0	\$17,767,000	\$18,384,499	\$2,231,499	13.8%
EPO	\$10,241,000	\$1,025,000	\$0	\$11,266,000	\$5,275,354	(\$4,965,646)	-48.5%
Copay	\$17,534,000	\$1,753,000	\$0	\$19,287,000	\$22,272,535	\$4,738,535	27.0%
Rx	\$4,364,000	\$0	\$0	\$4,364,000	\$4,096,889	(\$267,111)	-6.1%
Dental	\$1,742,000	\$175,000	\$0	\$1,917,000	\$1,387,010	(\$354,990)	-20.4%
State Total	\$50,034,000	\$4,567,000	\$0	\$54,601,000	\$51,416,287	\$1,382,287	2.8%



Deborah Donaldson, FSA, MAAA
Senior Vice President
M 303.908.9031
ddonaldson@segalco.com

7951 E Maplewood Avenue
Suite 327
Greenwood Village, CO 80111-4774
segalco.com

August 4, 2026

Monica McJoy, MPA, MHA
Chief Financial Officer
Public Employees' Benefits Program
3427 Goni Road Suite 109
Carson City, NV 89706

Re: Estimate of IBNR as of June 30, 2026

Dear Monica:

Segal has completed its evaluation of the State of Nevada Public Employees' Benefits Program (PEBP) liability for claims that were Incurred but Not Reported (IBNR) as of June 30, 2026. The reserve is calculated to estimate the outstanding liability for covered services received prior to July 1, 2026 and paid after June 30, 2026. Our estimate of incurred but not reported (IBNR) claims includes unreported claims, reported but unprocessed claims, and claims processed but unpaid by your administrator. Segal has estimated the reserves for the PEBP's self-insured active and retiree medical, prescription drug, and dental plans to be **\$62,967,000** as of June 30, 2026. This is an increase of \$8,366,000 or 15.3% from the prior reserve estimate as of June 30, 2025.

The IBNR estimates by coverage as of June 30, 2026 are shown in the following table. Medical and dental IBNR estimates include a 10% catastrophic margin. Prescription drug IBNR estimates do not include a margin due to the minimal time between claim adjudication and plan payment. Included in the FY2026 Prescription Drug IBNR figures is an estimate of incurred but not paid tertiary claims attributable to the SaveOnSP program in the amount of \$504,000.

Benefit Plan	FY2025			FY2026		
	CDHP	Premier (EPO)	Copay	CDHP	Premier (EPO)	Copay
Medical	\$16,153,000	\$10,241,000	\$17,534,000	\$19,956,000	\$5,377,000	\$25,945,000
10% Margin	\$1,164,000	\$1,025,000	\$1,753,000	\$1,995,000	\$538,000	\$2,593,000
Prescription Drugs	<u>\$1,562,000</u>	<u>\$769,000</u>	<u>\$2,033,000</u>	<u>\$1,820,000</u>	<u>\$766,000</u>	<u>\$2,741,000</u>
Total Medical IBNR	\$19,329,000	\$12,035,000	\$21,320,000	\$23,771,000	\$6,681,000	\$31,279,000
	Dental			Dental		
Dental		\$1,742,000			\$1,123,000	
10% Margin		<u>\$175,000</u>			<u>\$113,000</u>	
Total Dental IBNR		\$1,917,000			\$1,236,000	
	Total			Total		
Total All Reserves	\$54,601,000			\$62,967,000		

The change in liabilities from the previous reserve estimate incorporates ongoing migration to the Copay plan, which has a lower benefit value than the EPO and a faster claims processing rate than the CDHP option. Higher deductible plans generally have slower processing rate than plans with a point-of-sale copay-based benefit structure.

	CDHP	Premier (EPO)	Copay	Total
FY2025	22,946	5,166	23,220	51,333
FY2026	22,308	4,431	25,509	52,249
Percent Change	-2.8%	-14.2%	9.9%	1.8%

Due to the anticipated plan design and contribution changes for FY2027, we have observed higher medical and pharmacy claims over the last few months of the plan year, specifically April through June 2026. It is not uncommon for members to incur more expenses in response to expected plan design or contribution changes if they plan to migrate to a lower cost plan with less generous benefits the following year. Our estimates incorporate incurred and paid claims through June 30, 2026.

Our estimate does not include any amounts for accounts payable due to claims paid by UMR or Express Scripts prior to July 1, 2026, that had been recorded on the carrier's lag report as paid on or before June 30, 2026. Furthermore, if your financial statements identify actual amounts known to be paid after June 30, 2026 for services that were incurred prior to July 1, 2026 (e.g. recorded as an account payable) from the unknown amounts, those known amounts should be subtracted from the estimated liability we have provided so that the total amount of known and unknown liability remains equal to our estimated IBNR. A breakdown of liabilities by coverage, plan, State/Non-State and eligibility status can be found in Exhibits I, II and III. A description of our standard calculation methodology, which was employed for our Medical, Prescription Drug, and Dental estimates, is also enclosed.

Our Medical and Dental estimates rely upon claims paid through June 30, 2026, as furnished by UMR. Our Prescription Drug estimates rely upon claims paid through June 30, 2026 as furnished by Express Scripts. We did not audit this data, and our review was limited to determining that it appears to be reasonable and acceptable for the projection of outstanding liabilities under the plan. The estimated number of months of claims covered by the IBNR are shown below, by plan and coverage.

Benefit Plan	FY2025			FY2026		
	CDHP	Premier (EPO)	Copay	CDHP	Premier (EPO)	Copay
Medical	2.2	2.8	1.8	2.4	1.7	2.2
Prescription Drugs	0.5	0.5	0.5	0.5	0.5	0.5
	Dental			Dental		
Dental	0.7			0.4		
	Overall			Overall		
Total IBNR	1.6	2.0	1.4	1.8	1.3	1.6

Catastrophic Reserve

PEBP determined the appropriate Catastrophic Reserve level to be 45 days of claims. We have estimated the Catastrophic Reserve to be \$53.0 million as of June 30, 2026 for PEBP's CDHP, Premier (EPO) and Copay plans. This is based on the projected total claims incurred for FY2026 (\$442,534,000).

Plan	As of 6/30/2025 (45 days)	As of 6/30/2026 (45 days)
CDHP	\$16,539,000	\$18,592,000
Premier (EPO)	\$8,305,000	\$7,178,000
Copay	\$21,681,000	\$27,240,000
Total	\$46,525,000	\$53,010,000

Actuarial Certification

We certify to the best of our knowledge, the data, methods, and assumptions used to develop the estimated liability for IBNR claims are reasonable and are calculated in accordance with generally accepted and consistently applied actuarial principles. Although our conclusions are based on assumptions and methods that are reasonable for this purpose, actual experience can vary from our estimate, and this difference may be material. This estimate is intended to measure PEBP's liability for unpaid claims as of June 30, 2026 and it should not be relied upon for any other purpose.

This document has been prepared for the exclusive use and benefit of the Nevada PEBP, based upon information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. Except as required by law or required for the Nevada PEBP's proper administration, this document should not be copied, reproduced, or shared with other parties without Segal's consent and, in such instances, should only be shared in its entirety. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

I am a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a Member of the American Academy of Actuaries. I meet the *Qualification Standards for Actuaries Issuing Statements of Opinion in the United States* promulgated by the American Academy of Actuaries and am qualified to render an opinion with regard to loss reserves, actuarial liabilities, and related items.

Sincerely yours,

A handwritten signature in dark ink, reading "Deborah L. Donaldson". The signature is fluid and cursive, with the first name "Deborah" and last name "Donaldson" clearly legible.

Deborah Donaldson, FSA, MAAA
Senior Vice President

cc: Theresa Carsten, Executive Officer

Exhibit I Medical IBNR Estimate

Plan	IBNR Reserves as of June 30, 2025	IBNR Reserves as of June 30, 2026	Change %	% of Prior 12 Months Paid Claims	10% Margin	Total IBNR with Margin
CDHP						
State						
Actives	\$11,207,000	\$13,446,000	20.0%	18.5%	\$1,345,000	\$14,791,000
Retirees	<u>\$4,502,000</u>	<u>\$5,941,000</u>	<u>32.0%</u>	<u>24.3%</u>	<u>\$594,000</u>	<u>\$6,535,000</u>
Sub-total	\$15,709,000	\$19,387,000	23.4%	19.9%	\$1,939,000	\$21,326,000
Non-State						
Actives	\$4,000	\$2,000	-50.0%	18.3%	\$0	\$2,000
Retirees	<u>\$440,000</u>	<u>\$567,000</u>	<u>28.9%</u>	<u>24.4%</u>	<u>\$56,000</u>	<u>\$623,000</u>
Sub-total	\$444,000	\$569,000	28.2%	24.3%	\$56,000	\$625,000
<i>Plan Total</i>	<i>\$16,153,000</i>	<i>\$19,956,000</i>	<i>23.5%</i>	<i>20.0%</i>	<i>\$1,995,000</i>	<i>\$21,951,000</i>
EPO						
State						
Actives	\$9,142,000	\$3,845,000	-57.9%	12.9%	\$385,000	\$4,230,000
Retirees	<u>\$1,057,000</u>	<u>\$1,353,000</u>	<u>28.0%</u>	<u>20.9%</u>	<u>\$135,000</u>	<u>\$1,488,000</u>
Sub-total	\$10,199,000	\$5,198,000	-49.0%	14.3%	\$520,000	\$5,718,000
Non-State						
Actives	\$1,000	\$1,000	0.0%	22.0%	\$0	\$1,000
Retirees	<u>\$41,000</u>	<u>\$178,000</u>	<u>334.1%</u>	<u>20.9%</u>	<u>\$18,000</u>	<u>\$196,000</u>
Sub-total	\$42,000	\$179,000	326.2%	20.9%	\$18,000	\$197,000
<i>Plan Total</i>	<i>\$10,241,000</i>	<i>\$5,377,000</i>	<i>-47.5%</i>	<i>14.5%</i>	<i>\$538,000</i>	<i>\$5,915,000</i>
Copay						
State						
Actives	\$16,112,000	\$23,828,000	47.9%	18.5%	\$2,382,000	\$26,210,000
Retirees	<u>\$1,389,000</u>	<u>\$2,033,000</u>	<u>46.4%</u>	<u>13.8%</u>	<u>\$203,000</u>	<u>\$2,236,000</u>
Sub-total	\$17,501,000	\$25,861,000	47.8%	18.0%	\$2,585,000	\$28,446,000
Non-State						
Actives	\$3,000	\$12,000	300.0%	18.5%	\$1,000	\$13,000
Retirees	<u>\$30,000</u>	<u>\$72,000</u>	<u>140.0%</u>	<u>13.9%</u>	<u>\$7,000</u>	<u>\$79,000</u>
Sub-total	\$33,000	\$84,000	154.5%	14.4%	\$8,000	\$92,000
<i>Plan Total</i>	<i>\$17,534,000</i>	<i>\$25,945,000</i>	<i>48.0%</i>	<i>18.0%</i>	<i>\$2,593,000</i>	<i>\$28,538,000</i>
Grand Total	\$43,928,000	\$51,278,000	16.7%	18.2%	\$5,126,000	\$56,404,000

Exhibit II Prescription Drug IBNR Estimate

Plan	IBNR Reserves as of June 30, 2025	IBNR Reserves as of June 30, 2026	Change %	% of Prior 12 Months Paid Claims	0% Margin	Total IBNR with Margin
CDHP	\$1,562,000	\$1,820,000	16.5%	4.5%	\$0	\$1,820,000
EPO	\$769,000	\$779,000	-0.4%	4.5%	\$0	\$766,000
Copay	\$2,033,000	\$2,787,000	34.8%	4.5%	\$0	\$2,741,000
Grand Total	\$4,364,000	\$5,327,000	22.1%	4.5%	\$0	\$5,327,000

- Estimates do not reflect the impact of any pharmaceutical manufacturer rebates due to PEBP resulting from the utilization of brand drugs.
- Estimates for PY2025 include an estimate of SaveOnSP tertiary claims IBNR of \$424,000.
- Estimates for PY2026 include an estimate of SaveOnSP tertiary claims IBNR of \$504,000.

Exhibit III Dental IBNR Estimate

Plan	IBNR Reserves as of June 30, 2025	IBNR Reserves as of June 30, 2026	Change %	% of Prior 12 Months Paid Claims	10% Margin	Total IBNR with Margin
State						
Actives	\$1,163,000	\$770,000	-33.8%	3.7%	\$77,000	\$847,000
Retirees	<u>\$441,000</u>	<u>\$272,000</u>	<u>-38.3%</u>	<u>3.7%</u>	<u>\$28,000</u>	<u>\$300,000</u>
Sub-total	\$1,604,000	\$1,042,000	-35.0%	3.7%	\$105,000	\$1,147,000
Non-State						
Actives	\$0	\$0	-100.0%	0.0%	\$0	\$0
Retirees	<u>\$138,000</u>	<u>\$81,000</u>	<u>-41.3%</u>	<u>3.7%</u>	<u>\$8,000</u>	<u>\$89,000</u>
Sub-total	\$138,000	\$81,000	-41.3%	3.7%	\$8,000	\$89,000
Grand Total	\$1,742,000	\$1,123,000	-35.5%	3.7%	\$113,000	\$1,236,000

**Exhibit IV
FY2026 Average Employee Count**

Group	Medical			Dental
	CDHP	Premier (EPO)	Copay	
State				
Active	11,489	1,958	12,359	28,617
<u>Retiree</u>	<u>2,010</u>	<u>441</u>	<u>1,066</u>	<u>9,799</u>
Sub-total	13,499	2,399	13,425	38,416
Non-State				
Active	7	3	3	12
<u>Retiree</u>	<u>267</u>	<u>43</u>	<u>22</u>	<u>3,445</u>
Sub-total	273	46	25	3,457
Total	13,772	2,445	13,450	41,873

**Medical IBNR – CDHP Plan
As of 6/30/2026**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-23	24,156	\$7,598,397	\$8,646,799	\$8,646,799	\$0	1.000
Jan-24	23,958	\$7,430,385	\$7,878,500	\$7,878,500	\$0	1.000
Feb-24	23,900	\$7,518,863	\$8,069,386	\$8,069,386	\$0	1.000
Mar-24	23,916	\$11,623,045	\$8,732,840	\$8,732,840	\$0	1.000
Apr-24	23,938	\$8,926,423	\$7,788,050	\$7,788,050	\$0	1.000
May-24	23,901	\$9,870,588	\$9,159,259	\$9,159,259	\$0	1.000
Jun-24	23,861	\$7,946,209	\$8,095,994	\$8,095,994	\$0	1.000
Jul-24	22,708	\$8,334,467	\$6,559,938	\$6,559,938	\$0	1.000
Aug-24	22,719	\$6,380,604	\$5,571,027	\$5,574,378	\$3,350	0.999
Sep-24	22,666	\$5,989,149	\$6,075,775	\$6,088,697	\$12,922	0.998
Oct-24	22,843	\$8,127,940	\$7,199,028	\$7,231,033	\$32,005	0.996
Nov-24	22,987	\$6,316,132	\$6,808,615	\$6,847,084	\$38,468	0.994
Dec-24	23,062	\$6,627,227	\$7,317,533	\$7,362,987	\$45,454	0.994
Jan-25	23,001	\$8,190,535	\$8,080,440	\$8,142,955	\$62,515	0.992
Feb-25	23,026	\$7,720,077	\$6,884,753	\$6,971,014	\$86,261	0.988
Mar-25	23,142	\$7,096,312	\$7,602,010	\$7,703,881	\$101,871	0.987
Apr-25	23,120	\$7,113,585	\$9,534,933	\$9,673,048	\$138,116	0.986
May-25	23,092	\$8,216,419	\$9,336,647	\$9,503,365	\$166,718	0.982
Jun-25	22,991	\$8,241,387	\$8,745,832	\$8,923,190	\$177,357	0.980
Jul-25	22,526	\$7,863,638	\$7,216,463	\$7,414,467	\$198,004	0.973
Aug-25	22,446	\$7,181,740	\$7,227,520	\$7,480,523	\$253,003	0.966
Sep-25	22,384	\$8,502,858	\$6,908,548	\$7,170,063	\$261,515	0.964
Oct-25	22,400	\$7,963,029	\$7,844,542	\$8,213,278	\$368,736	0.955
Nov-25	22,491	\$6,124,206	\$6,753,703	\$7,161,688	\$407,986	0.943
Dec-25	22,402	\$8,992,964	\$6,636,029	\$7,149,194	\$513,165	0.928
Jan-26	22,242	\$7,674,419	\$7,866,791	\$8,688,284	\$821,493	0.905
Feb-26	22,137	\$8,217,530	\$7,252,987	\$8,272,731	\$1,019,744	0.877
Mar-26	22,212	\$9,482,071	\$8,339,159	\$10,072,366	\$1,733,207	0.828
Apr-26	22,204	\$9,649,690	\$6,929,894	\$9,115,235	\$2,185,341	0.760
May-26	22,187	\$9,531,436	\$5,840,050	\$9,496,424	\$3,656,374	0.615
Jun-26	22,070	\$8,386,184	\$2,369,581	\$10,041,897	<u>\$7,672,316</u>	0.236
					\$19,955,922	

**Medical IBNR – EPO Plan
As of 6/30/2026**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-23	5,724	\$3,734,840	\$4,296,199	\$4,296,199	\$0	1.000
Jan-24	5,698	\$4,057,469	\$3,666,643	\$3,666,643	\$0	1.000
Feb-24	5,674	\$3,811,471	\$4,809,894	\$4,809,894	\$0	1.000
Mar-24	5,654	\$4,446,221	\$3,669,961	\$3,669,961	\$0	1.000
Apr-24	5,623	\$4,461,541	\$3,652,242	\$3,652,242	\$0	1.000
May-24	5,616	\$4,361,346	\$3,461,341	\$3,461,341	\$0	1.000
Jun-24	5,562	\$4,204,369	\$3,144,691	\$3,144,691	\$0	1.000
Jul-24	5,289	\$3,582,436	\$4,713,502	\$4,713,502	\$0	1.000
Aug-24	5,264	\$5,825,669	\$3,420,425	\$3,422,761	\$2,336	0.999
Sep-24	5,210	\$3,577,342	\$3,164,207	\$3,167,333	\$3,126	0.999
Oct-24	5,185	\$4,875,613	\$3,056,430	\$3,059,344	\$2,914	0.999
Nov-24	5,183	\$3,034,408	\$2,668,522	\$2,671,484	\$2,962	0.999
Dec-24	5,171	\$3,482,849	\$2,710,309	\$2,717,626	\$7,318	0.997
Jan-25	5,162	\$3,081,845	\$3,201,391	\$3,213,095	\$11,704	0.996
Feb-25	5,149	\$3,270,523	\$3,284,164	\$3,304,669	\$20,505	0.994
Mar-25	5,128	\$3,752,750	\$3,308,121	\$3,329,382	\$21,261	0.994
Apr-25	5,104	\$3,124,377	\$4,825,342	\$4,861,847	\$36,505	0.992
May-25	5,096	\$3,176,290	\$3,147,962	\$3,175,347	\$27,385	0.991
Jun-25	5,052	\$3,958,172	\$3,240,046	\$3,273,204	\$33,158	0.990
Jul-25	4,621	\$3,426,113	\$3,633,402	\$3,664,080	\$30,679	0.992
Aug-25	4,565	\$2,493,498	\$2,897,744	\$2,936,411	\$38,666	0.987
Sep-25	4,544	\$3,002,461	\$4,339,642	\$4,402,504	\$62,863	0.986
Oct-25	4,505	\$2,681,531	\$2,148,618	\$2,199,247	\$50,629	0.977
Nov-25	4,475	\$2,690,524	\$2,204,589	\$2,278,805	\$74,216	0.967
Dec-25	4,444	\$2,515,953	\$2,663,318	\$2,809,658	\$146,339	0.948
Jan-26	4,422	\$2,881,221	\$2,427,264	\$2,590,749	\$163,485	0.937
Feb-26	4,376	\$2,950,634	\$2,588,494	\$2,845,174	\$256,680	0.910
Mar-26	4,352	\$2,764,824	\$2,945,260	\$3,365,283	\$420,023	0.875
Apr-26	4,329	\$7,141,052	\$2,797,400	\$3,392,590	\$595,190	0.825
May-26	4,300	\$3,329,475	\$2,449,137	\$3,418,008	\$968,871	0.717
Jun-26	4,245	\$1,293,397	\$800,462	\$3,200,142	<u>\$2,399,679</u>	0.250
					\$5,376,493	

**Medical IBNR – Copay Plan
As of 6/30/2026**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-23	18,844	\$6,650,543	\$7,170,738	\$7,170,738	\$0	1.000
Jan-24	18,936	\$8,547,177	\$7,111,224	\$7,111,224	\$0	1.000
Feb-24	19,222	\$7,401,970	\$6,454,032	\$6,454,032	\$0	1.000
Mar-24	19,520	\$8,877,729	\$7,875,038	\$7,875,038	\$0	1.000
Apr-24	19,770	\$7,529,176	\$8,457,549	\$8,457,549	\$0	1.000
May-24	19,925	\$9,354,190	\$8,532,546	\$8,532,546	\$0	1.000
Jun-24	20,108	\$6,955,036	\$7,484,987	\$7,484,987	\$0	1.000
Jul-24	22,286	\$8,132,949	\$10,043,508	\$10,043,508	\$0	1.000
Aug-24	22,452	\$8,061,678	\$9,604,452	\$9,612,596	\$8,145	0.999
Sep-24	22,640	\$9,246,520	\$9,607,197	\$9,622,323	\$15,126	0.998
Oct-24	22,863	\$9,924,783	\$9,286,582	\$9,306,306	\$19,724	0.998
Nov-24	23,095	\$8,255,479	\$10,783,696	\$10,813,709	\$30,013	0.997
Dec-24	23,281	\$9,959,254	\$9,441,170	\$9,471,208	\$30,038	0.997
Jan-25	23,294	\$10,981,331	\$11,447,692	\$11,490,192	\$42,500	0.996
Feb-25	23,567	\$10,906,753	\$10,080,409	\$10,125,746	\$45,336	0.996
Mar-25	23,688	\$9,439,359	\$11,639,841	\$11,695,695	\$55,854	0.995
Apr-25	23,795	\$11,540,189	\$12,020,140	\$12,194,570	\$174,430	0.986
May-25	23,869	\$10,582,354	\$11,132,004	\$11,300,214	\$168,210	0.985
Jun-25	23,812	\$9,207,291	\$9,891,475	\$10,053,875	\$162,399	0.984
Jul-25	25,181	\$13,160,574	\$10,281,399	\$10,472,940	\$191,541	0.982
Aug-25	25,252	\$9,148,953	\$11,770,519	\$12,027,906	\$257,387	0.979
Sep-25	25,299	\$12,947,500	\$10,549,396	\$10,840,462	\$291,066	0.973
Oct-25	25,462	\$10,731,685	\$12,348,225	\$12,801,535	\$453,311	0.965
Nov-25	25,584	\$9,485,284	\$9,677,091	\$10,253,246	\$576,155	0.944
Dec-25	25,516	\$12,482,584	\$11,759,063	\$12,646,691	\$887,628	0.930
Jan-26	25,457	\$10,799,660	\$11,375,725	\$12,528,062	\$1,152,337	0.908
Feb-26	25,579	\$13,071,548	\$9,808,374	\$11,118,988	\$1,310,614	0.882
Mar-26	25,663	\$12,023,583	\$11,616,881	\$13,694,691	\$2,077,810	0.848
Apr-26	25,660	\$14,224,281	\$10,240,086	\$13,120,975	\$2,880,889	0.780
May-26	25,727	\$12,658,994	\$8,803,279	\$13,065,009	\$4,261,730	0.674
Jun-26	25,727	\$13,651,497	\$3,883,568	\$14,735,061	<u>\$10,851,493</u>	0.264
					\$25,943,735	

Data, Assumptions, and Methodology

We have relied upon claims and membership data provided by UMR, Express Scripts and LifeWorks, with payments through June 30, 2026. We accepted this information without audit and have relied upon the source for the accuracy of the data; however, we did review the information for reasonableness and consistency. On the basis of this review, we believe the data and information provided to be sufficiently complete and accurate, and that it is appropriate for the purposes intended.

Assumptions and Methodology – Segal IBNR reserve model

The Segal IBNR model utilizes **detailed** monthly claims data that shows the amount of monthly claim dollars paid in each month of the reserve determination period relative to the month services were incurred. We project total Incurred Claims by month and then subtract known Paid Claim runoff by incurred month to calculate the completion factors for the estimated IBNR reserves. This method results in highly accurate estimates of IBNR reserves in large stable environments.

Calculation Methodology

Consistent with best practices in the industry, Segal blends two distinct methods to estimate monthly incurred claims:

1. *Claims Lag Method* - The first method estimates incurred claims by determining the payment patterns for each month of incurred claims. For example, for claims incurred in September 2025, we will review claims paid in September, October, November, and each succeeding month through June 2026. We review each month's payment patterns and utilize these cashflows to estimate the remaining claims to be paid that have been incurred for each month.
2. *Claims Projection Method* – The second method develops a projected per capita total incurred claims estimate for each month. This estimate is based on the expected total incurred claims for prior months, trended forward and adjusted for plan changes. The per capita incurred claims are multiplied by that month's enrollment and the total paid claims reported to date are subtracted to determine the expected incurred but not paid for that month.

The first method (Claims Lag Method) generally provides better estimates for more mature months, meaning months with more paid claims data. The second method (Claims Projection Method) generally provides better estimates for more recent months, where there is less paid data available. Our approach develops an estimate for each method for each month and blends the two based on the relative credibility, resulting in the Claims Lag Method estimates receiving more weight for older months and the Claims Projection Method estimates receiving more weight for recent months

6.

6. Q4 Budget Report. (Monica McJoy, Chief Financial Officer)
(Information/Discussion)



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

Joe Lombardo
Governor

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: August 20, 2026

Item Number: 6

Title: Chief Financial Officer Q4 Budget Report

FY26 BUDGET SUMMARY

This report provides an overview of the Operation Budget. The budget status as of June 30, 2026, is shown below. The report is prepared on a cash basis and does not include all income owed to the Health Fund. As of June 30, 2026, actual income totaled \$616.1 million, compared to the published budget of \$690.1 million. FY26 expenses closed at \$563.6 million, which is \$5.2 million below budget. Realized Funding Available (cash) is reported at \$52.5 million. This budget reflects end-of-year actual totals.

BUDGETED & ACTUAL INCOME (BUDGET ACCOUNT 1338)				
Description	Budget	Actuals as of 6/30/2026	Difference	% Remaining
Funds Carried Forward from Prior Year	66,888,128	66,888,128	-	
State Subsidies (4325)	440,038,912	402,815,609	(37,223,303)	-8.5%
Non-State Subsidies (4321)	22,214,260	19,173,850	(3,040,410)	-13.7%
State Premium Income (4323)	110,047,197	84,872,781	(25,174,416)	-22.9%
Non-State Premium Income (4319)	5,015,705	2,736,950	(2,278,755)	-45.4%
All Other Income	45,957,505	39,679,865	(6,277,640)	-13.7%
Total Income	690,161,707	616,167,183	(73,994,524)	-10.7%

BUDGETED & ACUTAL EXPENSES (BUDGET ACCOUNT 1338)				
Description	Budget	Actuals as of 6/30/2026	Difference	
Operating	7,521,240	6,597,737	(923,503)	-12.3%
State Insurance Costs (40)	504,507,236	507,977,628	3,470,392	0.7%
Non-State Ins, Costs (42)	7,972,679	7,957,636	(15,043)	-0.2%
Medicare Retiree Ins. Costs (44)	48,857,573	41,119,941	(7,737,632)	-15.8%
Total Insurance Costs	561,337,488	557,055,205	(4,282,283)	-0.8%
Total Expenses	568,858,728	563,652,942	(5,205,786)	-0.9%
Total Budgeted Revenue	616,167,183			
Less Total Expenditures	(563,652,942)			
Balance Remaining	52,514,241			
Less Actuary Estimated Reserves	(121,302,979)			
Over/(Under) Reserves	(68,788,738)			

7.

7. Discussion and possible action regarding framework for submission of Agency Budget Request for the 2028-2029 biennium. (Monica McJoy, Chief Financial Officer and Theresa Carsten, Executive Officer) (**For Possible Action**)
- A. Administrative Enhancements;
 - B. State Subsidization Policy;
 - C. Other items requested by the Board; and
 - D. Any Necessary Amendment to PEBP's Board and Agency Duties, Policies and Procedures Resulting from the discussion

7D.

7. Discussion and possible action regarding framework for submission of Agency Budget Request for the 2028-2029 biennium. (Monica McJoy, Chief Financial Officer and Theresa Carsten, Executive Officer) **(For Possible Action)**
 - A. Administrative Enhancements;
 - B. State Subsidization Policy;
 - C. Other items requested by the Board; and
 - D. Any Necessary Amendment to PEBP's Board and Agency Duties, Policies and Procedures Resulting from the 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

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

As approved by the Board

On

8/20/268

~~(Pending chart on page 21)~~

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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 relevant education

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 of influence.
- Be willing to adopt and abide by Duties, Policies and Procedures that preclude and inhibit misconduct.
- Eliminate the wasteful use of resources; and
- Embrace the concepts of sound cost effective measures.

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 be found 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 204 Carson City, Nevada 89703 Telephone: 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 ACCOUNTABILITY ACT (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 and Security 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 in 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"

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- 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 using agency to appoint members of the Board to evaluation committees pursuant to [NRS 333.335](#).
 - e. The duty of negotiating and administering the contracts is delegated 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 the Board other than the confidential review of the proposals pursuant to [NRS 333.335](#) may be taken or conducted by the evaluation 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 checklist 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 actuaries which fund the plan(s) for the forthcoming plan year on an actuarially sound basis. Rates so established will be sufficient to fund anticipated paid claims 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 2019-2021 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:

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- 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 claim trends 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, 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 is equal to the HSA contribution.
 - ✓ 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. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryover limit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.

Retirees cannot have more than \$8,000 in HRA funds on June 1 of each year. Any funds over and above \$8,000 will be reverted to the State.

- Self-Funded Plan Designs: See Master Plan Documents for details.
- Benefits other than medical, prescription, and vision: See Master Plan Documents for details.
 - ✓ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
 - ✓ Basic Life Insurance - fully insured
- Voluntary Benefits Option/s:
 - ✓ Flexible Spending Account (FSA) – [IRS section 125](#) voluntary plan guaranteed by PEBP. For active employees only, employees with an HSA are not eligible for a Medical FSA.
 - ✓ Additional Life Insurance – voluntary; fully insured

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- ✓ 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 included participants in all self-funded plans.
- 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)

- 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.
- Actuarial calculations by plan will reflect the costs associated with adults and children and result in the following:

<u>Consumer Driven Health Plan (CDHP)</u>			
<u>Adult</u>	<u>X</u>		
<u>Children</u>	<u>A</u>		
<u>Low Deductible Preferred Provider Organization Plan (LDPPO)</u>			
<u>Adult</u>	<u>Y</u>		
<u>Children</u>	<u>B</u>		
<u>Exclusive Provider Organization/Health Maintenance Organization Plan (EPO/HMO)</u>			
<u>Adult</u>	<u>Z</u>		
<u>Children</u>	<u>C</u>		
	<u>CDHP</u>	<u>LDPPO</u>	<u>EPO/HMO</u>
<u>Single</u>	<u>X+G</u>	<u>Y+G</u>	<u>Z+G</u>
<u>Single + Spouse</u>	<u>2X+G</u>	<u>2Y+G</u>	<u>2Z+G</u>
<u>Single + Child(ren)</u>	<u>X+A+G</u>	<u>Y+B+G</u>	<u>Z+C+G</u>
<u>Single + Family</u>	<u>2X+A+G</u>	<u>2Y+B+G</u>	<u>2Z+C+G</u>
<u>G = General Overhead Costs</u>			

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)
 - ✓ 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 self-funded participants:
 - ✓ Contracted CDHP administrative fees
 - ✓ HSA/HRA plan contributions
 - ✓ Rx Rebates (RGL 4218)
 - ✓ Adjustments to Catastrophic Reserves (Category 85) in accordance with reserve 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 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.
- Subsidy percentages (percent of premium paid by employee/retiree)
 - Active Employees: 6.5%

- Percentage based on CDHP total employee rate.
- Active Employee Dependents (active subsidy + 25%): 31.5%
 - Percentage applies to the dependent portion of the total CDHP rate, not the total rate
- Retirees: 30%
- Retiree Dependents (retiree subsidy+25%): 55%
 - Percentage applies to the dependent portion of the total rate, not the total rate itself.

PEBP reserves the right to adjust the YOS subsidy or the Retiree Only CDHP REGI contribution percentage subsidy amount would be determined such that it would result in no less than \$0 premium for members with 20 or more years of services.

- Retiree Years of Service (YOS) subsidy adjustment to the base subsidy ([NRS 287.046](#)):
 - ✓ 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.

Note for future rate setting: If a flat subsidy is used across all plans and is calculated on the base plan (CDHP), should the claims costs increase for the LDPPO and EPO/HMO plans at a higher trend rate (inflation+utilization) than the CDHP plan, the participant share for the LDPPO and EPO/HMO plans will increase at a faster rate unless plan design changes are made to offset the trend increases.

8.

8. Report Concerning Costs for Retired State Employees to Obtain Coverage through PEBP Under Medicare and Not Under Medicare for Transmittal to Interim Finance Committee Pursuant to NRS 297.04347. (Brandee Mooneyhan, Lead Insurance Counsel, and Debbie Donaldson, Segal) **(For Possible Action)**



Nevada Public Employees' Benefit Program (PEBP)

Results of Nevada PEBP Retiree Plan Offerings

Nevada Revised Statute 287.04347

July 2026



Deborah Donaldson, FSA, MAAA
Senior Vice President
M 303.908.9031
ddonaldson@segalco.com

7951 E Maplewood Avenue
Suite 327
Greenwood Village, CO
80111-4774
segalco.com

July 31, 2026

Theresa Carsten
Executive Officer
Nevada Health Authority
Public Employees' Benefit Program
3427 Goni Road, Suite 109
Carson City, NV 89706

Re: NV PEBP: Retiree Medical Legislation Analysis of NRS 287.04347

Dear Ms. Carsten:

At the request of Nevada Public Employees' Benefits Program (NV PEBP), Segal has performed an analysis pursuant to Nevada Revised Statute 287.04347. Segal has collaborated with Via Benefits who provided supporting information for Medicare retirees participating in the PEBP Via Benefits program. The attached report incorporates underlying assumptions incorporated into the analysis and details of the results.

In summary, the premiums paid by members participating in Via Benefits, including eligible HRA contributions, are lower than under PEBP programs, incorporating all eligible subsidies. In addition, PEBP retirees can find plans in the individual market that are at least equal to actuarial values as PEBP programs, in many cases, higher actuarial values for lower premiums, after consideration of eligible subsidies and HRA contributions.

Please see the attached report and let us know a convenient time to discuss the results. We would be pleased to address any questions.

Regards,

A handwritten signature in dark ink, appearing to read "Debbie Donaldson", is positioned above the typed name.

Debbie Donaldson, FSA, MAAA
Senior Vice President

cc: Stacie Weeks, Director, Nevada Health Authority
Brandee Mooneyhan, Lead Insurance Counsel, PEBP
Amy McClendon, FSA, MAAA, Vice President, Segal
Trevis Parson, Senior Managing Director, Chief Actuary, Via Benefits
Christopher Garcia, Senior Director Client Management, Via Benefits

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Overview

Nevada Public Employees' Benefits Program (PEBP) engaged Segal Consulting in coordination with Via Benefits to provide an analysis to support requirements outlined in NRS 287.04347. Segal determined the actuarial value (AV) of medical and pharmacy benefits offered under the PEBP Program. For comparison, Via Benefits provided the AV of benefits offered under traditional Medicare, various individual Medicare Supplement Plan offerings along with Part D, and individual Medicare Advantage plans with Part D (MAPD) that are offered to Medicare eligible retirees in Nevada under Via Benefits. This comparison satisfies NRS 287.04347(1)(a).

The analysis indicated that from an actuarial perspective, Medicare benefits offered to retirees in the individual market under Via Benefits tend to provide a higher actuarial value as compared to benefits offered to retirees in the PEBP program. This is largely due to the underlying traditional Medicare program Parts A and B and standalone Part D which have a combined actuarial value of 81%. Segal determined actuarial values, both medical and pharmacy combined in Nevada, range from 86% to 94% in actuarial value for the individual market plans available to PEBP members and were included in this study.

In addition, to comply with NRS 287.04347(2), premiums offered under PEBP program were compared to premiums offered with comparable as possible actuarial values for Medicare Supplement plans as well as Part D coverage in regions with largest Via Benefits PEBP membership concentration by age brackets. Additionally, Via Benefits provided MAPD plan actuarial values with \$0 premiums offered in Nevada for comparison. Lastly, dental and vision premiums offered under Medicare Advantage Plans were analyzed for regions with largest PEBP membership concentration.

For Via Benefits, the largest membership concentrations were in the Clark and Washoe Counties and Carson City. The premiums analyzed and utilized incorporates benefit offerings in these counties when compared to premiums offered under PEBP programs in this report. Subsidies for both PEBP plan retirees and HRA service-related contributions were considered and compared across the various retiree groups and incorporated when comparing premiums for retirees under PEBP program and Via Benefits.

From a premium perspective, in most scenarios reviewed, premiums available through Via Benefits were lower than premiums under the PEBP plan offerings for Medicare eligible retirees. Actuarial values were equal to or greater than PEBP plans through Via Benefits, taking into consideration eligible PEBP subsidies for various retiree groups.

NRS 287.04347 Excerpt

Below is the excerpt of the Nevada Revised Statute 287.04347 used as a guideline for the analysis:

- 1. To the extent that money and resources are available for this purpose, on or before August 31 of each even-numbered year, the Board shall:*
 - (a) Compile a report concerning the cost for a retired state employee to obtain coverage through the Program under Medicare that is actuarially comparable to the coverage provided through the Program but not under Medicare; and*
 - (b) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to the Interim Finance Committee.*
- 2. The report compiled pursuant to subsection 1 must consider, without limitation:*
 - (a) The cost of the lowest premium charged in this State for coverage pursuant to Medicare Part B, 42 U.S.C. §§ 1395j et seq.;*
 - (b) The average cost in this State to obtain a Medicare supplemental policy that provides comparable benefits to those provided under the applicable plan of health insurance offered under the Program;*
 - (c) The average cost in this State to obtain coverage of prescription drugs under Medicare Part D, 42 U.S.C. §§ 1395w-101 et seq.; and*
 - (d) The average cost in this State to obtain dental and vision coverage, other than limited coverage, through a Medicare Advantage Plan under Medicare Part C, 42 U.S.C. §§ 1395w-21 et seq.*
- 3. The Board may utilize the resources of the Authority, including, without limitation, the Office of Data Analytics of the Authority and persons and entities with which the Authority has contracted, to prepare the report required by this section.*

Analysis Background

Segal was directed by PEBP staff, and in collaboration with Via Benefits, to analyze benefits and premiums under the PEBP Plans to those offered to Medicare eligible members in the individual market through Via Benefits for retirees residing in Nevada. This analysis is based on NRS 287.04347. The analysis incorporates PEBP Program Plan Year 2026 premiums and benefit offerings. For the Via Benefits plans, premiums are provided on a calendar year basis to coincide with Medicare plan year schedule, and therefore, our analysis incorporates 2026 calendar year Nevada plan offerings and premiums under Via Benefits.

Associated Subsidies to Offset Total Premiums

Based on eligibility, there are different subsidies offered to retirees under PEBP benefit program. These annual subsidies to eligible members are used to offset the total premium for a given plan year and can vary by amount depending on eligibility criteria. For PEBP members participating in Via Benefits, there are annual Health Reimbursement Account (HRA) contributions made by PEBP that may be available to certain retiree groups meeting certain eligible criteria. For some retirees, the HRA contributions are based on years of service as an active employee eligible for PEPB benefits. We have summarized these groups below:

Retirees Participating in the PEBP Plan (not Participating in Via Benefits Program)

Retired Prior to January 1, 1994

Retiree premiums reflect a Base Subsidy or is equal to the Total Premium less Base Subsidy. If eligible for Part B, rates are reduced by Part B Subsidy, but not less than \$0.

Retired January 1, 1994 or After

Retiree premiums reflect Base Subsidy and Years of Service Subsidy, except:

- Retirees with less than fifteen years of service who are not disabled and were initially hired by their last employer on or after January 1, 2010 and before or on December 31, 2011

or

- Retirees hired on or after January 1, 2012.

These two groups of retirees are not eligible for the Base Subsidy or the Years of Service Subsidy and will be charged full annual premium.

If eligible for Part B, rates are reduced by Part B Subsidy, but not less than \$0.

To receive years of service (YOS) credit from a non-State or local participating agency, the retiree's last employer must be a current PEBP participating agency and have a hire date prior to 2012.

The Base, Years of Service and Part B Subsidy can change year to year. For 2026, the Base Subsidy for retirees was \$564.90 for retiree only. The Part B Subsidy for 2026 is up to \$145.30. The Years of Service Subsidy for 2026 is shown below:

Years of Service	Premium Differential	Years of Service	Premium Differential
5	+\$520.50	13	+\$104.10
6	+\$468.45	14	+\$52.05
7	+\$416.40	15 (Base)	-
8	+\$364.35	16	-\$52.05
9	+\$312.30	17	-\$104.10
10	+\$260.25	18	-\$156.15
11	+\$208.20	19	-\$208.20
12	+\$156.15	20	-\$260.25

Medicare Eligible Retirees (Via Benefits Program)

Medicare eligible retirees are those who have Medicare Part A and B coverage and are participating in the Via Benefits Program. Members participating in Via Benefits will receive an annual HRA contribution who meet the following criteria:

Retired Prior to January 1, 1994

This group receives the Base (15 years of service) HRA contribution which is currently \$13 per month times 15 years or \$195 per month.

Retired January 1, 1994 or After

This group receives the Years of Service HRA contribution, except:

- Retirees with less than fifteen years of service who are not disabled and were initially hired by their last employer on or after January 1, 2010 and before or on December 31, 2011

or

- Retirees hired on or after January 1, 2012.

These two groups of retirees do not receive an Exchange HRA Years of Service Subsidy. The Years of Service Exchange Subsidy HRA contribution is \$13 per month per year of service and is shown in the table below:

Years of Service	HRA Subsidy	Years of Service	HRA Subsidy
5	\$65	13	\$169
6	\$78	14	\$182
7	\$91	15 (Base)	\$195
8	\$104	16	\$208
9	\$117	17	\$221
10	\$130	18	\$234
11	\$143	19	\$247
12	\$156	20	\$260

Members should refer to PEBP issued Benefits Guide for specific details related to the plan. This document is intended to provide a summary of subsidies and is not intended to replace any benefit communication or documentation provided by PEBP. Retirees should rely on benefit information outlined and provided by PEBP regarding benefits. This document does not replace benefit information or documents provided by PEBP regarding member benefits and/or eligibility.

Assumptions

Actuarial Values

Actuarial values are a measurement of the percentage of healthcare expenses expected to be paid by the plan. Plans with higher values provide more generous benefits and require lower member cost sharing on average. Actuarial values determined by entity can vary slightly across models being used. In general, the results should be comparable and if variation occurs, is typically within a reasonable range due to nuances specific to the model being incorporated for the analysis.

For our analysis and premium comparison and per NRS 287.04347(1)(a), for the purpose of this analysis, it is assumed retirees participating in both PEBP programs and Via Benefits are paying Medicare Part B premiums. We have not incorporated Part B premiums in any of the analysis. We have included the Part B Subsidy for PEBP program premiums.

PEBP Plan

Segal developed PEBP actuarial values using the Optum Pricing model for medical and pharmacy benefits. Including in the pricing model were the following assumptions:

- The actuarial value is based on the estimated proportion of spend and incorporates 77% associated with medical on average; however, this ranges by plan between 64% and 80%.
- Actuarial values for each plan were calculated using a blend of in-network and out-of-network benefits, as applicable.

In addition, PEBP plans incorporate the following additional assumptions:

- For the Consumer Driven Health Plan (CDHP- PPO), the actuarial value incorporates the HRA annual contribution of \$700 for the retiree.

Via Benefits

Via Benefits separately provided medical-only actuarial values for Traditional Medicare (A and B combined) and Medicare Supplement Plans, Rx-only actuarial values for Standard Part D and standalone Part D plans, and combined medical and Rx actuarial values for Medicare Advantage with Part D Plans. Via Benefits utilized proprietary data and modeling. In addition:

- Premiums provided by Via Benefits are new business rates for January 1 through March 31, 2026. Actual rates can vary depending on enrollment date, underwriting and any applicable household or other discounts.
- MAPD plan features (dental, vision) reflect the CMS Plan Benefit Package files; benefit limits and networks vary by plan.

- This information supports a third-party cost analysis; Via Benefits has not evaluated that analysis's assumptions, methods, or results but reviewed a draft of this report.

Other Assumptions

For combining Medicare Supplement and Part D plans, Segal assumed 60% of total medical and pharmacy spend was associated with the medical plan. This assumption was then applied by Segal to the medical only and Rx only actuarial values provided by Via Benefits to derive the combined medical and Rx actuarial values for the Medicare Supplement plans.

For Via Benefits, HRA contributions illustrating various years of service were included in premiums for comparison to similar years of service premiums for members participating in PEBP Program. For Medicare Supplement plus Part D premiums, a Part D premium of \$35 was included in the analysis which is comparable to the average 2026 Part D premium of \$34.50. Part D premiums can vary based on plan design, geographic location and actuarial value.

Medicare Supplement premiums vary by age, county, plan and carrier. We have used average age range of PEBP retirees participating in Via Benefits which is age 75-79.

The retiree only PEBP program premiums are shown in comparison to Medicare Plans offered through Via Benefits given Medicare premiums are provided as retiree only basis.

Analysis

Segal, in coordination with Via Benefits, analyzed the benefits offered to retirees under the PEBP Plans and under Via Benefits Program. The results are provided below:

Plan Actuarial Values (AVs)

To satisfy NRS 287.04347(1)(a), the actuarial values PEBP Plans and various plans offered in Nevada under Via Benefits is illustrated in this section. The chart below displays the actuarial values of benefit offerings under the PEBP Program.

CDHP = Consumer Drive Health Plan - Preferred Provider Organization (CDHP- PPO)

LDPPPO = Low-Deductible Preferred Provider Organization Plan (LDPPPO)

EPO = Exclusive Provider Organization Plan

HMO = Health Maintenance Organization Plan

PEBP 2026 Plan Year Medical/Rx Plans

Actuarial Value	CDHP - PPO	LDPPPO	EPO	HMO
Medical	79%	84%	88%	91%
Pharmacy (Rx)	80%	91%	91%	92%
Medical + Rx	79%	85%	89%	91%

The total actuarial value combined for medical and pharmacy is based on the estimated proportion of spend. For PEBP plans, the premiums are determined by combining actives and retirees into a single risk pool for rating. We are using an estimated average 77% of total spend is associated with medical.

Under plans offered through Via Benefits in the Medical individual market, retirees can choose a benefit that best suits their insurance coverage needs. There are typically two types of benefits offerings for Medicare eligible retirees in the individual retiree market:

- **Medicare Supplement or Medigap Plans:** Provides additional benefits to cover out-of-pocket expenses not covered under traditional Medicare Parts A and B. There are a number of coverage level offerings available to Medicare eligible retirees under the Via Benefits Program. These offerings vary by plan design, carrier, age and zip code. Medicare Supplement plans are fee for service arrangements with no utilization or disease management. Depending on the coverage to supplement traditional Medicare, there are different cost sharing for services utilized and as a result, varying associated premiums depending on how generous of plan is chosen.
- **Medicare Advantage (MA) Plans:** Insurers provide benefits in lieu of traditional Medicare Part A and B. This type of plan offering is also known as Medicare Part C. Many MA plans cover benefits in addition to or more generous than traditional Medicare and can result in less member cost share as well when compared to traditional Medicare. There are various MA plan designs available to Nevada Medicare retirees within Via Benefits. MA plans can provide different member cost share when utilizing services and different premium levels. Utilization

management is typical in MA plans alongside care and disease management programs. In addition, there are different network options available such as HMO or national PPO options. All of these choices impact premiums which can vary by plan design, carrier and zip code. MA plans are not age rated. If also offered alongside a pharmacy benefit, the plan is known as a Medicare Advantage with Part D or MAPD plan. Again, under MAPD plans, there are various pharmacy benefits, networks, and drug formularies available, but plans must provide benefits at least equal to benefits covered under standard Part D. CMS issues specific rules and guidelines for MA and MAPD benefits and plan offerings.

- Medicare Part D plans can be offered alongside Medicare Supplement plans. There are CMS minimum requirements as the Part D benefit offering and carriers can offer more generous benefits. There can be differing premiums associated with benefit offerings, zip codes and carrier.

Approximately 68% of PEBP members residing in Nevada and participating in a Via Benefits medical plan have chosen a Medicare Supplement Plan. Of these members, 81% have also elected Part D. There were 31% of PEBP Medicare Via Benefits retirees that elected MAPD plans. The remaining 1% of PEBP retirees under Via Benefits have only elected a Part D plan.

Medicare medical plan offerings typically have higher actuarial values given underlying Medicare Part A and B cover the majority of medical expenses. Below are some ranges of actuarial values provided to Medicare eligible retirees for plans offered in Nevada with Via Benefits. Medicare Supplement plans provide a variety of plan offerings choices with medical actuarial values ranging from 90% to 100% medical actuarial value. Below is a sample of actuarial values after Rx is incorporated:

Via Benefits Individual Market Sample Medicare Supplement and Part D

Actuarial Value	Traditional Medicare A/B	Medicare Supplement Plan A	Medicare Supplement, Plan B, D, G	Medicare Supplement, Plan C, F*	Medicare Supplement, Plan G, High Deductible	Medicare Supplement Plan K	Medicare Supplement, Plan L	Medicare Supplement, Plan N
Medical	83%	95%	98%	100%	90%	91%	94%	97%
Trad. Part D	79%	79%	79%	79%	79%	79%	79%	79%
Med + Rx**	81%	89%	90%	91%	86%	86%	88%	90%

*Plans C and F cover Medicare Part B Deductible; Plan F covers Part B excess charges; Closed to newly Medicare eligible beginning 1/1/2020

**Derived by Segal assuming 60% of spend for Medical, 40% for Rx

Similar to Medicare Supplement plans, Part D plan offering can vary in actuarial values and as such, premiums can vary by plan carrier and zip code. An individual plan's actuarial value can be above or below standard Part D depending on the plan's cost sharing structure and the prescription cost distribution used to price it. Below is a sample actuarial values of Part D plan offerings in Nevada to Medicare Part D eligible members.

Via Benefits Individual Market Sample Part D Plans

Part D Plan	Actuarial Value (AV)
Standard Part D	79%
Humana Basic Rx Plan	82%
Humana Value Rx Plan	83%
Humana Premier Rx Plan	86%
HealthSpring Extra Rx	78%
AARP Medicare Rx Saver from UHC	77%

For MAPD plans and similar to individual Medical Supplemental and PEBP plan offerings, the more generous the benefit offering and network access, typically, the higher the premium. Benefit offerings for MAPD plans can vary by carrier, geographic location, network and plan design. Below are actuarial values for MAPD offerings in Nevada with Via Benefits with a \$0 premium:

MAPD Plan	Medical out-of-pocket Maximum	Actuarial Value (AV)
Anthem Blue Cross and Blue Shield Medicare Advantage (HMO- POS)	\$1,250	94%
Aetna Medicare Signature HMO	\$3,400	90%
UnitedHealthcare AARP PPO	\$6,700	88%

Hence, the tables above indicate that the benefits provided under individual Medicare offerings provide plans that are at least as generous and many more generous than plans offered under PEBP. Higher actuarial values translate into more generous benefits and networks or less out of pocket expenses paid by members when medical and/or pharmacy services are utilized. As noted above, the premiums associated with the MAPD actuarial values indicate \$0 premiums paid. While MAPD plans shown above can be considered comparable to PEBP plans, these plans come with a \$0 premium. Hence, the lowest premium offered to Medicare eligible retirees on the individual market in Nevada is \$0. The next component will be to compare the premiums offered under Medicare plans as compared to PEBP, incorporating various subsidies.

Comparison of Medical premiums

Per NRS 287.04347(2)(b) and (2)(c), it requests a determination of the average cost in Nevada for Medicare Supplement plans and for Part D coverage. Statewide average costs are not available. Therefore, the report illustrates premiums for various individual Supplemental plus Part D plan offerings with comparable actuarial values to PEBP Plans. The illustrations focus on the top three most areas with the highest concentration of PEBP participating in Via Benefits and incorporating the average age

for PEBP Via Benefits members residing in Nevada. In addition, it is important to take note of the varying subsidies offered to PEBP retirees within the PEBP plans as well as HRA contributions for Via Benefit retirees when comparing premiums offered under PEBP programs to Via Benefits. Lastly, we have also assumed in our exhibits the Part B subsidy for PEBP program retirees.

For this analysis, this analysis relies on PEBP premiums for July 1, 2025 to June 30, 2026 plan year. Medicare plans run on a calendar year, so the premiums included are offerings under Via Benefits in Nevada for 2026 calendar year. In addition, Medicare Supplemental plan premiums are attained age rated. Both Medicare Supplemental Plans and MAPD plans premiums can vary by carrier, plan and by geographic location. Hence, our analysis provides plan premiums under various carriers and the top counties of PEBP retirees under Via Benefits.

PEBP Programs – PY2026 Premiums - Retiree only

For comparison purposes to Via Benefit offerings, the Part B subsidy is added to the subsidies offered to retirees who participate in the PEBP plan as an offset to the total monthly amount paid by a retiree for premiums. Part B monthly premiums were not included in the rates shown below.

	PEBP CDHP with Rx*	PEBP LDPPO with Rx	PEBP EPO/HMO with Rx
Combined Medical/Rx AV	79%	85%	89%/91%
Retiree Groups			
- Retired Prior to 1/1/94	\$133	\$460	\$297
- Retired 1/1/94 or after with less than 15 Years of Service and hired between 1/1/2010 and 12/31/2011 OR -Hired 1/1/2012 and after	\$698	\$734	\$862
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 5 years of service	\$653	\$690	\$818
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 10 years of service	\$393	\$430	\$558
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 15 years of service	\$133	\$169	\$297
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 20 years of service	\$0	\$0	\$37

*PEBP premium for each retiree group adjusted by Part B subsidy of up to \$145.30, but premium may be no less than \$0.

Sample Via Benefits Medicare Supplement Premiums

Background

For the Medicare Supplement or Medigap Plans offered in the individual retiree market, premiums vary by geography, age, plan design, as well as carrier. Before we compare premiums available for individual Medicare Supplement plans under Via Benefits, the tables below indicate age bands for PEBP members participating in Via Benefits as of June 2026. In addition, a table illustrates for those PEBP retirees residing in Nevada, the portion of PEBP Via Benefit retirees by County. For this analysis, Via Benefits provided 2026 premiums available in Clark and Washoe Counties as well as Carson City which are top three PEBP dense membership areas geographically within Nevada. Via Benefits provided an age and geographic distribution of Medicare membership within Nevada which is shown below.

PEBP Via Benefits Nevada Retirees by Age Band and County

Age Band	Percent of Medicare Retirees
Under 65	1.4%
65-69	17.4%
70-74	25.5%
75-79	27.1%
80-84	18.7%
85-89	7.4%
90+	2.5%

County	Percent of Via Benefits PEBP Retirees in Nevada
Clark	35.2%
Washoe	24.3%
Carson City	17.7%
Storey	5.1%
Elko	3.2%
Lyon	3.2%
Douglas	2.9%
Churchill	2.7%
All other Nevada counties	5.7%

In the charts below, Via Benefits provided carrier offerings available in Nevada in the individual market, ranked by the number of distinct Medicare Supplement plans offered in Nevada on a statewide basis and then alphabetically:

Rank	Carrier	No. of Plans (Medigap Plans)
1	UnitedHealthcare	8 (A, C, D, F, G, K, L, N)
2	Aetna	6 (A, B, F, G, GH, N)
3	Humana	5 (A, F, G, GH, N)
4	Monitor Life Medicare Supplement	5 (A, F, G, GH, N)
5	Mutual of Omaha	5 (A, F, G, GH, N)
6	Anthem	4 (A, F, G, N)
7	CIGNA	4 (A, F, G, N)

Medigap and Part D premiums will vary by age, county, carrier, and plan. For premium comparisons under Via Benefits to eligible PEBP retirees, we have focused on the top three geographic Nevada retiree dense counties participating in Via Benefits, namely Clark and Washoe Counties, and Carson City. For the Medigap plans, Via Benefits provided 2026 premiums for a range of actuarial value Medigap plans plus Part D that are most similar to PEBP plan offering: Plan G (most popular election for recent PEBP retirees), Plan K and Plan HD-G.

For Part D plans, premiums can vary by actuarial values and geographic region. However, we found limited premium variability by plan across Nevada. Via Benefits noted that premiums were consistent across Clark, Washoe Counties and Carson City. Note that Part D premiums are community rates and don't vary by age like Medicare Supplement or Medigap plans. The following table provides a sample of lowest premiums of top three carriers providing most Part D plans in Nevada along with their actuarial values:

Plan	Actuarial Value	Premium
Standard Part D	79%	≈\$35
Humana Basic Rx Plan	82%	\$0
Humana Value Rx Plan	83%	\$44
Humana Premier Rx Plan	86%	\$149
HealthSpring	78%	\$53
UnitedHealthcare	77%	\$77

Sample 2026 Individual Medicare Supplement Plan Premiums offered by Via Benefits

In the charts below, 2026 plan premiums by top three counties provided by five-year age bands for Plans G (AV = 98%), Plan K (91%) and Plan HD-G (90%) as provided by Via Benefits for the following top-ranked carriers as defined in the prior section: UnitedHealthcare, Aetna and Humana.

For comparison purposes, the analysis shown later incorporates a Part D premium of \$35 in our analysis, although members may elect a more generous actuarial value plan at \$0. The premiums shown below do not incorporate any HRA subsidies.

Clark County – Medicare Supplement Plans by Age Band

Age band	UnitedHealthcare (UHC) Plan G	Aetna Plan G	Humana Plan G	UHC Plan K	Aetna Plan HD-G	Humana Plan HD-G
65–69	\$173	\$175	\$196	\$68	\$61	\$52
70–74	\$210	\$196	\$219	\$82	\$68	\$58
75–79	\$257	\$231	\$263	\$101	\$80	\$70
80–84	\$294	\$270	\$316	\$115	\$94	\$84
85–89	\$296	\$314	\$367	\$116	\$109	\$98
90–94	\$296	\$360	\$412	\$116	\$125	\$110
95–99	\$296	\$409	\$455	\$116	\$142	\$121

Washoe County and Carson City – Medicare Supplement Plans by Age Band

Age band	UnitedHealthcare (UHC) Plan G	Aetna Plan G	Humana Plan G	UHC Plan K	Aetna Plan HD-G	Humana Plan HD-G
65–69	\$162	\$162	\$178	\$64	\$56	\$47
70–74	\$196	\$181	\$199	\$77	\$63	\$53
75–79	\$241	\$214	\$239	\$95	\$74	\$64
80–84	\$275	\$250	\$288	\$108	\$87	\$76
85–89	\$276	\$291	\$334	\$109	\$101	\$89
90–94	\$276	\$333	\$374	\$109	\$116	\$100
95–99	\$276	\$379	\$413	\$109	\$132	\$110

Medicare Supplemental Monthly Premium Plan comparison to PEBP Plans

To compare PEBP plan premiums including subsidies available to various retiree groups to similar actuarial value plans offered on the individual Medicare market by Via Benefits, we compared age band of 75-79 given that is the largest PEBP retiree concentration participating in Via Benefits in Nevada. For this analysis, we included a Part D Plan premium of \$35.

Plan G plus Part D Monthly Premiums vs. PEBP EPO/HMO

For the first analysis, EPO/HMO plans with an actuarial value of 90% for Medical/Rx combined is compared to Plan G with a Part D premium. We have incorporated various Plan G premiums in top three Via Benefits membership counties plus an estimated Part D premium of \$35 per month. This includes HRA contributions eligible to PEBP Via Benefit retirees. This is compared with various premiums offered including subsidies for the PEBP plan retirees as well as for members participating in Via Benefits, including various HRA contributions. For PEBP Plan, it is assumed members are eligible for Part B subsidy. Note, we have highlighted in green premiums which are less than PEBP plan offerings. We are also showing negative values when HRA contributions exceed premiums given this money is contributed into the HRA account. Please see PEBP Benefit Guide for additional details on HRA accounts.

	PEBP EPO/HMO with Rx*	Clark County UHC Plan G + Part D	Clark County Aetna Plan G + Part D	Clark County Humana Plan G + Part D	Washoe/ Carson City- UHC Plan G + Part D	Washoe/ Carson City – Aetna Plan G + Part D	Washoe/ Carson City – Humana Plan G + Part D
Combined Medical/Rx AV**	89%/91%	90%	90%	90%	90%	90%	90%
Retiree Groups							
- Retired Prior to 1/1/94	\$297	\$97	\$71	\$103	\$81	\$54	\$79
- Retired 1/1/94 or after with less than 15 Years of Service and hired between 1/1/2010 and 12/31/2011 OR -Hired 1/1/2012 and after	\$862	\$292	\$266	\$298	\$276	\$249	\$274
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 5 years of service	\$818	\$227	\$201	\$233	\$211	\$184	\$209
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 10 years of service	\$558	\$162	\$136	\$168	\$146	\$119	\$144

	PEBP EPO/HMO with Rx*	Clark County UHC Plan G + Part D	Clark County Aetna Plan G + Part D	Clark County Humana Plan G + Part D	Washoe/ Carson City- UHC Plan G + Part D	Washoe/ Carson City – Aetna Plan G + Part D	Washoe/ Carson City – Humana Plan G + Part D
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 15 years of service	\$297	\$97	\$71	\$103	\$81	\$54	\$79
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 20 years of service	\$37	\$32	\$6	\$38	\$16	-\$11	\$14

*PEBP premium for each retiree group adjusted by Part B subsidy of up to \$145.30, but premium may be no less than \$0

**Derived by Segal assuming 60% of spend for Medical, 40% for Rx

The above chart indicates lower premiums, or comparable, in all subsidy categories for Medicare Supplement Plan G premiums with Part D (\$35) for these three counties using average age band of 75-79 as compared to EPO/PPO plan premiums. These plans all have comparable actuarial values including Part B subsidy in all subsidy categories. Note that Via Benefits indicated Plan G is the highest participating Medicare Supplement plan for recent PEBP retirees based on available plans.

At higher age bands, members could be paying higher premiums under a Plan G than under PEBP program for retirees with twenty years of service. However, as noted later in this report, there are lower cost options available under MAPD plans.

Medicare Supplemental Plan K with Part D at ages 75-79 compared to LDPPO Monthly Premiums, including any subsidies

To compare the PEBP LDPPO plan including Rx with an AV of 85%, we compared Plan K with Part D AV of 86% For this analysis, we have incorporated Plan K premiums in Nevada top three PEPB retiree counties plus an estimated Part D premium of \$35 per month. This is compared with LDPPO premiums offered including subsidies for the PEBP plan members, including Part B subsidy and includes for HRA benefits to eligible PEBP Via Benefits retirees. Note, we have highlighted green premiums which are less than PEBP plan premiums for a given subsidy group. For Plan K, only UHC provided an offer in the State of Nevada.

	PEBP LDPPO with Rx*	Clark County UHC Plan K + Part D	Washoe/Carson City- UHC Plan K + Part D
Combined Medical/Rx AV**	85%	86%	86%

Retiree Groups

	PEBP LDPPO with Rx*	Clark County UHC Plan K + Part D	Washoe/Carson City- UHC Plan K + Part D
- Retired Prior to 1/1/94	\$460	-\$59	-\$65
- Retired 1/1/94 or after with less than 15 Years of Service and hired between 1/1/2010 and 12/31/2011 OR	\$734	\$136	\$130
-Hired 1/1/2012 and after			
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 5 years of service	\$690	\$71	\$65
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 10 years of service	\$430	\$6	\$0
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 15 years of service	\$169	-\$59	-\$65
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 20 years of service	\$0	-\$124	-\$130

*PEBP premium for each retiree group adjusted by Part B subsidy of up to \$145.30, but premium may be no less than \$0

**Derived by Segal assuming 60% of spend for Medical, 40% for Rx

The above chart indicates lower premiums in all subsidy categories for Medicare Supplement Plan K premiums with Part D (\$35 per month) for these three counties using average age band of 75-79 as compared to LDPPO plan premiums including Part B subsidy in all subsidy categories. These plans all have comparable actuarial values.

Medicare Supplemental Plan G High Deductible (Plan G-HD) with Part D at ages 75-79 compared to HDHP with Rx Monthly Premiums, including any subsidies

The CDHP plan with Rx has an actuarial value of 79%. There is no plan offered by Via Benefits that compares to this actuarial value given traditional Medicare A/B paired with standard Part D has an estimated actuarial Value of 81%. For comparison purposes, we illustrated the premiums for a high-deductible plan offered on the individual Medicare plan on Via Benefits in Nevada that is called a Plan G-HD. This plan, including Part D, has an actuarial value of 86%. As with similar illustrations, we have included Part B subsidy and other subsidies (base and service related) for eligible PEBP retirees and HRA contributions at various categories for Via Benefits.

	PEBP CDHP with Rx*	Clark County Aetna Plan G- HD + Part D	Clark County Humana Plan G-HD + Part D	Washoe/Ca rson City – Aetna Plan G-HD + Part D	Washoe/Ca rson City – Humana Plan G-HD + Part D
Combined Medical/Rx AV**	79%	86%	86%	86%	86%

	PEBP CDHP with Rx*	Clark County Aetna Plan G- HD + Part D	Clark County Humana Plan G-HD + Part D	Washoe/Ca rson City – Aetna Plan G-HD + Part D	Washoe/Ca rson City – Humana Plan G-HD + Part D
Retiree Groups					
- Retired Prior to 1/1/94	\$133	-\$80	-\$90	-\$86	-\$96
- Retired 1/1/94 or after with less than 15 Years of Service and hired between 1/1/2010 and 12/31/2011 OR -Hired 1/1/2012 and after	\$698	\$115	\$105	\$109	\$99
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 5 years of service	\$653	\$50	\$40	\$44	\$34
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 10 years of service	\$393	-\$15	-\$25	-\$21	-\$31
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 15 years of service	\$133	-\$80	-\$90	-\$86	-\$96
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 20 years of service	\$0	-\$145	-\$155	-\$151	-\$161

*PEBP premium for each retiree group adjusted by Part B subsidy of up to \$145.30, but premium may be no less than \$0

**Derived by Segal assuming 60% of spend for Medical, 40% for Rx

Even with a higher actuarial value, benefits offered under Via Benefits High-Deductible Plan G Medicare Supplement Plan plus Part premium (\$35 per month) at average age band 75-79 in top three PEBP member dense counties have lower premiums than compared to the PEBP CDHP plan premiums adjusted for eligible subsidies. Note, the PEBP Plan HRA contribution of \$700 for CDHP members was incorporated into the actuarial value.

Medicare Advantage Plans with Part D (MAPD) compared to PEBP Plans

In addition to Medicare Supplement plans with Part D offered to PEBP Medicare retirees participating in Via Benefits, there are also Medicare Advantage with Part D (MAPD) Plans. Many of these plans are available with a \$0 monthly premium. As noted previously, MAPD plans are community rated with benefit designs and networks that vary across counties and carriers. Below is a comparison of MAPD offerings in Nevada under Via benefits as compared to PEBP plan offerings. PEBP plan offerings are compared to MAPD \$0 premiums with various HRA contributions and including Part B premiums. The MAPD premiums and actuarial values were selected as \$0-premium plans spanning low, mid, and high medical out-of-pocket maximums.

	PEBP CHDP with Rx	PEBP LDPPPO with Rx	PEBP EPO/HMO with Rx	Anthem MAPD HMO – POS	Aetna MAPD HMO	AARP MAPD UHC PPO
Combined Medical/Rx AV	79%	85%	89%/91%	94%	90%	88%
Retiree Groups						
- Retired Prior to 1/1/94	\$133	\$460	\$297	-\$195	-\$195	-\$195
- Retired 1/1/94 or after with less than 15 Years of Service and hired between 1/1/2010 and 12/31/2011 OR -Hired 1/1/2012 and after	\$698	\$734	\$862	\$0	\$0	\$0
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 5 years of service	\$653	\$690	\$818	-\$65	-\$65	-\$65
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 10 years of service	\$393	\$430	\$558	-\$130	-\$130	-\$130
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 15 years of service	\$133	\$169	\$297	-\$195	-\$195	-\$195
Retired 1/1/94 or after, not hired between 1/1/2010 and 12/31/2011, with 20 years of service	\$0	\$0	\$37	-\$260	-\$260	-\$260

Note the negative numbers are reflective of monthly HRA dollars allocated to various retiree groups which are offsetting the retiree only premiums associated with the illustrated plans. For MAPD plans, it is the networks that can vary in addition to plan design, with differing actuarial values and all offering \$0 premiums. Members with MAPD plans are required to pay Part B premiums similar to Medicare Supplement plans.

Dental and Vision Premiums

NRS 287.04347(2)(d) requested the average cost in Nevada to obtain dental and vision coverage, other than limited coverage through a Medicare Advantage plan. PEBP Program offers limited dental and vision benefits as part of premiums for medical and Rx coverage. Members enrolled with Via Benefits may participate in PEBP Dental Plan with a member only premium of \$53.18 per month for State retiree or \$50.31 for a non-state retiree. Vision costs are considered part of medical when determining premiums for PEBP programs and are not separately isolated.

Via Benefits noted that there are 41 MAPD plans available in Nevada. All of these plans offer supplemental dental and routine vision (eye exams and/or eyewear). The difference in offerings tend to be in dental plan offerings. Of the 41 MAPD plans that offer dental benefits, Via Benefits noted that five

plans offer preventive dental coverage only with a \$0 premium. The other dental plan offerings are comprehensive including major services with an average monthly premium of \$7.94. Comprehensive vs. preventive only is determined from CMS PBP section B16c (comprehensive dental benefit descriptions).

Summary

Medicare plan offerings (MAPD and Medicare Supplemental plans with Part D) generally provide higher actuarial values than the PEBP plan offerings, given Medicare A/B and D provide an actuarial value of approximately 81%. When comparing plans offered under Via Benefits with similar actuarial values of PEBP plans, the net premiums paid vary by applicable subsidy eligibility, plan design, county of residence, age, carrier and Medicare Plan type (Supplement or MAPD). Since premiums vary by county and age for Medicare Supplemental Plans, comparing premiums to PEBP can vary depending on retiree age and Nevada county of residence along with plan design and carrier. However, for the 75-79 age band, which represents the largest concentration of Via Benefits retirees as of June 2026, the analysis indicates that individual market options available to Medicare eligible PEBP retirees through Via Benefits often provide higher actuarial values at lower premiums compared to PEBP Plan premiums after reflecting applicable subsidies and HRA contributions. For example, a member may enroll in a MAPD plan with a \$0 monthly premium and a comparable actuarial value to a PEBP plan. By contrast, monthly premiums under the PEBP program may range for a retiree from \$0 to \$879, depending on applicable subsidy eligibility. For Medicare Supplement plans with Part D in the 75-79 age band, monthly premiums after reflecting applicable HRA contributions range from -\$155 to \$300 in Clark County or -\$161 to \$275 in Washoe County/Carson City.

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| Appendix

see Via Benefits, NV PEBP Medicare Coverage Legislative Report Support v5

Nevada PEBP — Medicare Retiree Coverage

Supporting Information for the Legislative Report

Prepared by Via Benefits (WTW) · July 1, 2026 · Plan year 2026

This document provides the actuarial values, premiums, and plan-feature counts requested to support Segal’s analysis of Medicare coverage options for PEBP retirees. Figures reflect the PEBP Medicare-enrolled population of 11,881 members (average age 75.8, median age 76). The three Nevada counties with the greatest PEBP Medicare enrollment — Clark (4,177), Washoe (2,891), and Carson City (2,106) — frame the geographic detail.

1. Data Sources & Methodology

- Actuarial values are computed using Via Benefits’ proprietary 2026 Medicare claims probability distribution (CPD) and Financial Impact Analysis modeling engine as of the time of this report. Actuarial value (AV) is reported as the plan-paid share of allowed cost: $AV = 1 - E[\text{member out-of-pocket}] / E[\text{allowed}]$.
- Traditional Medicare and Medicare Supplement AVs are medical-only (Parts A & B); the standard Part D value is reported separately on the prescription-drug allowed base; MAPD AVs are combined medical + Rx.
- Premiums are taken directly from publicly available files as well as Via Benefits’ quoting platform as of Q1 2026. Design features based on plan-data as filed. Medicare Supplement premiums vary by age; MAPD and Part D premiums are community-rated (do not vary by age).
- Dental and vision plan features are sourced from the CMS Plan Benefit Package (PBP) files (sections B16 dental, B17 eye exams & eyewear), joined to the Nevada MAPD plan list.
- All data reflected in this report is as of June 2026.

2. PEBP Medicare Population — Demographics & Plan Elections

The figures in this report are framed by the PEBP Medicare-enrolled census of 11,881 members (date of birth, ZIP code, and elected coverage). Average age is 75.8 and median age 76; 168 members are under 65 (Medicare by disability). Members reside across 17 Nevada counties.

Age distribution

Age band	Members	Share
Under 65	168	1.4%
65–69	2,072	17.4%
70–74	3,027	25.5%
75–79	3,218	27.1%
80–84	2,223	18.7%
85–89	875	7.4%
90+	298	2.5%

Plan elections

Coverage elected	Members	Share of population
MAPD (Medicare Advantage with Rx)	3,657	30.8%
Medicare Supplement (Medigap)	8,094	68.1%
— with a standalone Part D (PDP)	6,675	56.2%
Standalone vision elected	1,735	14.6%
Standalone dental elected	852	7.2%

A Medicare Supplement member pairs Medigap (medical) with a standalone Part D plan for drug coverage; MAPD bundles medical and Rx. Standalone dental/vision are ancillary policies elected alongside either. Medicare Supplement and MAPD together cover 98.8% of members; the remaining 146 (1.2%) elected a standalone Part D plan with no medical supplement (16 members appear under both MS and MAPD).

Geographic distribution

County	Members	Share
Clark	4,177	35.2%
Washoe	2,891	24.3%
Carson City	2,106	17.7%
Storey	611	5.1%
Elko	382	3.2%
Lyon	381	3.2%
Douglas	344	2.9%
Churchill	315	2.7%
All other Nevada counties	674	5.7%

The three highest-enrollment counties — Clark, Washoe, and Carson City — anchor the county-level premium detail in Section 8.

3. Traditional Medicare — 2026 Program Parameters

The values below are the statutory Medicare cost-sharing parameters used in the adjudication. A retiree in Traditional Medicare with no supplement is responsible for these amounts (Medicare has no annual out-of-pocket maximum).

Parameter	2026 Value
Part A hospital deductible (per benefit period)	\$1,736
Part A coinsurance, days 61–90	\$434 / day
Part A coinsurance, days 91+ (lifetime reserve)	\$868 / day
Skilled nursing facility coinsurance, days 21–100	\$217 / day
Part B annual deductible	\$283
Part B coinsurance (after deductible)	20%
Part B standard monthly premium	\$202.90
Part A hospice cost-sharing	5% coinsurance
Part D standard deductible	\$615
Part D initial coinsurance (member)	25%
Part D annual out-of-pocket cap (TrOOP)	\$2,100
Part D base beneficiary premium	\$38.99

4. Medicare Supplement (Medigap) — Gaps Covered by Plan Letter

Medigap plans are standardized by letter. The grid shows which Medicare cost-sharing gaps each plan covers. Nevada offers Plans A, B, C, D, F, G, High-Deductible G, K, L, N. (Plans C and F are closed to those newly eligible for Medicare on or after January 1, 2020.)

Benefit / Gap	A	B	C	D	F	G	K	L	N
Part A coinsurance & 365 extra hospital days	✓	✓	✓	✓	✓	✓	50%	75%	✓
Part B coinsurance / copayment	✓	✓	✓	✓	✓	✓	50%	75%	Copay*
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓
Part A hospice coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓
Skilled nursing facility coinsurance	—	—	✓	✓	✓	✓	50%	75%	✓
Part A deductible	—	✓	✓	✓	✓	✓	50%	75%	✓
Part B deductible	—	—	✓	—	✓	—	—	—	—
Part B excess charges	—	—	—	—	✓	✓	—	—	—
Foreign travel emergency	—	—	80%	80%	80%	80%	—	—	80%
Out-of-pocket limit (2026)	—	—	—	—	—	—	\$8,000	\$4,000	—

✓ = 100% covered. * Plan N pays Part B coinsurance in full except a copay up to \$20 per office visit and up to \$50 per emergency-room visit. High-Deductible G (offered in NV) mirrors Plan G after a \$2,950 annual deductible (2026).

5. Actuarial Values — Plan-Paid Share of Allowed Cost

5a. Traditional Medicare (medical only)

Coverage	Actuarial value	Member share of allowed (medical)
Traditional Medicare, no supplement	82.7%	17.3% (\$3,035)

5b. Medicare Supplement — combined Medicare + Medigap (medical only)

Important: each value below is the COMBINED actuarial value of Traditional Medicare PLUS the Medicare Supplement plan — that is, (Medicare’s payment + the Medigap plan’s payment) ÷ total allowed medical cost. The supplement is layered on top of Traditional Medicare’s 82.7% base (Section 5a), so these figures are stated on the same basis as the Traditional Medicare and MAPD values and are directly comparable to them. They are NOT the share of Medicare’s cost-sharing gap that the supplement fills — a plan shown at 95% does not cover 95% of the gap Medicare leaves. The “Added vs. Traditional alone” column isolates the coverage the supplement contributes on top of Original Medicare.

Medigap plan	Combined AV (Medicare + plan)	Added vs. Traditional alone
Plan A	95.1%	+12.4 pts
Plan B	97.6%	+14.9 pts
Plan C	99.8%	+17.1 pts
Plan D	98.3%	+15.6 pts
Plan F	99.8%	+17.1 pts
Plan G	98.3%	+15.6 pts
High-Deductible G	90.4%	+7.7 pts
Plan K	90.8%	+8.2 pts
Plan L	94.3%	+11.6 pts
Plan N	97.0%	+14.4 pts

Combined medical-only AV = (Medicare + Medigap paid) ÷ medical allowed. Plans F and C are highest because they also cover the Part B deductible and Part B excess charges. Prescription-drug coverage is reported separately in 5c.

5c. Standard Part D prescription-drug benefit (Rx only)

Coverage	Actuarial value
Standard Part D defined benefit (2026)	78.6%

5d. Medicare Advantage Prescription Drug (MAPD) — three \$0-premium plans (combined medical + Rx)

Plan (carrier)	Medical OOP max	Rx OOP max	Actuarial value
Anthem Medicare Advantage (HMO-POS) — Anthem Blue Cross and Blue Shield	\$1,250	\$2,100	93.5%
Aetna Medicare Signature (HMO) — Aetna Medicare	\$3,400	\$2,100	90.4%
AARP Medicare Advantage from UHC NV-0007 (PPO) — UnitedHealthcare	\$6,700	\$2,100	87.5%

All three carry a \$0 monthly plan premium and are offered in Clark County; selected to span low, mid, and high medical out-of-pocket maximums. MAPD AV is combined (medical + Rx) because the product bundles both. Lower out-of-pocket maximum → higher actuarial value.

6. MAPD Plans Used — Design Summary

The three \$0-premium MAPD plans priced in Section 5d are summarized below in side-by-side plan-design format (the layout used in the Via Benefits plan-comparison tool). They were selected to span low, mid, and high medical out-of-pocket maximums; lower cost-sharing corresponds to the higher actuarial value.

Benefit	Anthem Medicare Advantage (HMO-POS) — Anthem Blue Cross and Blue Shield · AV 93.5%	Aetna Medicare Signature (HMO) — Aetna Medicare · AV 90.4%	AARP Medicare Advantage from UHC NV-0007 (PPO) — UnitedHealthcare · AV 87.5%
Monthly plan premium	\$0	\$0	\$0
Medical deductible	\$0	\$615 (combined med+Rx)	\$0
Medical out-of-pocket max	\$1,250	\$3,400	\$6,700
Inpatient hospital	\$0	\$320/day (days 1–6); then \$0	\$395/day (days 1–6); then \$0
Skilled nursing facility	\$0 (days 1–20); \$218 (days 21–100)	\$10 (days 1–20); \$218 (days 21–100)	\$0 (days 1–20); \$218 (days 21–100)
Emergency room	\$150	\$150	\$130
Ambulance	\$250	\$315	\$290
Primary care visit	\$0	\$0	\$0
Specialist visit	\$0	\$45 †	\$45 †
Outpatient surgery	\$0	\$0	\$0
Diagnostic / radiology	\$0	\$0	\$35 †
Durable medical equipment	\$0	\$0	20% †
Rehabilitation (PT/OT)	\$0	\$20 †	\$35 †
Rx deductible	\$50	\$615	\$520
Rx out-of-pocket max (Part D cap)	\$2,100	\$2,100	\$2,100
Rx – preferred generic (retail)	\$0	\$0	\$0
Rx – generic (retail)	\$10	\$12	\$10
Rx – preferred brand (retail)	25% †	24% †	16% †
Rx – non-preferred (retail)	30% †	25% †	35% †
Rx – generic (mail, 90-day)	\$0	\$0	\$10
Rx – preferred brand (mail)	25% †	24% †	16% †

† Service is subject to the plan deductible before the cost-share applies. “\$0” indicates the plan covers the service in full. Cost-shares are in-network.

Source: 2026 plan-design data (CMS / carrier filings).

7. Prevalence of MAPD Plans — Dental & Vision Benefits

Nevada has 41 MAPD plans. Both supplemental dental and routine vision are effectively universal in this market: 41 of 41 plans offer a supplemental dental benefit and 41 of 41 offer routine vision (eye exam and/or eyewear). The direct answer to the requested split is therefore:

MAPD plans in Nevada	Count	Average monthly premium
DO offer dental or vision	41	\$6.98
Do NOT offer dental nor vision	0	\$0.00
All MAPD plans	41	\$6.98

“Offers dental” = CMS PBP coverage flag (section B16) indicates the plan provides a supplemental dental benefit; “offers vision” = supplemental eye-exam and/or eyewear benefit (section B17). Both are offered by all 41 plans, so no Nevada MAPD plan offers neither.

Because dental and vision are present in every plan, the feature that actually varies is the depth of the dental benefit. The breakdown below splits the plans by whether dental coverage extends beyond preventive care (cleanings, exams, x-rays) to comprehensive services (fillings, crowns, extractions, dentures):

Dental benefit depth	Count	Average monthly premium
Comprehensive dental (preventive + major services)	36	\$7.94
Preventive dental only	5	\$0.00
All MAPD plans	41	\$6.98

Comprehensive vs. preventive-only determined from CMS PBP section B16c (comprehensive dental benefit descriptions). Of the 41 plans, 35 carry a \$0 monthly premium.

8. Medicare Supplement Premiums by 5-Year Age Band

Medicare Supplement premiums are attained-age rated. The tables below show monthly premiums for Plan G, Plan K, and High-Deductible G across the top three counties, for the three Nevada carriers offering the most Medigap plans (UnitedHealthcare, Aetna, Humana). Among these three carriers, Plan G is offered by all three, Plan K only by UnitedHealthcare, and High-Deductible G only by Aetna and Humana. (MAPD premiums are community-rated and do not vary by age; Part D premiums are shown separately in Section 9.)

How the top three carriers were selected — carriers by plan count

The three carriers above were chosen as those offering the most distinct Medicare Supplement plans (letters) available in Nevada. The full ranking:

Rank	Carrier	Medigap plans (letters offered)
1	UnitedHealthcare	8 (A, C, D, F, G, K, L, N)
2	Aetna	6 (A, B, F, G, GH, N)
3	Humana	5 (A, F, G, GH, N)
4	Monitor Life Medicare Supplement	5 (A, F, G, GH, N)
5	Mutual of Omaha	5 (A, F, G, GH, N)
6	Anthem	4 (A, F, G, N)
7	CIGNA	4 (A, F, G, N)

Top three (UnitedHealthcare, Aetna, Humana) carry the premium detail below. Ties beyond rank 3 are broken alphabetically.

For reference, the Medicare Advantage (MAPD) market in Nevada is led by a different set of carriers by plan count (the MAPD design samples in Section 6 were chosen by out-of-pocket level, not carrier rank):

Rank	Carrier (MAPD)	MAPD plans offered
1	Aetna Medicare	13
2	Humana	10
3	UnitedHealthcare	10
4	Senior Care Plus	3
5	Wellcare	2
6	Anthem Blue Cross and Blue Shield	2
7	Champion Health Plan	1

Medicare Supplement monthly premiums by age — Clark County

Age band	UHC · G	Aetna · G	Humana · G	UHC · K	Aetna · HD-G	Humana · HD-G
65–69	\$173	\$175	\$196	\$68	\$61	\$52
70–74	\$210	\$196	\$219	\$82	\$68	\$58
75–79	\$257	\$231	\$263	\$101	\$80	\$70
80–84	\$294	\$270	\$316	\$115	\$94	\$84
85–89	\$296	\$314	\$367	\$116	\$109	\$98
90–94	\$296	\$360	\$412	\$116	\$125	\$110
95–99	\$296	\$409	\$455	\$116	\$142	\$121

Plan G covers all Part A/B gaps except the Part B deductible. Plan K covers 50% of most cost-sharing (annual out-of-pocket limit \$8,000). High-Deductible G (HD-G) mirrors Plan G after a \$2,950 annual deductible (2026). Among these three carriers, only UnitedHealthcare offers Plan K and only Aetna and Humana offer HD-G.

Medicare Supplement monthly premiums by age — Washoe County

Age band	UHC · G	Aetna · G	Humana · G	UHC · K	Aetna · HD-G	Humana · HD-G
65–69	\$162	\$162	\$178	\$64	\$56	\$47
70–74	\$196	\$181	\$199	\$77	\$63	\$53
75–79	\$241	\$214	\$239	\$95	\$74	\$64
80–84	\$275	\$250	\$288	\$108	\$87	\$76
85–89	\$276	\$291	\$334	\$109	\$101	\$89
90–94	\$276	\$333	\$374	\$109	\$116	\$100
95–99	\$276	\$379	\$413	\$109	\$132	\$110

Plan G covers all Part A/B gaps except the Part B deductible. Plan K covers 50% of most cost-sharing (annual out-of-pocket limit \$8,000). High-Deductible G (HD-G) mirrors Plan G after a \$2,950 annual deductible (2026). Among these three carriers, only UnitedHealthcare offers Plan K and only Aetna and Humana offer HD-G.

Medicare Supplement monthly premiums by age — Carson City County

Age band	UHC · G	Aetna · G	Humana · G	UHC · K	Aetna · HD-G	Humana · HD-G
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65–69	\$162	\$162	\$178	\$64	\$56	\$47
70–74	\$196	\$181	\$199	\$77	\$63	\$53
75–79	\$241	\$214	\$239	\$95	\$74	\$64
80–84	\$275	\$250	\$288	\$108	\$87	\$76
85–89	\$276	\$291	\$334	\$109	\$101	\$89
90–94	\$276	\$333	\$374	\$109	\$116	\$100
95–99	\$276	\$379	\$413	\$109	\$132	\$110

Plan G covers all Part A/B gaps except the Part B deductible. Plan K covers 50% of most cost-sharing (annual out-of-pocket limit \$8,000). High-Deductible G (HD-G) mirrors Plan G after a \$2,950 annual deductible (2026). Among these three carriers, only UnitedHealthcare offers Plan K and only Aetna and Humana offer HD-G.

When does premium “aging” stop? (illustrated for Plan G)

The age at which premiums stop increasing is carrier-specific, not a single statewide age:

- UHC: rises through age 81 (\$172 at 65 → \$296 at 99), then level
- Aetna: rises through age 99 (\$173 at 65 → \$430 at 99)
- Humana: rises through age 99 (\$194 at 65 → \$473 at 99)

In short, there is no uniform “aging stops at 75.” One carrier levels off in the early 80s while others continue grading premiums to age 99. Washoe and Carson City share a single Medigap rating area and therefore show identical premiums.

9. Part D (Prescription Drug) Premiums

Standalone Part D (PDP) carriers were selected the same way as the Medicare Supplement carriers — the three carriers offering the most PDP plans in Nevada, with ties broken alphabetically: Humana, HealthSpring, UnitedHealthcare. Part D premiums are community-rated (they do not vary by age) and are set at the regional level, so each carrier’s lowest premium is the same across all three counties. The table shows the lowest monthly premium offered by each carrier in each county.

County	Humana	HealthSpring	UnitedHealthcare
Clark	\$0.00	\$52.60	\$76.70
Washoe	\$0.00	\$52.60	\$76.70
Carson City	\$0.00	\$52.60	\$76.70

Lowest monthly Part D premium per carrier. Premiums are identical across the three counties because Nevada is a single Part D region.

Part D actuarial values

Actuarial value — the plan-paid share of prescription-drug allowed cost — for each carrier’s lowest-premium PDP, plus Humana’s Value and Premier plans. Adjudication applies the standard-relative true-out-of-pocket (TrOOP): plan payments above what the defined standard benefit would pay count toward the member’s out-of-pocket cap. The standard Part D defined benefit is 78.6% on this claims basis; an individual plan’s value can sit above or below that depending on its cost-sharing structure and the prescription-cost distribution used to price it.

Carrier	Plan	Premium	Actuarial value
Humana	Humana Basic Rx Plan	\$0.00	82.1%
Humana	Humana Value Rx Plan	\$43.70	83.1%
Humana	Humana Premier Rx Plan	\$148.70	86.4%
HealthSpring	HealthSpring Extra Rx	\$52.60	77.5%
UnitedHealthcare	AARP Medicare Rx Saver from UHC	\$76.70	76.8%

Part D actuarial value = $1 - E[\text{member Rx OOP}] / E[\text{Rx allowed}]$, Rx only (no medical). Reference: standard Part D defined benefit = 78.6%.

Humana Part D plans — design detail, premium & actuarial value

Humana offers the most Part D plans in Nevada. All three are shown below with design detail, monthly premium, and actuarial value. Each is available in all 17 Nevada counties at the same premium statewide (Nevada is a single Part D region).

Benefit / design	Humana Basic Rx Plan	Humana Value Rx Plan	Humana Premier Rx Plan
Monthly premium	\$0.00	\$43.70	\$148.70
Rx deductible	\$615	\$601	\$0
Rx out-of-pocket max (Part D cap)	\$2,100	\$2,100	\$2,100
Preferred generic (retail / mail)	\$0 / \$0	\$0 / \$0	\$0 / \$0
Generic (retail / mail)	\$1 / \$0	\$3 / \$0	\$10 / \$0
Preferred brand (retail / mail)	25% / 20%	18% / 13%	\$47 / \$45
Non-preferred (retail / mail)	32% / 32%	34% / 34%	50% / 50%
Actuarial value	82.1%	83.1%	86.4%

Actuarial value = plan-paid share of prescription-drug allowed cost (Rx only, no medical), adjudicated with the standard-relative TrOOP. Reference: standard Part D defined benefit = 78.6%. Cost-shares are shown as retail / mail-order; coinsurance applies after the Rx deductible.

How the three Part D carriers were selected — carriers by plan count

Rank	Carrier (PDP)	PDP plans offered
1	Humana	3
2	HealthSpring	2
3	UnitedHealthcare	2
4	Wellcare	2
5	Aetna Medicare	1

Top three (selected for the premiums above) carry the most PDP plans; ties beyond rank 1 are broken alphabetically — the same rule used for the Medicare Supplement carriers in Section 8.

10. Independent Verification of 2026 Parameters & Plan Designs

Every statutory parameter used in this report was checked against the official 2026 CMS releases. All values match the published figures.

Sources: CMS, “2026 Medicare Parts A & B Premiums and Deductibles” fact sheet (Nov 14, 2025); CMS Final CY2026 Part D benefit parameters; CMS Plan K & L Out-of-Pocket Limits announcement. The standardized Medigap benefit grid in Section 4 was verified against the CMS / Medicare.gov standardized-benefits chart and matches for every plan letter offered in Nevada.

Notes & Limitations

- Actuarial values are model values reflecting Via Benefits’ proprietary data and modeling; they are not a certification of any specific carrier’s filed actuarial value for any individual plan.
- Premiums are new-business rates as of Q1 2026; actual rates depend on enrollment date, underwriting (if applicable), and any applicable household or other discounts.
- MAPD plan features (dental, vision) reflect the CMS Plan Benefit Package files; benefit limits and networks vary by plan.
- This information supports a third-party cost analysis; Via Benefits has not evaluated that analysis’s assumptions, methods, or results.

9.

9. Pharmacy Benefit Manager Rebate Changes.
(Amy Donohue and Amy Daily, ESI)
(Information/Discussion)

9.1 Impact of Rebate Changes to the Biennial
Budget and Premiums (Debbie Donaldson,
Segal) (Information/Discussion)

10.

10. NVHA Statewide Purchasing Delegation.

(Theresa Carsten, Executive Officer) (**For Possible Action**)

10.1 Pharmacy Benefit Manager

10.2 Dental Benefit Network/Manager

10.3 Actuarial Services

11.

11. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) (**For Possible Action**)

11.1 Contract Overview

11.2 New Contracts

11.3 Contract Amendments

11.4 Status of Current Solicitations



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



Information Only

Date: August 20, 2026

Item Number: 11

Title: Contract Status Report

Summary

This report addresses the status of PEBP's contracts, including an overview of the Plan's current contracts and the planned strategy to manage them going forward; potential new contracts; contract amendments; and the status of current solicitations.

1. Contracts Overview

A. Contracts Set to Expire in 2026

Financial Auditor – Set to expire 12/31/2026: An amendment extending PEBP's contract with Eide Bailly until December 2030 is presented below for Board consideration.

Benefits Management System – Set to expire 12/31/2026: PEBP and NVHA staff meet weekly with the vendor chosen during the RFP process. It is anticipated that negotiations will be completed by the end of August, and a new contract will be presented for the Board's consideration at its September meeting.

B. Strategy Regarding Other Contracts

As discussed in detail by Executive Officer Carsten in a separate agenda item, NVHA and PEBP staff have designed a strategy in which the NVHA will assume responsibility for procuring some services for PEBP. Additionally, PEBP is seeking approval to extend some contracts.

I. NVHA Assuming Procurement of Services for PEBP

Dental PPO: NVHA will assume procurement for a dental network for PEBP. As set forth below, PEBP is seeking an extension of its current contract to allow time for NVHA to do so.

Pharmacy Benefit Manager: NVHA has assumed procurement for pharmacy benefit management services to PEBP members. It is anticipated that the contract will be awarded in January 2027, with pharmacy benefit management services for PEBP beginning when its current contract with Express Scripts expires on July 1, 2028. Until the RFP for these services is finalized, it is assumed the contract term will be the standard four years, thus expiring in 2032.

Actuarial/Consulting Services: NVHA will assume procurement for actuarial/consulting services for PEBP. PEBP's current contract with the Segal Company for these services is set to expire June 30, 2027.

II. Extensions

PEBP is seeking the Board's approval of the following contract extensions:

Dental PPO: Additional one-year extension of current contract with Diversified Dental Services, until June 30, 2028.

Health Plan Auditor: One-year extension of current contract with Brown & Brown/Claims Technologies, until June 30, 2028.

HSA/HRA Account Manager: Four-year extension of current contract with HSA Bank, until June 30, 2032.

Please note: If the Board approves these extensions, PEBP will still need to seek agreement with the relevant vendors and appropriate approvals from State Purchasing. If these steps change any extension(s) approved by the Board, staff will advise the Board in future contract status reports.

III. Unbundling Services

Third-Party Administration & Other Services: Currently, UMR, Inc., bundles provision of medical and dental claims administration, medical PPO network services, and utilization/case management services to PEBP. NVHA and PEBP are exploring whether unbundling these services in future procurements might provide better value.

C. Effect on Status of PEBP Contracts

Contracts Summary Including Above Strategies			
SERVICE	CURRENT VENDOR	CURRENT EXPIRATION DATE	ANTICIPATED EXPIRATION DATE
Actuarial/Consulting Services	Segal Company	06/30/2027	06/30/2027 + assumed by NVHA
Benefits Management System	Lifeworks/TELUS Health	12/31/2026	12/31/2026
Centers of Excellence	Carrum Health	06/30/2028	06/30/2028
Dental PPO	Diversified Dental Services	06/30/2027	06/30/2028 + assumed by NVHA
Financial Auditor	Eide Bailly	12/31/2026	12/31/2030
Group Basic Life Insurance	United Healthcare Insurance	06/30/2028	06/30/2028

Health Plan Auditor	Brown & Brown/Claims Technologies	06/30/2027	06/30/2028
HSA/HRA Account Management	HSA Bank	06/30/2028	06/30/2032
Medical PPO	UMR, Inc.	06/30/2028	06/30/2028
Medicare Exchange	Willis Towers Watson (Via Benefits)	06/30/2030	06/30/2030
Oncology Concierge	Carrum Health	06/30/2028	06/30/2028
Pharmacy Benefit Manager	Express Scripts	06/30/2028	06/30/2032 + assumed by NVHA
Southern Nevada HMO	Health Plan of Nevada	06/30/2030	06/30/2030
Third-Party Claims Administration	UMR, Inc.	06/30/2028	06/30/2028
Utilization/Case Management	UMR, Inc.	06/30/2028	06/30/2028

Recommendations:

- (1) Approve an additional extension of PEBP's contract with Diversified Dental Services for providing a dental network for one year (until June 30, 2028);**
- (2) Approve an extension of PEBP's contract with Brown & Brown/Claim Technologies to provide health plan auditing services for one year (until June 30, 2028); and**
- (3) Approve an extension of PEBP's contract with HSA Bank for HSA/HRA account management services for four years (until June 30, 2032).**

2. New Contracts

There are no new contracts for the Board's consideration.

No action necessary.

3. Contract Amendments

Eide Bailly - Financial Auditor: Terms of a four-year extension of PEBP's contract with Eide Bailly have been negotiated. If the Board approves the amendment, it will be considered by the Board of Examiners at its October meeting. The new terms will take effect January 1, 2027.

Recommendation: Approve the amendment extending PEBP's contract with Eide Bailly until December 31, 2030.

4. Current Solicitations

Benefits Management System: As noted above, PEBP continues to negotiate with the vendor chosen during the RFP process, including incorporation of Nevada Health Authority contract management goals, and anticipates finalizing a contract for the Board's consideration at its next meeting.

Other solicitations: NVHA and PEBP staff are developing RFPs consistent with the strategy outlined above, with actuarial/consulting services and the potential unbundling of services being the most immediate priorities.

No action necessary.

12.

12. Q2 & Q3 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by UMR. (Joni Amato, CTI)
(For Possible Action)

Comprehensive Claim Administration Audit
QUARTERLY FINDINGS REPORT

**State of Nevada Public Employees' Benefit Plan Plans
Administered by UMR**

Audit Period: October 1, 2025 – December 31, 2025
Audit Number 1.FY26.Q2

Presented to
State of Nevada Public Employees' Benefit Plan
July 23, 2026



CTI Audit Solutions

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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 administration of the State of Nevada Public Employees' Benefit Plan (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of October 1, 2025 through December 31, 2025 (quarter 2 (Q2) for Fiscal Year (FY) 2026). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	\$71,592,539
Total Number of Claims Paid/Denied/Adjusted	269,326

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

- 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 27 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time within 30 Days did not meet the service objectives and a penalty is owed (breakdown in summary below).
3. CTI recommends UMR should:
 - Review financial errors identified in our random sample audit and determine if 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 of 200 claims, UMR did not meet its target for Financial Accuracy, Overall Accuracy and Claim Turnaround Time within 30 days in Q2 FY2026 and a penalty is assessed. The penalty is 3.5% of the quarter's total administrative fees of \$1,473,410.65. The following outlines results and any assessed penalties for not meeting guarantees.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Not Met – 99.16%	1.5%	\$22,101.16
Overall Accuracy	98.0%	Not Met – 97.5%	1.0%	\$14,734.11
Claim Turnaround Time	92% in 14 Days	Met – 92.9%	NA	\$0.00
	99% in 30 Days	Not Met – 98.6%	1.0%	\$14,734.11
Total Penalty			3.5%	\$51,569.38

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	Q3 FY25	Q4 FY25	Q1 FY26	Q2 FY26
Financial Accuracy	99.4%	99.56%	99.20%	99.84%	99.16%
Overall Accuracy	98.0%	99.00%	97.00%	98.00%	97.50%
Claim Turnaround Time	92% in 14 Days	93.10%	92.60%	92.00%	92.90%
	99% in 30 Days	97.50%	98.10%	98.10%	98.60%

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR's administration of the 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.

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 Q2 FY2026 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	96.1%	Met
1.5	Telephone Service Factor: Defined as percentage of Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from 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	95.7%	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%	0.9%	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%	96.4%	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	98.5%	Met
		98.00% 5 Business Days	99.7%	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%	98.5%	Met
1.10	CSR Callback Performance: measured from CSR commitment data in hours and/or days to 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	100%	Met
		95.00% Within 24 Hours	100%	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	4.5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account rep is unavailable.			
	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/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. Representative 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 the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met

Metric		Service Objective	Actual	Met/ Not 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/Regulatory documents).	100% 10 Business Days	100%	Met
1.17	ID Card Production and Distribution	100% 10 Business Days	100%	Met
1.18	Disclosure of Subcontractors: Offeror will provide 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 changes	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	EDI Claims Re-Pricing Turnaround Time: At least 97% 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%	99.1%	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 complaints filed	Met
2.6	Website: A website hosting a reasonably accurate and updated Provider directory must be available/accessible on all major browsers 99% of time.	99.00%	100%	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 a single claim or treatment plan expected to exceed \$100,000.00. Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	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 changes	Met

ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's 100% 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				
34	\$1,312.60	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☒ M ☐ S
35	\$312.13			☒ M ☐ S
38	\$140.00			☒ M ☐ S
Plan Limitations				
Hearing Aids \$1,500 Per Device Per Ear				
40	\$1,800.00	Agree. This claim was adjusted on 1/22/26 to apply the correct maximum allowable.	Procedural deficiency and overpayment remain. Hearing aids were limited to \$1,500 per unit every three years for a maximum of \$3,000.00. UMR reimbursed \$4,800.00.	☒ M ☐ S
Bitewing X-Rays Two Per Plan Year				
42	\$26.00	Disagree. UMR's standard processing guidelines do not apply a frequency limit to procedure code D0270. Based on internal subject-matter expertise, D0270 is considered comparable to a periapical x-ray, which also does not carry a frequency limitation under UMR's current dental processing standards. Therefore, original processing is correct in accordance with established guidelines.	Procedural deficiency and overpayment remain. Bitewings were limited to two per year. UMR paid for bitewings for this member on service dates 7/1/25, 10/2/25, and 11/25/25 exceeding the plan limit. Dental code D0270 refers to a single bitewing radiographic image. The Dental MPD, page 15, limits bitewing x-rays to two per plan year.	☒ M ☐ S
Enteral Formula \$2,500 Per Plan Year				
43	\$1,127.29	Agree. The maximum allowed amount for Enteral Formulas and Special Food Products was exceeded. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Enteral formula was limited to \$2,500 per year. UMR paid \$3,637.29 during the plan year.	☒ M ☐ S
Paid Greater Than Charged				
17	\$66.49	Agree. The claim should not have allowed greater than billed charges. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. The claim paid greater than the charge amount billed.	☒ M ☐ S
Office Visit – Specialist				
7	\$50.00	Agree. Based on provider specialty, specialist copay should have applied. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. A \$50.00 copay was applicable for a specialist office visit, and none was applied.	☒ M ☐ S

Diagnostic Mammography				
10	\$3.45	Agree. A \$40 copay should have applied on this claim. The claim was adjusted on 1/21/2026.	Procedural deficiency and overpayment remain. The diagnostic mammography copay of \$40.00 should have been applied and coinsurance of \$36.55 was applied in error.	☒ M ☐ S
Behavioral Health Counseling				
12	\$20.00	Agree. A separate copay should have been applied on claim as patient had two distinct and separate visits on same day. Claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. A \$20.00 copay was applicable for behavioral health counseling, and none was applied.	☒ M ☐ S
Preventive Services				
Denied				
1	(\$418.00)	Disagree. The claim was denied correctly. The denial is based on the CPT code billed as an initial comprehensive preventive medicine evaluation for a new patient for 18-39 age range. The member previously established care with this group and provider should have been billed accordingly. UMR utilizes a Claims Editing System (CES) as an automated pre-payment auditing tool to support claim accuracy, policy compliance, and payment integrity prior to adjudication. CES applies standardized clinical, coding, and billing rules at both the claim-line and claim-header levels to identify discrepancies based on industry-accepted guidelines. In this case, the CES edit correctly flagged the billed CPT code as inappropriate because the patient does not meet the criteria for a new patient visit. Records confirm that the patient was previously evaluated by the same provider group (same TIN) on 05/21/25 under claim number xxxx9944. Therefore, the patient should have billed as an established patient, not a new patient. Based on this information, the original claim processing was accurate.	Procedural deficiency and underpayment remain. In reviewing member claim history, there was no indication member saw this provider, Amelia Porciuncula, in 2023, 2024, or 2025 with the exception of the sampled claim dated 11/10/25. Amelia Porciuncula is part of the University Medical Center (UMC) group of facilities and physicians that use the same TIN. The provider of service on 5/21/25 was Quick Care; an Urgent Care facility that is also part of the UMC and uses the same TIN. The claim should have been paid as a preventive visit but was denied.	☐ M ☒ S
With Coinsurance Applied				
2	(\$32.91)	Agree. This service should have been allowed at 100%.	Procedural deficiency and underpayment remain. The charge should have been allowed without patient cost-share.	☒ M ☐ S
With Deductible Applied				
3	(\$8.26)	Agree. Service should have been considered at 100% of the allowed amount. Claim was corrected and adjusted on 1/16/26.	Procedural deficiency and underpayment remain. The charge should have been allowed without patient cost-share.	☒ M ☐ S

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 on the principles of statistical process control with a 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 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 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 \$1,609,117.86. The claims sampled and reviewed revealed \$28.19 in underpayments and \$989.80 in overpayments. This reflects a weighted Financial Accuracy rate of 99.16% over the stratified sample. This is a decrease in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2026 of 99.40% for this measure and the penalty owed is 1.5% of the administrative fees of \$1,473,410.65 or \$22,101.16.

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 5 incorrectly paid claims and 195 correctly paid claims. This is a decrease in performance from the prior period. Detail is provided in the Random Sample Findings Detail Report below.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	2	3	97.5%

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 decreased from the prior period, and UMR did not meet the Performance Guarantee for PEBP in Q2 FY2026 of 98.00% for this measure. The penalty owed is 1.0% of the administrative fees of \$1,473,410.65 or \$14,734.11. Detail is provided in the Random Sample Findings Detail Report below.

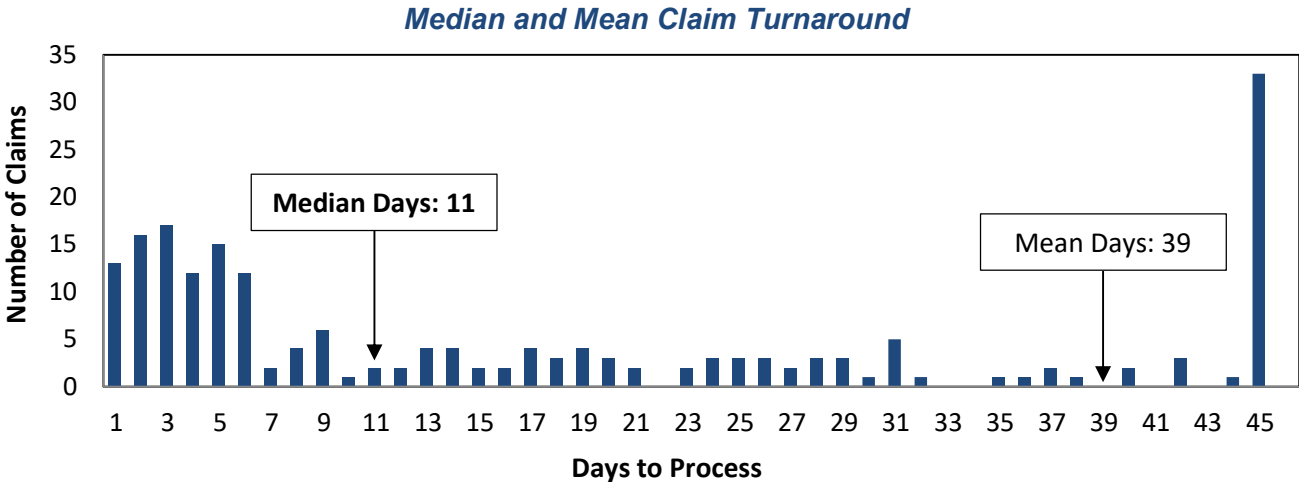
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	1	4	97.5%

Random Sample Findings Detail Report				
Audit No.	Under/Overpaid	UMR Response	CTI Conclusion	Manual or System
Incorrect Provider Discount				
1059	\$262.61	Agree. The original allowed amounts and adjustments associated with the surprise bill were reviewed, along with the additional allowed amounts applied through the appeal and IDR authorization. Based on this complete review, the correct overpaid amount is \$262.61.	Procedural error and overpayment remain. An incorrect amount was allowed due to incorrect pricing from an appeal and IDR authorization.	☒ M ☐ S
Deductible Error				
1079	(\$18.19)	Agree. An incorrect deductible amount was applied to this claim because the required internal review and release process was not followed. The claim will be adjusted to apply the correct copay.	Procedural error and underpayment remain. The deductible applied should have been \$500.00, and it was \$518.19.	☒ M ☐ S
Coinsurance Error				
1139	\$182.03	Disagree. The claim was submitted with a combination of routine and non-routine services; however, the provider selected a routine primary diagnosis code. Per standard processing guidelines, the primary diagnosis drives the classification of the claim. Accordingly, the claim was correctly processed as routine based on the primary diagnosis submitted by the provider.	Procedural error and overpayment remain. There was incorrect coinsurance on this claim. The sample claim included a routine mammogram, however, line 1 of the claim was an x-ray of the abdomen and should not have been paid as routine. The abdominal x-ray was a diagnostic service to evaluate symptoms (acute cystitis). The professional component of the claim was paid correctly applying coinsurance.	☐ M ☒ S
Denied Eligible Expense				
1140	(\$10.00)	Agree. The claim meets the requirements for reimbursement under the fifty-mile rule and should have allowed accordingly. The claim was adjusted on 3/23/26, resulting in an underpayment of \$10.00.	Procedural error and underpayment remain. An eligible expense for lab test was denied. The claim was denied <i>service provided by a non-approved medical facility</i> . The sample claim was not routine/preventive and therefore not excluded based on place of service (outpatient hospital). It should have been allowed under general lab service plan provision on page 38 of the LDMPD as the tests performed on 9/11/25 were diagnostic.	☒ M ☐ S
Incorrect Copay Applied				
1145	\$545.16	Agree. Manual processor error for an ER visit. We should have applied a \$750 copay, not coinsurance. The out-of-pocket maximum is met with this claim, however, so we only applied \$545.16 against copay amount. Total overpayment is \$545.16.	Procedural error and overpayment remain. The sample claim was an emergency room (ER) visit <i>without admission</i> and therefore an ER copay should have applied.	☒ M ☐ S

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.



UMR met the Performance Guarantee for PEBP in Q2 FY2026 of 92% processed within 14 days but did not meet the standard of 99% processed within 30 days. The penalty owed is 1.0% of the administrative fees of \$1,473,410.65 or \$14,734.11.

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
2040	CTI notes the incorrect allowable was used to process the sample claim creating a \$5.00 overpayment. Prior to sending the data file for audit to CTI, the sample claim was corrected, and a refund has been requested.

CONCLUSION

UMR did not meet the performance metric for PEBP for financial accuracy, overall accuracy and claim turnaround time within 30 days in the second quarter of FY2026. A penalty of \$51,569.38, 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 follows. Additional information submitted to CTI from UMR 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

April 7, 2026

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y26 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 34 – Medical [REDACTED] 3200 is a duplicate to claim [REDACTED] 9540. The claim was adjusted on 1-26-2026, resulting in an overpayment of \$1312.60.

QID 35 – Medical claim [REDACTED] 3575 is a duplicate to claim [REDACTED] 7190. The claim was adjusted on 1-26-2026, resulting in an overpayment of \$312.13.

QID 38 – Medical claim [REDACTED] 0998 was allowed twice in error. The claim was adjusted on 3-23-2026, resulting in an overpayment of \$140.00.

Plan Limitations – Hearing Aids \$1,500 Per Device Per Ear

QID 40 – UMR agrees with this finding. The binaural benefit was not processed correctly. With two copays applied, the member owes \$100.00. The plan language specifies a maximum plan payment of \$1500.00 not to exceed \$3000.00. The claim was adjusted on 1-22-2026, resulting in an overpayment of \$1800.00.

Plan Limitations – Bitewing X-Rays Two Per Plan Year

QID 42 – UMR disagrees with this finding. UMR's standard processing guidelines do not apply a frequency limit to procedure code D0270. Based on internal subject-matter expertise, D0270 is considered comparable to a periapical X-ray, which also does **not** carry a frequency limitation under UMR's current dental processing standards. Therefore, the original processing is correct in accordance with UMR's established guidelines.

Plan Limitations – Enteral Formula \$2,500 Per Plan Year

QID 43 – UMR agrees with this finding. An incorrect maximum allowed amount was applied to this claim. This claim was adjusted on 3-23-2026, resulting in an overpayment of \$1,127.29.

Paid Greater than Charged

QID 17 – UMR agrees with this finding. The claim should not have allowed greater than billed charges. The claim was adjusted on 3-26-2026, resulting in an overpayment of \$66.49.

Copay Application – Occupational Therapy

QID 6 – After further review, UMR continues to disagree with this finding. This claim was submitted with diagnosis code F84.0 (Autistic Disorder). Therefore, with UMR's standard claim-processing guidelines, this diagnosis is classified within the Autism Spectrum and is

therefore considered a mental health condition. Based on this classification, the original claim processing is accurate.

Copay Application – Office Visit – Specialist

QID 7 – UMR agrees with this finding. Specialist office visit co-pay should apply to this claim. The claim was adjusted on 3-20-2026, resulting in an overpayment of \$50.00.

Copay Application – Diagnostic Mammography

QID 10 – UMR agrees with this finding. Diagnostic mammography co-pay should apply to this claim. The claim was adjusted on 1-21-2026, resulting in an overpayment of \$3.45.

Copay Application – Behavioral Health Counseling

QID 12 – UMR agrees with this finding. A separate co-pay should have applied to this claim as there were two distinct and separate visits on the same day. The claim was adjusted on 3-27-2026, resulting in an overpayment of \$20.00.

Preventive Services – Denied

QID 1 – After further review, UMR continues to disagree with this finding. UMR utilizes a Claims Editing System (CES) as an automated pre-payment auditing tool to support claim accuracy, policy compliance, and payment integrity prior to adjudication. CES applies standardized clinical, coding, and billing rules at both the claim-line and claim-header levels to identify discrepancies based on industry-accepted guidelines.

In this case, the CES edit correctly flagged the billed CPT code as inappropriate because the patient does not meet the criteria for a new patient visit. Records confirm that the patient was previously evaluated by the same provider group (same TIN) on 05/21/2025 under claim number [REDACTED] 9944. Therefore, the patient should have been billed as an established patient, not a new patient. Based on this information, the original claim processing was accurate.

Preventive Services – With Coinsurance Applied

QID 2 – UMR agrees with this finding. This service should have allowed at 100%. The claim was adjusted on 3-23-2026, resulting in an underpayment of \$32.91.

Preventive Services – With Deductible Applied

QID 3 – UMR agrees with this finding. This service should have allowed at 100% of the allowed amount. The claim was adjusted on 1-16-2026, resulting in an underpayment of \$8.26.

Random Sample Findings

Incorrect Provider Discount

Sample 1059 – UMR agrees with this finding. An incorrect allowed amount applied to this claim due to incorrect pricing from an appeal and IDR authorization. The claim was adjusted on 3-24-2026, resulting in an overpayment of \$262.61.

Deductible Error

Sample 1079 – UMR agrees with this finding. An incorrect deductible amount applied to this claim because the required internal review and release process was not followed by the claim processor. The claim was adjusted on 3-23-2026, resulting in an underpayment of \$18.19.



Coinurance Error

Sample 1139 – After further review, UMR disagrees with this finding. The claim was submitted with a combination of routine and non-routine services; however, the provider selected a routine primary diagnosis code. Per standard processing guidelines, the primary diagnosis drives the classification of the claim. Accordingly, the claim was correctly processed as routine based on the primary diagnosis submitted by the provider.

Denied Eligible Expense

Sample 1140 – After further review, UMR agrees with this finding. The claim meets the requirements for reimbursement under the fifty-mile rule and should have been allowed accordingly. The claim was adjusted on 3-23-2026, resulting in an underpayment of \$10.00.

Incorrect Copay Applied

Sample 1145 - UMR agrees with this finding. An emergency room co-pay of \$750.00 should have been applied to this claim. The claim was adjusted on 3-3-2026, resulting in an overpayment of \$545.16.

UMR remains committed to enhancing the overall experience for State of Nevada PEBP members and will continue working diligently to address any issues identified in this review. We provide ongoing coaching and training for our dedicated processing team, ensuring continuous improvement.

Our team meets daily to review quality reports, identify trending errors, and implement refresher training where skill gaps are observed. These insights are used to strengthen processes and improve overall service quality.

Sincerely,

[REDACTED]

Sr. UMR External Audit Coordinator

[REDACTED]



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.



CTI Audit Solutions

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

Comprehensive Claim Administration Audit
QUARTERLY FINDINGS REPORT

**State of Nevada Public Employees' Benefit Plans
Administered by UMR**

Audit Period: January 1, 2026 – March 31, 2026
Audit Number 1.FY26.Q3

Presented to
State of Nevada Public Employees' Benefit Plans
July 23, 2026



CTI Audit Solutions

Proprietary and Confidential

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EXECUTIVE SUMMARY

This **Quarterly Findings Report** is a compilation of the detailed information, findings, and conclusions drawn from CTI Audit Solutions' (CTI's) audit of UMR's administration of the State of Nevada Public Employees' Benefit Plans (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of January 1, 2026 through March 31, 2026 (quarter 3 (Q3) for Fiscal Year (FY) 2026). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	\$77,640,150
Total Number of Claims Paid/Denied/Adjusted	250,452

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

- 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 27 self-reported performance guarantees in which CTI reviewed UMR's summary reports.
2. UMR's Financial Accuracy and Overall Accuracy did not meet the service objectives, and a penalty is owed (breakdown in summary below).
3. CTI recommends UMR should:
 - Review financial errors identified in our random sample audit and determine if 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 of 200 claims, UMR did not meet its target for Financial Accuracy and Overall Accuracy in Q3 FY2026 and a penalty is assessed. The penalty is 2.5% of the quarter's total administrative fees of \$1,479,542.69. The following outlines results and any assessed penalties for not meeting guarantees.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Not Met – 98.78%	1.5%	\$22,193.14
Overall Accuracy	98.0%	Not Met – 97.00%	1.0%	\$14,795.43
Claim Turnaround Time	92% in 14 Days	Met – 96.10%	NA	\$0.00
	99% in 30 Days	Met – 99.10%	NA	\$0.00
Total Penalty			2.5%	\$36,988.57

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	Q4 FY25	Q1 FY26	Q2 FY26	Q3 FY26
Financial Accuracy	99.4%	99.20%	99.84%	99.16%	98.78%
Overall Accuracy	98.0%	97.00%	98.00%	97.50%	97.00%
Claim Turnaround Time	92% in 14 Days	92.60%	92.00%	92.90%	96.10%
	99% in 30 Days	98.10%	98.10%	98.60%	99.10%

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR's administration of the 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.

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 Q3 FY2026 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	95.6%	Met
1.5	Telephone Service Factor: Defined as percentage of Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from 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	94.7%	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%	0.5%	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%	97.2%	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	98.9%	Met
		98.00% 5 Business Days	99.7%	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%	97.7%	Met
1.10	CSR Callback Performance: measured from CSR commitment data in hours and/or days to 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	100%	Met
		95.00% Within 24 Hours	100%	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	4.5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account rep is unavailable.			
	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/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. Representative 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 the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met

	Metric	Service Objective	Actual	Met/ Not 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/Regulatory documents).	100% 10 Business Days	100%	Met
1.17	ID Card Production and Distribution	100% 10 Business Days	100%	Met
1.18	Disclosure of Subcontractors: Offeror will provide 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 changes	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	EDI Claims Re-Pricing Turnaround Time: At least 97% 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	99.6% 99.8%	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%	99.14%	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 complaints filed	Met
2.6	Website: A website hosting a reasonably accurate and updated Provider directory must be available/accessible on all major browsers 99% of time.	99.00%	99.99%	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 a single claim or treatment plan expected to exceed \$100,000.00. Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	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 changes	Met

ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's 100% 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				
40	\$1,755.97	Agree. Claim will be adjusted at the end of the audit.	Procedural deficiencies and overpayment remain. UMR paid duplicate charges.	☒ M ☐ S
Plan Exclusions				
Experimental Treatment				
36	\$80.00	Agree. CPT code 0055T should have been denied as unbundled. The claim was adjusted on 6/11/26, resulting in an overpayment of \$80.00.	Procedural deficiency and overpayment remain. The information provided did not support payment of procedure code 0055T. It stated procedure 0055T is a component of the main procedure 27447. Procedure 0055T should have been denied as unbundled from 27447.	☒ M ☐ S
Plan Limitations				
Chiropractic Care 20 Visits Per Plan Year				
44	\$63.44	Agree. This claim was adjusted on 6/11/26, resulting in an overpayment of \$63.44.	Procedural deficiency and overpayment remain. The visit on 12/23/25 (processed on 2/6/26) was the 22nd chiropractic visit paid for the plan year and should have been denied. The services on 12/31/25 (processed 2/5/26) and 2/26/26 (processed 3/23/26) should have also been denied as over the plan limit; creating an additional \$71.06 overpayment on this member's file. The first 20 visits were on: 7/3, 7/8, 7/24, 7/31, 8/6, 8/13, 8/20, 9/4, 9/10, 9/18, 9/25, 10/2, 10/9, 10/15, 10/22, 10/29, 11/6, 11/12, 12/4 and 12/11.	☒ M ☐ S
Enteral Formula \$2,500 Per Plan Year				
46	\$762.60	Agree. More than \$2,500 has been allowed for the plan year under code B4153.	Procedural deficiency and overpayment remain. Enteral formula was limited to \$2,500 per year. UMR exceeded the limitation on this member by \$762.60.	☒ M ☐ S
Provider Discount Error				
21	\$10,651.20	Agree. Incorrect pricing was received for newborn services. Claim should have fully discounted as newborn delivery charges are included in the mother's per diem rate per provider contract. An adjustment will be completed upon completion of the review.	Procedural deficiency and overpayment remain. The contract rate was not applied to this claim.	☒ M ☐ S

ESAS Findings Detail Report				
QID	(Under)/ Over Paid	UMR Response	CTI Conclusion	Manual or System
Prior Authorization Error				
48	\$940.96	Agree. There is no authorization on file.	Procedural deficiency and overpayment remain. This genetic testing service required prior authorization, and it was not obtained prior to payment of the claim.	☒ M ☐ S
Paid Greater Than Charged				
19	\$450.79	Agree. The claim should not have allowed greater than billed charges.	Procedural deficiency and overpayment remain. The claim paid greater than the charge amount billed.	☐ M ☒ S
Copay Application				
Speech Therapy				
16	\$50.00	Agree. A copayment of \$50.00 should have applied. Claim will be adjusted at the end of the audit.	Procedural deficiency and overpayment remain. A \$50.00 copay was applicable for speech therapy, and none was applied.	☒ M ☐ S
Fraud, Waste and Abuse				
Specialty Medications				
23	\$2,352.88	Agree. The claim did not obtain the correct out of network Medicare pricing, as it should have applied the rate of 40 x 140%. The claim was adjusted on 5-7-26, resulting in an overpayment of \$2352.88.	Procedural deficiency and overpayment remain. The specialty medication J0878 did not pay the correct Medicare out of network rate.	☒ M ☐ S
Maternity Ante-Partum Unbundling				
35	\$730.08	Agree. The provider should not have billed for both CPT 59425 and CPT 59426. The claim was adjusted on 6-11-26, resulting in an overpayment of \$730.08.	Procedural deficiency and overpayment remain. The provider billed and was reimbursed for both CPT 59425 (4 – 6 antepartum visits) and CPT 59426 (7+ antepartum visits), in addition to billing for a cesarean delivery and postpartum care. Billing both 59425 and 59426 is only appropriate when a patient transfers care between providers and there is a documented break in services. There was no evidence to support a transfer of care in this case. Accordingly, the provider should have billed only CPT 59426 for 7+ antepartum visits, along with the cesarean delivery and postpartum care. The current billing reflects duplicative antepartum charges and represents an overpayment.	☒ M ☐ S

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 on the principles of statistical process control with a 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 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 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 \$1,423,695.16. The claims sampled and reviewed revealed \$2,539.60 in underpayments and \$15,588.86 in overpayments. This reflects a weighted Financial Accuracy rate of 98.78% over the stratified sample. This is a decrease in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q3 FY2026 of 99.40% for this measure and the penalty owed is 1.5% of the administrative fees of \$1,479,542.69 or \$22,193.14.

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 5 incorrectly paid claims and 195 correctly paid claims. This is a decrease in performance from the prior period. Detail is provided in the Random Sample Findings Detail Report below.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	4	97.50%

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 decreased from the prior period, and UMR did not meet the Performance Guarantee for PEBP in Q3 FY2026 of 98.00% for this measure. The penalty owed is 1.0% of the administrative fees of \$1,479,542.69 or \$14,795.43. Detail is provided in the Random Sample Findings Detail Report below.

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

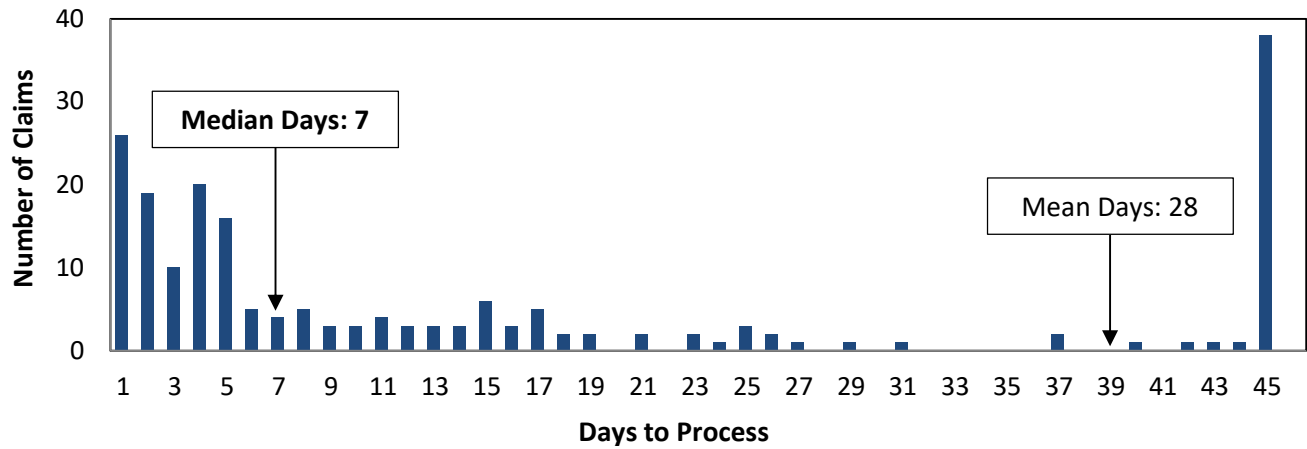
Random Sample Findings Detail Report				
Audit No.	Under/Overpaid	UMR Response	CTI Conclusion	Manual or System
Incorrect Provider Discount				
1026	\$14,029.08	Agree. This claim was processed at billed charges in error. Claim paid \$24,950.28, however the discount is \$14,029.08 and therefore should have allowed \$10,921.20. The claim will be adjusted upon completion of the audit.	Procedural error and overpayment remain. The discount amount was processed on the claim as \$0.00 and it should have been \$14,029.08.	☒ M ☐ S
1038	(\$2,539.60)	Agree. This claim was processed with the incorrect allowed amount. The claim should be priced with the below MRU pricing as noted, and per outcome of Zelis review. Underpayment of \$2,539.60. The claim will be adjusted upon completion of the audit.	Procedural error and underpayment remain. The discount should have been processed according to the contract and Zelis review.	☒ M ☐ S
1041	NA	Agree. The processor originally entered the incorrect allowable amount. The claim was adjusted on 5/1/26 to correct.	Procedural error remains. The allowed amount on the claim was processed as \$1,170.02 and it should have been \$1,755.03; this caused under application of \$585.01 to the member's deductible. Claim was adjusted and correct benefit applied.	☒ M ☐ S
1127	\$523.09	Agree. This claim was manually processed with the incorrect SHO pricing, as it should have been routed to UHC for pricing. Overpayment \$523.09.	Procedural error and overpayment remain. The sample claim was processed with the incorrect SHO pricing, it should have been routed to UHC for pricing.	☒ M ☐ S
1135	\$129.38	Agree. The claim was denied as a total discount in error. The correct allowable is \$157.84. The claim was adjusted on 5/14/26 with a payment of \$129.38.	Procedural error and overpayment remain. The discount amount was processed on the claim as \$1,151.00 and it should have been \$993.16. The claim was adjusted by UMR on 5/14/26 with payment of \$129.38.	☒ M ☐ S
Coinurance Error				
1145	\$907.31	Agree. This claim is manually processed; the claim will be adjusted upon completion of the audit.	Procedural error and overpayment remain. The coinsurance applied should have been \$907.31 and it was \$0.00. Billing for an observation room over 23 hours should have been processed under the inpatient benefit provision at 80% coinsurance.	☒ M ☐ S

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 met the Performance Guarantees for PEBP in Q3 FY2026 of 92% processed within 14 days and 99% processed within 30 days and no penalty is due.

CONCLUSION

UMR did not meet the performance metric for PEBP for Financial Accuracy and Overall Accuracy in the third quarter of FY2026. A penalty of \$36,988.57, or 2.5% 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 follows. Additional information submitted to CTI from UMR 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

June 15, 2026

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y26 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 40 – UMR agrees with this finding. Medical claim [REDACTED] 4154 is a duplicate to claim [REDACTED] 9900. The claim was adjusted on 5-21-26, resulting in an overpayment of \$1755.97.

Plan Exclusions – Experimental Treatment

QID 36 – Upon the further review, UMR agrees with this finding. CPT code 0055T should have been denied as unbundled. The claim was adjusted on 6-11-26, resulting in an overpayment of \$80.00

Plan Limitations – Timely Filing

QID 9 and 10 – UMR disagrees with this finding. An LOA is on file approving a waiver of timely filing requirements. PEBP's QC Officer also previously advised that, if documentation could be provided demonstrating timely efforts to resolve the issue from a filing perspective, the claim could be reviewed and reconsidered. It was subsequently determined that the initial LOA contained an incorrect TIN for claim submissions. Based on this, these claims are processed appropriately.

Plan Limitations – Chiropractic Care

QID 44 – Upon further review, UMR agrees with this finding. This claim was adjusted on 6-11-26, resulting in an overpayment of \$63.44.

Plan Limitations – Enteral Formula

QID 46 – UMR agrees with this finding. More than \$2500 has been allowed for the plan year under code B4153. The claim was adjusted on 6-11-26, resulting in an overpayment of \$762.60.

Provider Discount Error

QID 21 – UMR agrees with this finding. The claim should have been fully discounted as newborn delivery charges are included in the mother's per diem rate per the provider contract. The claim was adjusted on 5-6-26, resulting in an overpayment of \$10651.20.

Prior-Authorization Error

QID 48 – UMR agrees with this finding. There is no authorization on file for these services. This claim was adjusted on 6-11-26, resulting in an overpayment of \$940.96.

Paid Greater than Charged

QID 19 – UMR agrees with this finding. The claim should not have allowed greater than billed charges. The claim was adjusted on 6-3-26, resulting in an overpayment of \$521.79.

Copay Application – Speech Therapy

QID 16 – UMR agrees with this finding. A copayment of \$50.00 should have applied. The claim was adjusted on 4-29-26, resulting in an overpayment of \$37.00.

Preventive Services – Denied

QID 8 – UMR disagrees with this finding. The member does not meet the age requirements for preventive coverage under HCR guidelines. Please see below for additional support documentation. Based on this information, the claim was processed appropriately. Per plan guidelines routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date. This member did not have any other services on file for the plan year except for the independent lab service.

Population	Recommendation	Grade
Adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (CVD) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	B

Per Master Plan Document outlined below.

Annual check-ups, including related screening lab and x-rays.

- Note: routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date

Fraud, Waste and Abuse – Specialty Medications

QID 23 – UMR agrees with this finding. The claim did not obtain the correct out of network Medicare pricing, as it should have applied the rate of 40 x 140%. The claim was adjusted on 5-7-26, resulting in an overpayment of \$2352.88.

Fraud, Waste and Abuse – Applied Behavioral Analysis

QID 32 – UMR disagrees with this finding. The correct authorization number for these approved services is documented below.

Line # 3			
Begin Date	01/01/26	End Date	07/01/26
Place of Service	OP	Procedure Code	97153
Diagnosis	F840	Occurrences	0072
Precert#		Type of Vendor	S
Provider Name		Allowed \$	.00
		Reason Code	M
		Level of Care	
		Modifier	
		Appeals	
		Approval	APPR



Fraud, Waste and Abuse – Maternity

QID 35 – Upon further review, UMR agrees with this finding. The provider should not have billed for both CPT 59425 and CPT 59426. The claim was adjusted on 6-11-26, resulting in an overpayment of \$730.08.

Observations

QID 1 and 2 - These claims are paid correctly and were handled according to the specific provider contracts for services rendered.

██████████ 9110 was priced as a case rate for revenue code 450 in which CPT code 74177 TC is inclusive of this case rate.

██████████ 6904 was priced according to the provider contract which excludes CPT codes with NDC numbers from editing, in this case CPT code J1568 was billed.

Random Sample Findings**Incorrect Provider Discount**

Sample 1026 – UMR agrees with this finding. This claim was processed at billed charges in error. The discount is \$14029.08 and therefore should have allowed \$10921.20. The claim was adjusted on 6/10/26, resulting in an overpayment of \$14259.08.

Sample 1038 – UMR agrees with this finding. This claim was processed with the incorrect allowed amount. The claim was adjusted on 5-13-26, resulting in an underpayment of \$2539.60.

Sample 1041 – UMR agrees with this finding. The processor originally entered the incorrect allowed amount. The claim was adjusted on 5-1-26, resulting in underpayment of \$585.02.

Sample 1127 – UMR agrees with this finding. This claim was manually processed with incorrect network pricing. The claim was adjusted on 6/15/26, resulting in an overpayment of \$523.09.

Sample 1135 – UMR agrees with this finding. The claim was denied as total discount in error. The claim was adjusted on 5-14-26, with a payment of \$129.38.

Coinurance Error

Sample 1145 – UMR agrees with this finding. The claim was adjusted on 6-4-26, and the overpayment is only \$750, due to the patient's out of pocket being met.

Service Not Medically Necessary / Ineligible Expense

Sample 1148 – UMR disagrees with this finding. The claim was considered without member cost share due the ER claim on file for a non-routine diagnosis. The physician billed for the read of the CT scan that was provided in the ER.



UMR remains committed to enhancing the overall experience for State of Nevada PEBP members and will continue working diligently to address any issues identified in this review. We provide ongoing coaching and training for our dedicated processing team, ensuring continuous improvement.

Our team meets daily to review quality reports, identify trending errors, and implement refresher training where skill gaps are observed. These insights are used to strengthen processes and improve overall service quality.

Sincerely,

Miranda McCullough
Sr. UMR External Audit Coordinator
303-993-1713



CTI 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.



CTI Audit Solutions

1415 28th Street, Suite 300 | Des Moines, IA 50266

13.

13. Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report. (Chris Garcia, Willis Towers Watson/VIA) (Information/Discussion)

Public Employees' Benefits Programs

Quarterly Update – 3rd Quarter Fiscal Year 2026

WTW's Individual Marketplace (Via Benefits)



May 21, 2026



Executive Summary

Quarterly Update – 3rd Quarter Fiscal Year 2026

Plan Enrollment

- As of FY Q3, 19,725 plan applications have been processed for PEBP retirees through Via Benefits, selecting 978 plans across 105 carriers.
- Medicare Supplement (MS) plans made up 82% of enrollments, led by AARP (5,551) and Anthem BCBS NV (1,440). Average MS premium: \$149 per month.
- Medicare Advantage (MA) enrollment remained at 18%, with top selections from Humana (444) and Hometown Health Plan (426). Average MA premium: \$6 per month.

Customer Satisfaction

- Enrollment Calls: 4.8/5.0 from 28 surveys.
- Service Calls: 4.2/5.0 from 330 surveys.
- Combined Q3 satisfaction: 4.2/5.0.

Health Reimbursement Arrangement

- 12,306 HRA accounts were active at the end of Q3 2026.
- 118,457 claims were processed, with 88.6% auto-reimbursed (104,966 claims).
- Total reimbursements: \$8.5M across 43,650 payments, averaging \$195.66 per payment.

Summary of Retiree Decisions and Costs

Quarterly Update – 3rd Quarter Fiscal Year 2026

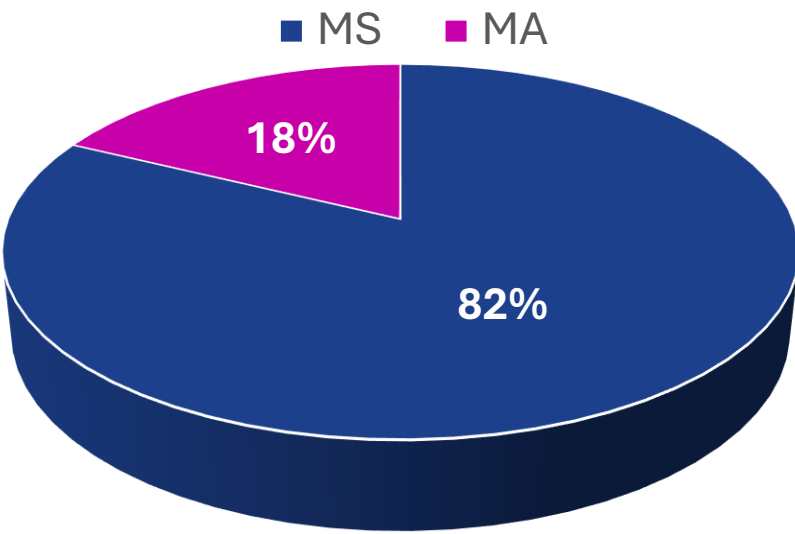
Retiree Plan Selection Through 3/31/2026	Q3	Previous Qtr.
Total applications through Individual Marketplace	19,725	19,661
Number of carriers**	105	104
Number of plans**	978	969

Plan Type Selection Through 3/31/2026	Q3	Previous Qtr.
Medicare Advantage (MA, MAPD)	2,056	2,032
Medicare Supplement (MS)	9,513	9,483

Summary of Retiree Decisions and Costs - Continue

Quarterly Update – 3rd Quarter Fiscal Year 2026

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)	9,513	\$150
Medicare Advantage (MA,MAPD)	2,056	\$2 / \$5
Part D drug coverage	5,530	\$25
Dental coverage	899	\$38
Vision coverage	1,727	\$15

Summary of Retiree Carrier Choice

Quarterly Update – 3rd Quarter Fiscal Year 2026

Top Medicare Supplement Plans

Carrier	Total
AARP	5,551
Anthem BCBS of NV	1,440
Humana	702
Anthem BCBS	401
Cigna Health	297

Medicare Supplement Carrier Choice

Carrier	Percentage
AARP	59%
Anthem BCBS of NV	15%
Humana	7%
Anthem BCBS	4%
Cigna Health	3%
All Others	12%

Cost Data For MS Plans

Data	Cost
Minimum	\$0
Average	\$149
Median	\$141
Maximum	\$2,249

Summary of Retiree Carrier Choice - Slide 2

Quarterly Update – 3rd Quarter Fiscal Year 2026

Top Medicare Advantage Plans

Carrier	Total
Humana	444
Hometown Health Plan	426
Aetna	391
AARP from UHC	344
AllWell	112

Medicare Advantage Carrier Choice

Carrier	Percentage
Humana	22%
Hometown Health Plan	21%
Aetna	19%
AARP from UHC	17%
AllWell	5%
All Others	16%

Cost Data For MA Plans

Data	Cost
Minimum	\$0
Average	\$6
Median	\$0
Maximum	\$248

Summary of Retiree Carrier Choice – Slide 3

Quarterly Update – 3rd Quarter Fiscal Year 2026

Top Part D Plans

Carrier	Total
WellCare	2,891
Humana	1,557
AARP Part D from United Healthcare	505
Aetna Medicare Rx	289
CIGNA	282

Part D (RX) Carrier Choice

Carrier	Percentage
WellCare	52%
Humana	28%
AARP Part D from United Healthcare	9%
Aetna Medicare Rx	5%
CIGNA	5%
All Others	1%

Cost Data For Part D Plans

Data	Cost
Minimum	\$0
Average	\$15
Median	\$13
Maximum	\$165

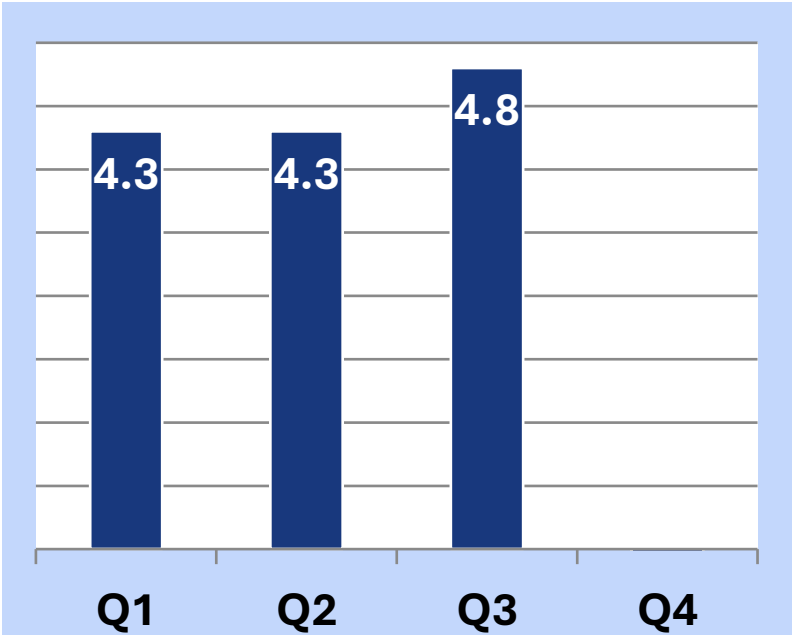
Customer Service – Voice of the Customer (VoC)

Quarterly Update – 3rd Quarter Fiscal Year 2026

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.

Q2 Enrollment Satisfaction

CSAT score	Count	%
5	23	82%
4	4	14%
3	0	0%
2	0	0%
1	1	4%
	28	100%



Customer Service – Voice of the Customer (VoC) – Slide 2

Quarterly Update – 3rd Quarter Fiscal Year 2026

Q2 Service Satisfaction

CSAT score	Count	%
5	202	61%
4	48	15%
3	31	9%
2	20	6%
1	29	9%
	330	100%

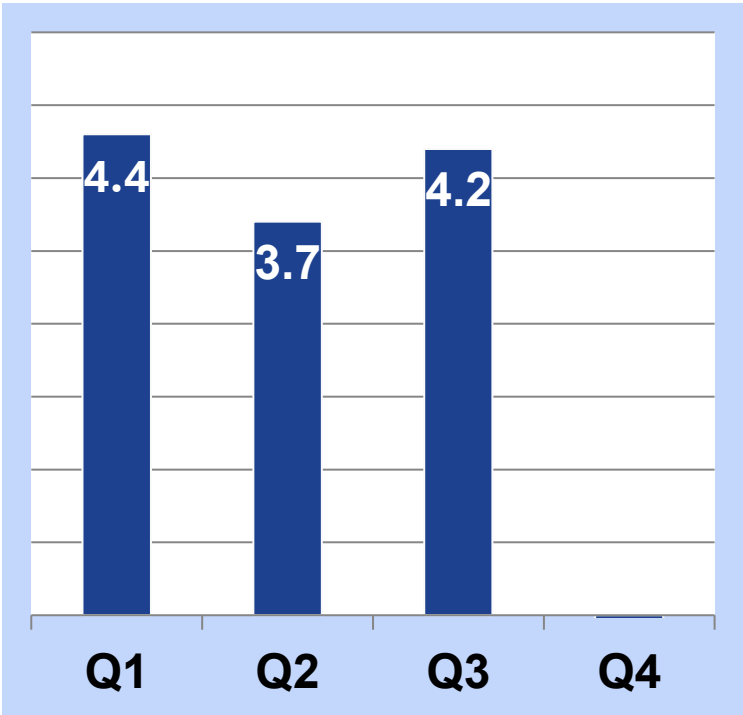


Customer Service – Voice of the Customer (VoC) – Slide 3

Quarterly Update – 3rd Quarter Fiscal Year 2026

Q2 Enrollment and Service Combined

CSAT score	Count	%
5	225	63%
4	52	15%
3	32	9%
2	20	5%
1	29	8%
	358	100%



Customer Service – Issues Log Resolution

Quarterly Update – 3rd Quarter Fiscal Year 2026

Each quarter, PEBP and WTW receive participant inquiries that require escalation to the Individual Marketplace Issues Log. WTW staff monitor and resolve these items. In Q3-FY 2026, 108 inquiries were reviewed, falling into the following categories:

Automatic Reimbursement	0
Call Review	0
Carrier Issue	0
Eligibility Data	0
Enrollment Request	9
Enrollment Status	26

General Questions	2
HRA	23
Mailings/Email	2
Reimbursement	7
Update Participant Information	0
Website Issues	1

Health Reimbursement Arrangement (HRA)

Quarterly Update – 3rd Quarter Fiscal Year 2026

Claim Activity for the Quarter	Q3 Total	Prior Quarter
HRA accounts	12,306	12,746
Number of payments	43,650	43,341
Accounts with no balance	7,985	7,916
Accounts with Direct Deposit	11,513	11,523
% of Accounts with Direct Deposit	94%	90%
Claims paid amount	\$8,540,376	\$8,066,764

Health Reimbursement Arrangement (HRA) - Continued

Quarterly Update – 3rd Quarter Fiscal Year 2026

Claims by Source	Q3 Total	Prior Quarter
Automatic Reimbursement Premium File	104,966	102,086
Mail	6,160	7,595
Website	4,963	5,235
Mobile App	2,368	4,066
TOTAL	118,457	118,982

Performance Guarantees*

Quarterly Update – 3rd Quarter Fiscal Year 2026

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.2 Days	Yes
Claim Financial Precision	≥ 98%	99.6%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.8%	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.	34 seconds	Yes

*Performance guarantees are reviewed as part of the Fiscal Year claims audit. Any penalties due to Nevada PEPB for missed performance guarantees are addressed then.

Performance Guarantees* - Continued

Quarterly Update – 3rd Quarter Fiscal Year 2026

Category	Commitment	Outcome	PG MET
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	0.7%	Yes
Customer Satisfaction	≥ 80%	86.3%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

*Performance guarantees are reviewed as part of the Fiscal Year claims audit. Any penalties due to Nevada PEPB for missed performance guarantees are addressed then.

Operations Report

Quarterly Update – 3rd Quarter Fiscal Year 2026

HRA Available Balance Cap of \$8,000

Effective May 29, 2026, Via Benefits will process the annual \$8,000 HRA Available Balance Cap reduction on accounts with a balance of more than \$8,000. (Note that May 31, 2026 is on a Sunday so the process this year will occur on the last business day of May.) Nevada PEBP has sent communications related to the Available Balance Cap to 696 participants with balances of \$7,000 or greater as they are expected to be the ones who will potentially be impacted by the Cap this year. The goal of the communication is to remind participants to submit claims against their balance to reduce it below the \$8,000 threshold so they do not lose any of their HRA balance. Once funds are removed from an account because they are over the \$8,000 cap, they cannot be added back.

Operations Report – Slide 2

Quarterly Update – 3rd Quarter Fiscal Year 2026

Spring 2026 Retiree Meetings

WTW and Nevada PEBP hosted four virtual retiree meetings on April 15 and 16, with a live attendance option at the PEBP offices in Carson City. The meetings were designed to:

- 1) Educate Pre-65 retirees who are aging into Medicare
- 2) Educate active employees who are 65 or older who are considering retiring on the transition to Medicare
- 3) Educate Medicare eligible retirees who are already enrolled through Via Benefits with additional information Medicare and the HRA

Recordings of the meetings are available on the [Nevada PEBP Via Benefits website](#) for participants to review.

14.

- 14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)
 - 14.1 Q3 UMR – Obesity & Diabetes Care Management
 - 14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
 - 14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management
 - 14.4 Q3 UnitedHealthcare – Basic Life Insurance
 - 14.5 Q3 Express Scripts – Utilization Report
 - 14.6 Q3 Express Scripts – Summary Report
 - 14.7 Q3 CDHP Performance Report
 - 14.8 Q3 LD PPO Performance Report
 - 14.9 Q3 EPO Performance Report
 - 14.10 Q3 HPN Performance Report
 - 14.11 Q3 Dental Performance Review
 - 14.12 Q3 Doctor on Demand Engagement Report

14.1

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management



Public Employees' Benefits Program

Quarterly Plan Performance Review OCM & DCM • 2026-3Q



A UnitedHealthcare Company





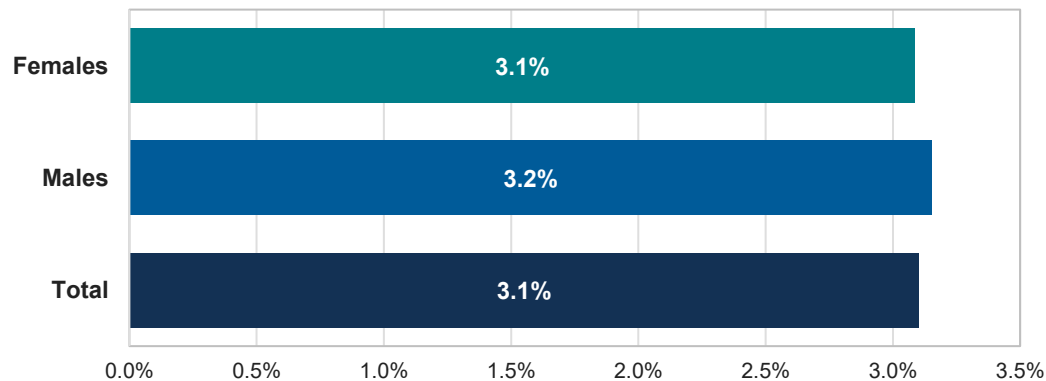
Obesity Care Management

Overview

Weight Management Summary	Females	Males	Total
Members Enrolled in OCM	271	63	334
Average Pounds Lost	6.5	8.2	6.8
Total Pounds Lost	1,757.8	516.7	2,274.5
% Pounds Lost	3.1%	3.2%	3.1%
Average Paid per Member	\$4,533	\$4,638	\$4,553

➤ At \$505.45, Paid PMPM for OCM participants is significantly (-43.8%) lower than non-participants (\$899.41)

Average % Pounds Lost



Obesity Care Management participation is for the 2026 Plan Year with activity through 3/31/2026

Claims Date Range (for Avg. Paid per Member): Service Dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026



Obesity Care Management

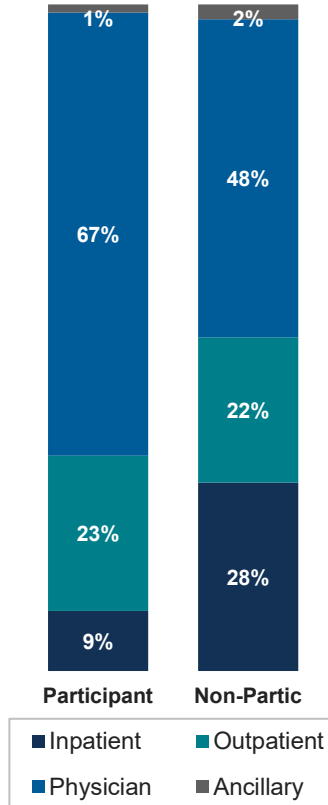
Financial & Utilization Summary

Financial Summary

Financial Measure	Participants	Non-Partic.	Variance
Average Enrollment			
Employees	295	521	-43.4%
Tot. Members	334	607	-45.0%
Emp to Total Ratio	1.1	1.2	-2.8%
Financial Summary			
Allowed	\$1,969,880	\$5,738,544	-65.7%
Plan Paid	\$1,520,778	\$4,917,976	-69.1%
Member Paid (OOP)	\$273,793	\$787,739	-65.2%
Paid PEPY*	\$6,867	\$12,575	-45.4%
Paid PMPY*	\$6,065	\$10,793	-43.8%
Paid PEPM	\$572	\$1,048	-45.4%
Paid PMPM	\$505	\$899	-43.8%
High-Cost Claimants (Med Paid \$100,000+)			
# of HCCs	1	5	-80.0%
HCCs per 1000	3.0	8.2	-63.7%
Paid per HCC	\$159,786	\$309,029	-48.3%
HCC Paid % of Tot	10.5%	31.4%	-20.9 pts
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	\$547	\$3,050	-82.1%
Outpatient	\$1,412	\$2,352	-40.0%
Physician	\$4,034	\$5,148	-21.6%
Ancillary	\$72	\$242	-70.2%

* Annualized

Cost Distribution By Claim Type



Utilization Summary

Utilization Measure	Participants	Non-Partic.	Variance
Inpatient Admissions			
# of Admits	10	49	-79.6%
# of Admit Days	41	313	-86.9%
Paid per Admit	\$16,201	\$33,382	-51.5%
Paid per Admit Day	\$3,951	\$5,226	-24.4%
Admits per 1000	39.9	107.5	-62.9%
Average LOS	4.1	6.4	-35.8%
Emergency Room Visits			
# of ER Visits	47	152	-69.1%
~ % resulting in Admit	10.6%	14.5%	-3.8 pts
ER Visits per Patient	1.3	1.5	-13.1%
ER Visits per 1000	187.5	333.6	-43.8%
Paid per ER Visit	\$4,075	\$3,235	26.0%
Urgent Care Visits			
# of UC Visits	108	195	-44.6%
UC Visits per Patient	1.4	1.5	-2.5%
UC Visits per 1000	430.7	427.9	0.7%
Paid per UC Visit	\$110	\$103	6.0%
Office Visits			
Off Visits per Patient	14.6	6.7	119.2%
Paid per Office Visit	\$123	\$94	31.0%
Office Visits Paid PMPY	\$2,386	\$801	197.8%
Services			
Radiology Svcs per 1000	5,767.2	5,817.9	-0.9%
Radiology Paid PMPY	\$376	\$707	-46.8%
Lab Services per 1000	17,325.5	21,364.3	-18.9%
Labs Paid PMPY	\$311	\$496	-37.3%

Non-participants are defined as members identified with a morbid obesity condition in the prior 12 months (4/1/2025 - 3/31/2026), but who are not enrolled in the Obesity Care Management program

Claims Date Range: Service Dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026



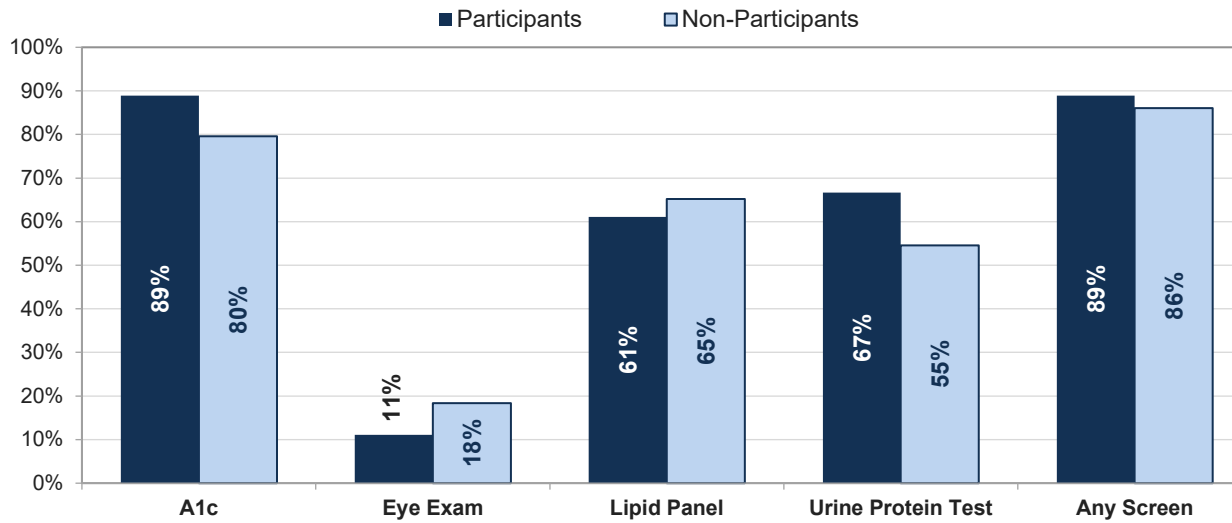


Diabetes Care Management

Screenings Breakout: Participants vs. Non-Participants

Diabetes Screening	Participants			Non-Participants			Participant vs. Non-Variance
	Members	# with Screening	Screening Rate	Members	# with Screening	Screening Rate	
A1c Test	18	16	88.9%	3,470	2,762	79.6%	9.3
Eye Exam	18	2	11.1%	3,470	636	18.3%	-7.2
Lipid Panel	18	11	61.1%	3,470	2,262	65.2%	-4.1
Urine Protein Test	18	12	66.7%	3,470	1,892	54.5%	12.1
Any Diabetes Screen	18	16	88.9%	3,470	2,986	86.1%	2.8

- 77.8% of DCM participants had an office visit for Diabetes, while 64.4% of non-participants had a visit
- 11.1% of DCM participants received all four screenings, while 9.3% of non-participants did



Diabetes Care Management participation is for the 2026 Plan Year with activity through 3/31/2026

Non-participants are defined as members identified with diabetes in the prior 12 months (4/1/2025 - 3/31/2026), but who are not enrolled in the Diabetes Care Management program

Screening Date Range: Service Dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026



Diabetes Care Management

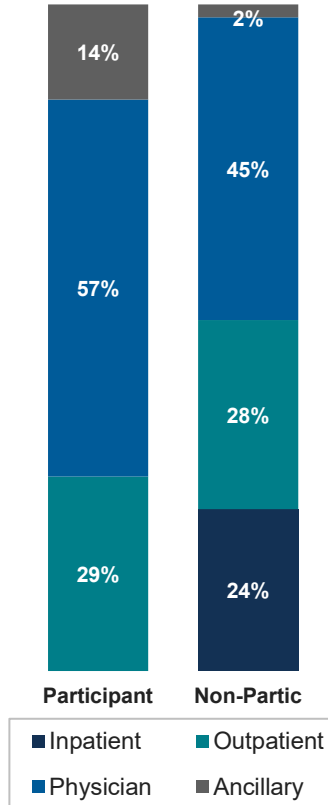
Financial & Utilization Summary

Financial Summary

Financial Measure	Participants	Non-Partic.	Variance
Average Enrollment			
Employees	13	2,788	-99.5%
Tot. Members	18	3,470	-99.5%
Emp to Total Ratio	1.4	1.2	11.2%
Financial Summary			
Allowed	\$51,310	\$28,142,302	-99.8%
Plan Paid	\$32,581	\$22,024,358	-99.9%
Member Paid (OOP)	\$18,729	\$4,157,281	-99.5%
Paid PEPY*	\$3,339	\$10,523	-68.3%
Paid PMPY*	\$2,411	\$8,455	-71.5%
Paid PEPM	\$278	\$877	-68.3%
Paid PMPM	\$201	\$705	-71.5%
High-Cost Claimants (Med Paid \$100,000+)			
# of HCCs	0	32	-100.0%
HCCs per 1000	0.0	9.2	-100.0%
Paid per HCC	\$0	\$183,398	-
HCC Paid % of Tot	0.0%	26.6%	-26.6 pts
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	\$0	\$2,051	-100.0%
Outpatient	\$704	\$2,399	-70.7%
Physician	\$1,364	\$3,840	-64.5%
Ancillary	\$344	\$165	108.3%

* Annualized

Cost Distribution By Claim Type



Utilization Summary

Utilization Measure	Participants	Non-Partic.	Variance
Inpatient Admissions			
# of Admits	0	208	-100.0%
# of Admit Days	0	1,159	-100.0%
Paid per Admit	\$0	\$30,462	-
Paid per Admit Day	\$0	\$5,467	-
Admits per 1000	0.0	79.9	-100.0%
Average LOS	0.0	5.6	-
Emergency Room Visits			
# of ER Visits	1	796	-99.9%
~ % resulting in Admit	0.0%	17.5%	-17.5 pts
ER Visits per Patient	1.0	1.5	-32.3%
ER Visits per 1000	74.0	305.6	-75.8%
Paid per ER Visit	\$3,218	\$3,351	-4.0%
Urgent Care Visits			
# of UC Visits	2	900	-99.8%
UC Visits per Patient	1.0	1.5	-32.7%
UC Visits per 1000	148.0	345.5	-57.2%
Paid per UC Visit	\$104	\$99	5.0%
Office Visits			
Off Visits per Patient	3.1	6.0	-48.2%
Paid per Office Visit	\$57	\$91	-37.3%
Office Visits Paid PMPY	\$224	\$677	-67.0%
Services			
Radiology Svcs per 1000	1,406.1	7,010.7	-79.9%
Radiology Paid PMPY	\$243	\$627	-61.3%
Lab Services per 1000	15,171.3	19,898.4	-23.8%
Labs Paid PMPY	\$151	\$418	-63.9%

Non-participants are defined as members identified with diabetes in the prior 12 months (4/1/2025 - 3/31/2026), but who are not enrolled in the Diabetes Care Management program

Claims Date Range: Service Dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026



14.2

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	99.46%	
Q2 Results	99.11%	
Q3 Results	99.14%	
Q4 Results		

Network Repricing Turnaround Time - UMR		
PEBP PG Target	Returned 97% in 3 Days	Returned 99% in 5 days
Q1 Results	99.50%	99.50%
Q2 Results	99.50%	99.50%
Q3 Results	99.60%	99.80%
Q4 Results		

Network Provider Directory Disputes - UMR

PEBP PG Target	Total Directory Disputes	TAT - Within 10 Business Days
Q1 Results	0	N/A
Q2 Results	0	N/A
Q3 Results	0	N/A
Q4 Results		

14.3

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management



SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review



SIERRA HEALTH-CARE OPTIONS, INC.™

Executive Summary

Metrics	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Average
Enrollment	52,682	52,593	52,775	52,835	52,791	52,778	52,520	52,668	52,598	52,693

Inpatient All - LTACH, AIR, SNF, and OOA

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Total Discharges	179	154	147	166	143	175	146	143	193	1,446	161
Total Discharges LOS	1,113	956	944	968	591	998	873	903	699	8,045	894
Average LOS	6.2	6.2	6.4	5.8	4.1	5.7	6.0	6.3	3.6	5.6	5.6

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

Inpatient Hospital Acute Only

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Total Discharges	135	110	111	119	94	126	100	102	134	1,031	115
Total Discharges LOS	675	546	538	478	377	523	493	503	448	4,581	509
Average LOS	5.0	5.0	4.8	4.0	4.0	4.2	4.9	4.9	3.3	4.4	4.4

Beddays by Facility Type

Metrics						Beddays						
Facility Type	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average	
Hospital	675	551	538	478	378	523	567	548	527	4,785	532	
Hospital Rehabilitation	6	7	18	30	46	14	10	13	26	170	19	
Skilled Nursing	38	16	0	24	19	57	0	54	17	225	32	
Out of Area	394	389	388	439	149	404	370	375	366	3,274	364	

Beddays per K

Metrics	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Facility Type										
Hospital	153.8	125.7	122.3	108.6	85.9	118.9	129.6	124.9	120.2	121.1
Hospital Rehabilitation	1.4	1.6	4.1	6.8	10.5	3.2	2.3	3.0	5.9	4.3
Skilled Nursing	8.7	3.7	0.0	5.5	4.3	13.0	0.0	12.3	3.9	5.7
Out of Area	89.7	88.8	88.2	99.7	33.9	91.9	84.5	85.4	83.5	82.8

Admits by Facility Type

Metrics						Admits						
Facility Type	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average	
Hospital	133	120	110	111	92	132	98	113	131	1,040	116	
Hospital Rehabilitation	1	1	2	2	2	1	1	1	3	14	2	
Skilled Nursing	3	1	0	1	3	1	0	3	1	13	2	
Out of Area	45	39	41	50	35	49	48	37	63	407	45	

Admits per K

Metrics	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Facility Type										
Hospital	30.3	27.4	25.0	25.2	20.9	30.0	22.4	25.7	29.9	26.3
Hospital Rehabilitation	0.2	0.2	0.5	0.5	0.5	0.2	0.2	0.2	0.7	0.4
Skilled Nursing	0.7	0.2	0.0	0.2	0.7	0.2	0.0	0.7	0.2	0.3
Out of Area	10.3	8.9	9.3	11.4	8.0	11.1	11.0	8.4	14.4	10.3

Readmits by Facility Type

Metrics						Readmits							
Facility Type	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average		
Hospital	12	10	13	5	10	10	6	3	0	69	8		
Hospital Rehabilitation	0	0	0	0	0	0	0	0	0	0	0		
Skilled Nursing	0	0	0	0	0	0	0	0	0	0	0		
All Other	3	4	4	3	5	2	1	0	0	22	2		

Average Length of Stay by Facility

Facility Type	Metrics	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Average LOS											
Facility Name											
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	1.5	4.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	2.0
	CARSON TAHOE REGIONAL MEDICAL CENTER	2.9	3.4	2.8	6.1	4.6	2.9	2.1	3.8	3.0	3.5
	CENTENNIAL HILLS HOSPITAL MEDICAL	5.4	2.8	3.5	3.8	3.7	2.3	2.7	2.3	3.5	3.6

Facility Type	Beddays by Facility												
	Metrics						Beddays						
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average	
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	3	4	0	1	0	0	0	6	0	14	4	
	CARSON TAHOE REGIONAL MEDICAL CENTER	49	93	39	73	82	75	19	65	68	563	63	
	CENTENNIAL HILLS HOSPITAL MEDICAL	65	17	42	15	37	16	16	9	39	256	28	
	HENDERSON HOSPITAL	13	16	6	17	24	16	0	10	17	119	11	
	LAS VEGAS VAMC	0	0	0	0	3	7	5	0	0	15	5	
	MOUNTAIN VIEW HOSPITAL	3	15	43	14	4	42	15	71	21	228	25	
	NORTH VISTA HOSPITAL	5	0	1	0	1	0	1	1	0	9	2	
	RENOWN REGIONAL MEDICAL CENTER	359	180	207	152	115	183	314	190	193	1,893	210	
	SOUTHERN HILLS HOSPITAL	54	33	17	8	5	12	44	0	10	183	23	
	SPRING VALLEY HOSPITAL	23	29	5	8	19	33	12	5	7	141	16	
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN	0	0	3	9	0	2	5	6	15	40	7	
	ST ROSÉ DOMINICAN HOSPITAL SIENA	33	21	67	20	24	39	27	37	42	310	34	
	SUMMERLIN HOSPITAL MEDICAL CTR	19	41	37	68	23	40	75	77	29	409	45	
	SUNRISE HOSPITAL	11	26	52	62	9	32	12	17	56	277	31	
	UNIVERSITY MEDICAL CENTER SO NV	31	40	19	27	30	20	17	46	22	252	28	
	VALLEY HOSPITAL MEDICAL CTR	7	36	0	4	2	6	5	8	8	76	10	
	Total	675	551	538	478	378	523	567	548	527	4,785	0	
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT	0	0	0	0	0	0	10	0	0	10	10	
	ENCOMPASS HEALTH HOSPITAL OF	6	7	8	5	9	0	0	0	1	36	6	
	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	0	0	0	14	0	0	15	29	15	
	HORIZON SPECIALTY HOSPITAL OF	0	0	0	25	0	0	0	0	0	25	25	
	KINDRED HOSPITAL W SAHARA	0	0	0	0	37	0	0	0	10	47	24	
	PAM REHABILITATION HOSPITAL OF	0	0	10	0	0	0	0	0	0	10	10	
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	0	0	0	0	0	13	0	13	13	
	Total	6	7	18	30	46	14	10	13	26	170	0	
Skilled Nursing	HARMON HOSPITAL	0	0	0	0	13	0	0	0	0	13	13	
	SANDSTONE SPRING VALLEY LLC	15	0	0	24	6	57	0	54	17	173	29	
	TRELLIS CENTENNIAL	0	16	0	0	0	0	0	0	0	16	16	
	WELBROOK CENTENNIAL HILLS	23	0	0	0	0	0	0	0	0	23	23	
	Total	38	16	0	24	19	57	0	54	17	225	0	
Out of Area	Out of Area	394	389	388	439	149	404	370	375	366	3,274	364	
	Total	394	389	388	439	149	404	370	375	366	3,274	0	

Facility Name		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	1	1	0	1	0	0	0	3	0	6	2
	CARSON TAHOE REGIONAL MEDICAL CENTER	17	28	12	12	20	24	9	17	23	162	18
	CENTENNIAL HILLS HOSPITAL MEDICAL	14	6	10	5	9	7	6	4	8	69	8
	HENDERSON HOSPITAL	4	4	2	4	6	5	0	4	6	35	4
	LAS VEGAS VAMC	0	0	0	0	1	1	1	0	0	3	1
	MOUNTAIN VIEW HOSPITAL	1	4	9	5	1	9	4	10	8	51	6
	NORTH VISTA HOSPITAL	1	0	1	0	1	0	1	1	0	5	1
	RENOWN REGIONAL MEDICAL CENTER	54	28	35	36	20	42	35	36	44	330	37
	SOUTHERN HILLS HOSPITAL	5	6	6	2	2	3	7	0	2	33	4
	SPRING VALLEY HOSPITAL	7	6	2	3	3	6	4	2	3	36	4
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN	0	0	2	3	0	1	1	2	2	11	2
	ST ROSE DOMINICAN HOSPITAL SIENA	11	8	10	7	10	8	10	11	11	86	10
	SUMMERLIN HOSPITAL MEDICAL CTR	5	12	9	13	8	9	10	10	11	87	10
	SUNRISE HOSPITAL	5	7	8	11	6	8	5	6	8	64	7
	UNIVERSITY MEDICAL CENTER SO NV	7	6	4	8	4	8	3	6	2	48	5
	VALLEY HOSPITAL MEDICAL CTR	1	4	0	1	1	1	2	1	3	14	2
	Total	133	120	110	111	92	132	98	113	131	1,040	0
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT	0	0	0	0	0	0	1	0	0	1	1
	ENCOMPASS HEALTH HOSPITAL OF	1	1	1	1	1	0	0	0	1	6	1
	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	0	0	0	1	0	0	1	2	1
	HORIZON SPECIALTY HOSPITAL OF	0	0	0	1	0	0	0	0	0	1	1
	KINDRED HOSPITAL W SAHARA	0	0	0	0	1	0	0	0	1	2	1
	PAM REHABILITATION HOSPITAL OF	0	0	1	0	0	0	0	0	0	1	1
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	0	0	0	0	0	1	0	1	1
	Total	1	1	2	2	2	1	1	1	3	14	0
	HARMON HOSPITAL	0	0	0	0	1	0	0	0	0	1	1
Skilled Nursing	SANDSTONE SPRING VALLEY LLC	1	0	0	1	2	1	0	3	1	9	1
	TRELLIS CENTENNIAL	0	1	0	0	0	0	0	0	0	1	1
	WELBROOK CENTENNIAL HILLS	2	0	0	0	0	0	0	0	0	2	1
	Total	3	1	0	1	3	1	0	3	1	13	0
Out of Area	Out of Area	45	39	41	50	35	49	48	37	63	407	45
	Total	45	39	41	50	35	49	48	37	63	407	0

		Readmits by Facility										
Facility Type	Metrics	Readmits										
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0	0	0	0	0	0	0	0	0	0	0
	CARSON TAHOE REGIONAL MEDICAL CENTER	1	2	1	1	2	1	0	0	0	8	1
	CENTENNIAL HILLS HOSPITAL MEDICAL	1	1	2	1	3	2	0	0	0	10	1
	HENDERSON HOSPITAL	0	1	0	0	2	0	0	0	0	3	0
	LAS VEGAS VAMC	0	0	0	0	0	1	0	0	0	1	0
	MOUNTAIN VIEW HOSPITAL	0	1	3	0	0	1	1	0	0	6	1
	NORTH VISTA HOSPITAL	0	0	0	0	0	0	0	0	0	0	0
	RENOWN REGIONAL MEDICAL CENTER	7	2	3	1	2	2	2	2	0	21	2
	SOUTHERN HILLS HOSPITAL	0	0	0	0	0	0	0	0	0	0	0
	SPRING VALLEY HOSPITAL	0	0	1	0	1	1	0	0	0	3	0
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN	0	0	0	0	0	0	0	0	0	0	0
	ST ROSE DOMINICAN HOSPITAL SIENA	0	1	2	1	0	1	1	0	0	6	1
	SUMMERLIN HOSPITAL MEDICAL CTR	1	1	0	0	0	0	1	0	0	3	0
	SUNRISE HOSPITAL	0	0	1	1	0	0	0	0	0	2	0
	UNIVERSITY MEDICAL CENTER SO NV	2	1	0	0	0	1	1	1	0	6	1
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	0	0	0
	Total	12	10	13	5	10	10	6	3	0	69	0
Out of Area	Out of Area	3	4	4	3	5	2	1	0	0	22	2
	Total	3	4	4	3	5	2	1	0	0	22	0

		Readmits by Facility										
Facility Type	Metrics	Readmit Rate										
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital	CARSON TAHOE REGIONAL HEALTHCARE	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	CARSON TAHOE REGIONAL MEDICAL CENTER	5.9%	7.1%	8.3%	8.3%	10.0%	4.2%	0.0%	0.0%	0.0%	4.9%	4.9%
	CENTENNIAL HILLS HOSPITAL MEDICAL	7.1%	16.7%	20.0%	20.0%	33.3%	28.6%	0.0%	0.0%	0.0%	14.5%	14.5%
	HENDERSON HOSPITAL	0.0%	25.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	8.6%	8.6%
	LAS VEGAS VAMC	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	33.3%	33.3%
	MOUNTAIN VIEW HOSPITAL	0.0%	25.0%	33.3%	0.0%	0.0%	11.1%	25.0%	0.0%	0.0%	11.8%	11.8%
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	RENOWN REGIONAL MEDICAL CENTER	13.0%	7.1%	8.6%	2.8%	10.0%	4.8%	5.7%	5.6%	0.0%	6.4%	6.4%

	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	SPRING VALLEY HOSPITAL	0.0%	0.0%	50.0%	0.0%	33.3%	16.7%	0.0%	0.0%	0.0%	8.3%	8.3%
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	ST ROSE DOMINICAN HOSPITAL SIENA	0.0%	12.5%	20.0%	14.3%	0.0%	12.5%	10.0%	0.0%	0.0%	7.0%	7.0%
	SUMMERLIN HOSPITAL MEDICAL CTR	20.0%	8.3%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	3.4%	3.4%
	SUNRISE HOSPITAL	0.0%	0.0%	12.5%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	3.1%
	UNIVERSITY MEDICAL CENTER SO NV	28.6%	16.7%	0.0%	0.0%	0.0%	12.5%	33.3%	16.7%	0.0%	12.5%	12.5%
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Total	9.0%	8.3%	11.8%	4.5%	10.9%	7.6%	6.1%	2.7%	0.0%	6.6%	0.0%
Out of Area	Out of Area	6.7%	10.3%	9.8%	6.0%	14.3%	4.1%	2.1%	0.0%	0.0%	5.4%	5.4%
	Total	6.7%	10.3%	9.8%	6.0%	14.3%	4.1%	2.1%	0.0%	0.0%	5.4%	0.0%



SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review



SIERRA HEALTH-CARE OPTIONS, INC.™

Utilization Summary

Outpatient Case Management											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
New Cases	275	226	265	260	204	276	228	243	299	2,276	253
Accepted	174	141	159	142	121	164	146	150	176	1,373	153
Acceptance Rate	63.3%	62.4%	60.0%	54.6%	59.3%	59.4%	64.0%	61.7%	58.9%	60.3%	60.3%
Average Duration (closed only)	8.8	5.4	12.0	6.0	7.8	5.4	6.0	5.2	3.2	6.6	6.6

Inpatient Case Management											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Open End of Month	35	34	37	33	20	32	26	36	21	274	30
Cases opened in the month	182	161	153	164	132	183	147	154	198	1,474	164
Cases closed in the month	179	154	147	166	143	175	146	143	193	1,446	161
Denied Days	8	13	16	11	6	3	19	29	6	111	12
Average LOS	6.2	6.2	6.4	5.8	4.1	5.7	6.0	6.3	3.6	5.6	5.6
NICU Open at End of Month	3	2	4	3	0	1	6	1	0	20	2
NICU Cases opened in the month	7	4	7	5	2	7	9	3	4	48	5
NICU Cases closed in the month	4	6	5	5	5	6	5	7	4	47	5
NICU Average Legth of Stay	29.5	3.8	22.8	11.2	1.8	13.5	44.6	10.3	6.3	15.3	15.3

Authorizations											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Total services reviewed	4,550	4,266	4,086	4,288	3,511	3,998	4,399	3,946	4,479	37,523	4,169
Services Approved	4,451	4,175	4,003	4,154	3,411	3,861	4,255	3,854	4,365	36,529	4,059
Approval Rate	97.8%	97.9%	98.0%	96.9%	97.2%	96.6%	96.7%	97.7%	97.5%	97.4%	97.4%
Services Denied	99	91	83	134	100	137	144	92	114	994	110
Denied Charges	\$71,186	\$83,730	\$83,728	\$152,687	\$68,691	\$144,284	\$119,488	\$90,049	\$88,732	\$902,575	\$100,286
Denial Rate	2%	2%	2%	3%	3%	3%	3%	2%	3%	3%	3%

Denial Reason											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Denial Reason	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied
Not medically necessary	99	89	83	117	100	137	144	91	113	973	108
Lack of information	0	2	0	17	0	0	0	0	0	19	10
Not medically necessary	0	0	0	0	0	0	0	1	0	1	1
Network Provider Available	0	0	0	0	0	0	0	0	1	1	

Turn Around Time											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
2 or fewer days	1,173	1,001	801	751	481	562	1,011	864	1,012	7,656	851
2 or fewer Pct	64.7%	59.7%	49.6%	42.4%	33.7%	33.9%	57.9%	55.1%	57.4%	50.9%	50.9%
5 or fewer days	1,259	1,196	1,182	1,192	638	740	1,318	1,083	1,324	9,932	1,104
5 or fewer Pct	69.5%	71.4%	73.2%	67.3%	44.6%	44.7%	75.4%	69.1%	75.1%	66.0%	66.0%
15 or fewer Days	1,789	1,661	1,602	1,764	1,392	1,581	1,738	1,562	1,760	14,849	1,650
15 or fewer Pct	98.7%	99.1%	99.2%	99.5%	97.4%	95.4%	99.5%	99.6%	99.8%	98.7%	98.7%
Over 15 days	23	15	13	8	37	76	9	6	4	191	21
Over 15 days Pct	1.3%	0.9%	0.8%	0.5%	2.6%	4.6%	0.5%	0.4%	0.2%	1.3%	1.3%

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

Stat											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Stat Request	1,096	918	1,083	1,054	893	1,052	1,245	1,027	1,227	9,595	1,066

Appeals											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Appeals 1st Level	2	2	6	2	1	4	2	4	2	25.00	2.78
Appeals 2nd Level	0	0	1	0	0	0	0	0	0	1.00	0.11
Appeals 3rd Level	0	0	0	0	0	0	0	0	0	0.00	0.00
Appeals Overturned	0	0	1	0	0	1	1	0	1	4.00	0.44
Appeals Upheld	2	0	4	4	1	3	2	4	1	21.00	2.33

Retro Reviews											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Retros	6	19	2	6	2	3	6	5	7	56	6

Telephone Advise Nurse											
Metrics											
Outcome description	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Call 911	1	1	3	1	2	2	0	2	5	17	2
ER	5	4	7	5	7	4	3	9	4	48	5
Information or Advice Only	3	4	3	1	2	1	2	4	1	21	2
Other	16	16	18	9	15	11	8	12	9	114	13
PCP	5	13	10	8	5	8	13	6	9	77	9
Poison Center	0	0	1	1	0	0	0	0	0	2	1
Self-Care/Home Care	3	2	5	3	2	3	4	1	3	26	3
Urgent Care	10	7	16	9	7	8	10	9	11	87	10



SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review



SIERRA HEALTH-CARE OPTIONS, INC.SM

Bedday Summary

Acute only

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

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Membership	52,682	52,593	52,775	52,835	52,791	52,778	52,520	52,668	52,598	52,693
Beddays per K	219.6	193.5	166.9	181.0	120.7	193.0	185.1	190.3	185.9	181.8
Admits per K	39.4	35.8	33.2	35.4	28.9	40.2	31.8	33.7	42.9	35.7
Average LOS	5.7	5.8	5.1	4.9	4.0	5.0	5.2	5.8	3.4	5.0
Readmits per K	3.4	3.2	3.9	1.8	3.4	2.7	1.6	0.7	0.0	2.3
Readmit Rate	8.7%	8.9%	11.6%	5.1%	11.8%	6.8%	5.0%	2.0%	0.0%	6.4%

SHO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Beddays per K	183.9	185.4	159.2	191.9	178.4	186.9	175.9	179.3	166.3	178.6
Admits per K	38.5	36.5	34.6	36.7	36.0	40.8	36.0	36.5	40.3	37.3
Average LOS	4.7	5.2	4.6	4.9	4.9	4.7	4.6	4.9	3.5	4.7
Readmits per K	3.9	3.4	3.2	2.4	3.0	3.6	3.3	0.9	0.0	2.6
Readmit Rate	10.0%	9.3%	9.3%	6.5%	8.3%	8.7%	9.1%	2.5%	0.0%	7.0%

SHL PPO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Beddays per K	171.4	180.6	169.1	157.7	143.2	126.2	112.5	138.6	129.3	147.8
Admits per K	46.4	45.6	42.7	37.8	34.9	39.1	30.9	38.5	36.2	39.1
Average LOS	3.6	5.1	4.4	4.5	5.7	3.9	4.7	3.6	4.6	4.5
Readmits per K	4.9	4.9	3.6	4.5	1.8	1.5	2.5	2.2	0.9	3.0
Readmit Rate	10.5%	10.7%	8.5%	12.0%	5.2%	3.9%	8.0%	5.6%	2.6%	7.6%

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



SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review



SIERRA HEALTH-CARE OPTIONS, INC.™

Executive Summary (Behavioral Health)

Metrics	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Average
Enrollment	52,682	52,593	52,775	52,835	52,791	52,778	52,520	52,668	52,598	52,693

Inpatient All - Acute, RTC, and OOA

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Total Discharges	18	17	26	27	19	19	24	30	23	203	23
Total Discharges LOS	89	113	288	123	208	197	221	177	97	1,513	168
Average LOS	4.9	6.6	11.1	4.6	10.9	10.4	9.2	5.9	4.2	7.5	7.5

Beddays by Facility Type

Metrics		Beddays										
Facility Type	BHO	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital		49	41	92	47	55	63	74	88	48	557	62
RTC		16	0	5	8	0	15	7	0	16	67	11
Out of Area		24	74	192	68	154	126	145	89	36	908	101

Beddays per K

Metrics	Beddays per K									
Facility Type BHO	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Hospital	11.2	9.4	20.9	10.7	12.5	14.3	16.9	20.1	11.0	14.1
RTC	3.6	0.0	1.1	1.8	0.0	3.4	1.6	0.0	3.7	1.7
Out of Area	5.5	16.9	43.7	15.4	35.0	28.6	33.1	20.3	8.2	23.0

Admits by Facility Type

Metrics						Admits					
Facility Type BHO	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital	11	9	19	11	13	15	13	19	13	123	14
RTC	1	0	1	1	0	1	1	0	2	7	1
Out of Area	5	7	12	9	8	8	12	12	6	79	9

Admits per K

Metrics	Admits per K									
Facility Type BHO	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Hospital	2.5	2.1	4.3	2.5	3.0	3.4	3.0	4.3	3.0	3.1
RTC	0.2	0.0	0.2	0.2	0.0	0.2	0.2	0.0	0.5	0.2
Out of Area	1.1	1.6	2.7	2.0	1.8	1.8	2.7	2.7	1.4	2.0

Readmits by Facility Type

Metrics		Readmits										
Facility Type	BHO	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital		1	2	2	0	1	3	4	3	0	16	2
RTC		0	0	0	0	0	0	0	0	0	0	0
Out of Area		0	0	1	3	1	0	1	0	0	6	1

Average Length of Stay by Facility

Metrics		Average LOS									
Facility Type BHO	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	1.0	0.0	7.3	2.7	4.3	5.3	2.5	7.7	2.8	4.4
	DESERT HOPE CENTER	0.0	2.5	0.0	0.0	0.0	6.0	0.0	0.0	0.0	4.0
	DESERT PARKWAY BEHAVIORAL HEALTHCARE	7.0	2.5	3.0	0.0	3.0	0.0	0.0	2.0	5.5	3.8
	DESERT WINDS HOSPITAL	0.0	0.0	5.0	0.0	4.0	0.0	13.0	2.3	0.0	4.9
	NORTH VISTA HOSPITAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	7.0	7.3	2.8	4.0	6.3	4.5	6.0	10.7	2.8	5.3
	SEVEN HILLS HOSPITAL INC	8.0	0.0	4.5	5.5	3.0	4.0	0.0	2.7	4.0	4.2
	SOUTHERN HILLS HOSPITAL	0.0	3.0	15.0	0.0	5.0	4.0	9.0	3.0	0.0	5.6
	VALLEY HOSPITAL MEDICAL CTR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	4.0
	VIRTUE RECOVERY LAS VEGAS LLC	0.0	0.0	4.5	0.0	0.0	8.0	0.0	0.0	0.0	5.7
	Total	7.0	4.0	5.1	3.4	4.5	5.1	6.2	5.2	3.2	4.7
RTC	DESERT HOPE CENTER	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	15.0	10.0
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0	0.0	7.0

	VIRTUE RECOVERY LAS VEGAS LLC	0.0	0.0	0.0	8.0	0.0	15.0	0.0	0.0	0.0	13.0
	Total	0.0	0.0	5.0	8.0	0.0	15.0	7.0	0.0	15.0	11.0
Out of Area	Out of Area	2.2	12.2	27.3	5.7	22.0	18.0	12.7	6.8	4.9	11.1
	Total	2.2	12.2	27.3	5.7	22.0	18.0	12.7	6.8	4.9	11.1

Facility Type BHO	Beddays by Facility											
	Metrics											
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Beddays				Total	Average
	Dec-25	Jan-26	Feb-26	Mar-26								
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	1	0	29	8	17	19	10	23	14	121	15
	DESERT HOPE CENTER	0	5	0	0	0	6	0	5	0	16	5
	DESERT PARKWAY BEHAVIORAL HEALTHCARE	7	5	6	0	3	0	0	2	11	34	6
	DESERT WINDS HOSPITAL	0	5	10	0	4	0	13	7	0	39	8
	NORTH VISTA HOSPITAL	4	0	0	0	0	0	0	0	0	4	4
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	21	23	14	28	20	22	36	32	11	207	23
	SEVEN HILLS HOSPITAL INC	16	0	9	11	6	4	6	16	8	76	10
	SOUTHERN HILLS HOSPITAL	0	3	15	0	5	4	9	3	0	39	7
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	4	4	4
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	9	0	0	8	0	0	0	17	9
	Total	49	41	92	47	55	63	74	88	48	557	0
RTC	DESERT HOPE CENTER	0	0	5	0	0	0	0	0	15	20	10
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0	0	0	0	0	0	7	0	0	7	7
	VIRTUE RECOVERY LAS VEGAS LLC	16	0	0	8	0	15	0	0	1	40	10
	Total	16	0	5	8	0	15	7	0	16	67	0
Out of Area	Out of Area	24	74	192	68	154	126	145	89	36	908	101
	Total	24	74	192	68	154	126	145	89	36	908	

Facility Type BHO	Admits by Facility											
	Metrics											
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	1	0	5	2	4	5	3	4	4	28	4
	DESERT HOPE CENTER	0	2	0	0	0	1	0	1	0	4	1
	DESERT PARKWAY BEHAVIORAL HEALTHCARE	2	1	2	0	1	0	0	1	3	10	2
	DESERT WINDS HOSPITAL	0	1	2	0	1	0	2	2	0	8	1
	NORTH VISTA HOSPITAL	1	0	0	0	0	0	0	0	0	1	1
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	4	4	4	7	4	6	6	5	2	42	5
	SEVEN HILLS HOSPITAL INC	3	0	2	2	2	1	1	5	3	19	2
	SOUTHERN HILLS HOSPITAL	0	1	2	0	1	1	1	1	0	7	1
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	1	1	1
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	2	0	0	1	0	0	0	3	2
	Total	11	9	19	11	13	15	13	19	13	123	0
RTC	DESERT HOPE CENTER	0	0	1	0	0	0	0	0	1	2	1
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0	0	0	0	0	0	1	0	0	1	1
	VIRTUE RECOVERY LAS VEGAS LLC	1	0	0	1	0	1	0	0	1	4	1
	Total	1	0	1	1	0	1	1	0	2	7	0
Out of Area	Out of Area	5	7	12	9	8	8	12	12	6	79	9
	Total	5	7	12	9	8	8	12	12	6	79	

Facility Type BHO	Readmits by Facility											
	Metrics											
	Facility Name	Readmits										
Jul-25		Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average	
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	0	0	0	0	1	2	1	1	0	5	1
	DESERT HOPE CENTER	0	0	0	0	0	0	0	0	0	0	0
	DESERT PARKWAY BEHAVIORAL HEALTHCARE	1	1	0	0	0	0	0	0	0	2	0
	DESERT WINDS HOSPITAL	0	0	0	0	0	0	0	0	0	0	0
	NORTH VISTA HOSPITAL	0	0	0	0	0	0	0	0	0	0	0
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0	0	1	0	0	1	2	1	0	5	1
	SEVEN HILLS HOSPITAL INC	0	0	0	0	0	0	1	1	0	2	0
	SOUTHERN HILLS HOSPITAL	0	1	1	0	0	0	0	0	0	2	0
	VALLEY HOSPITAL MEDICAL CTR	0	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	0
	Total	1	2	2	0	1	3	4	3	0	16	0
RTC	DESERT HOPE CENTER	0	0	0	0	0	0	0	0	0	0	0
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0	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	0
	Total	0	0	0	0	0	0	0	0	0	0	0
Out of Area	Out of Area	0	0	1	3	1	0	1	0	0	6	1
	Total	0	0	1	3	1	0	1	0	0	6	0

Facility Type BHO	Readmits by Facility												
	Metrics	Readmit Rate											
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Average	
Hospital	CARSON TAHOE REGIONAL MEDICAL CENTER	0.0%	0.0%	0.0%	0.0%	25.0%	40.0%	33.3%	25.0%	0.0%	17.9%	17.9%	
	DESERT HOPE CENTER	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	DESERT PARKWAY BEHAVIORAL HEALTHCARE	50.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	20.0%	
	DESERT WINDS HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0.0%	0.0%	25.0%	0.0%	0.0%	16.7%	33.3%	20.0%	0.0%	11.9%	11.9%	
	SEVEN HILLS HOSPITAL INC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	20.0%	0.0%	10.5%	10.5%	
	SOUTHERN HILLS HOSPITAL	0.0%	100.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.6%	28.6%	
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Total	9.1%	22.2%	10.5%	0.0%	7.7%	20.0%	30.8%	15.8%	0.0%	13.0%	0.0%	
RTC	DESERT HOPE CENTER	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	RENO BEHAVIORAL HEALTHCARE HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Out of Area	Out of Area	0.0%	0.0%	8.3%	33.3%	12.5%	0.0%	8.3%	0.0%	0.0%	7.6%	7.6%	
	Total	0.0%	0.0%	8.3%	33.3%	12.5%	0.0%	8.3%	0.0%	0.0%	7.6%	0.0%	

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.SM

Utilization Summary (Behavioral Health)

Inpatient Case Management											
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Open End of Month	6	4	9	2	4	6	7	7	4	49	5
Cases opened in the month	17	16	32	21	21	24	26	31	21	209	23
Cases closed in the month	18	17	26	27	19	19	24	30	23	203	23
Denied Days	11	0	28	6	4	5	17	21	8	100	11
Average LOS	4.9	6.6	11.1	4.6	10.9	10.4	9.2	5.9	4.2	7.5	7.5

	Authorizations										
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average
Total services reviewed	20	40	41	33	46	200	95	51	36	562	62
Services Approved	20	33	38	27	46	162	81	41	32	480	53
Approval Rate	100.0%	82.5%	92.7%	81.8%	100.0%	81.0%	85.3%	80.4%	88.9%	85.4%	85.4%
Services Denied	0	7	3	6	0	38	14	10	4	82	9
Denied Charges	\$0	\$1,710	\$855	\$855	\$0	\$74,075	\$7,599	\$14,125	\$10,259	\$109,477	\$12,164
Denial Rate	0%	18%	7%	18%	0%	19%	15%	20%	11%	15%	15%

Denial Reason										
Month	Aug-25	Sep-25	Oct-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average	
Denial Reason	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	
Non-covered service(s)	0	0	0	1	0	0	0	1	1	
Not medically necessary	7	3	5	31	13	9	4	72	10	
In network provider(s)	0	0	1	0	1	1	0	3	1	
Not medically necessary	0	0	0	2	0	0	0	2	2	
Non-covered service(s)	0	0	0	1	0	0	0	1	1	
Non-covered service	0	0	0	2	0	0	0	2	2	
Not medically necessary	0	0	0	1	0	0	0	1	1	

[illegible]

Appeals												
Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Average	
Appeals 1st Level	2	2	6	2	1	4	2	4	2	25.00	2.78	
Appeals 2nd Level	0	0	1	0	0	0	0	0	0	1.00	0.11	
Appeals 3rd Level	0	0	0	0	0	0	0	0	0	0.00	0.00	
Appeals Overturned	0	0	1	0	0	1	1	0	1	4.00	0.44	
Appeals Upheld	2	0	4	4	1	3	2	4	1	21.00	2.33	

[illegible]



SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review



SIERRA HEALTH-CARE OPTIONS, INC.SM

Bedday Summary (Behavioral Health)

Acute only

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

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Membership	52,682	52,593	52,775	52,835	52,791	52,778	52,520	52,668	52,598	52,693
Beddays per K	13.7	13.7	29.1	15.2	15.2	16.8	23.3	28.3	18.9	19.4
Admits per K	3.2	3.0	5.7	3.9	3.4	4.3	4.6	6.4	4.1	4.3
Average LOS	5.5	4.2	5.3	3.5	4.4	4.5	5.7	4.8	4.1	4.7
Readmits per K	0.2	0.5	0.7	0.5	0.2	0.7	0.9	0.7	0.0	0.5
Readmit Rate	7.1%	15.4%	12.0%	11.8%	6.7%	15.8%	20.0%	10.7%	0.0%	11.2%

SHO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Beddays per K	11.6	17.8	20.0	14.3	13.7	12.6	17.1	15.0	15.2	15.3
Admits per K	2.5	3.5	4.1	3.3	2.8	3.1	3.7	3.4	3.9	3.4
Average LOS	5.1	5.1	5.1	4.1	5.1	4.1	4.8	4.5	4.1	4.7
Readmits per K	0.3	0.5	0.5	0.3	0.2	0.4	0.4	0.4	0.0	0.3
Readmit Rate	10.2%	13.0%	11.1%	9.2%	7.3%	13.1%	11.0%	10.4%	0.0%	9.4%

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

14.4

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

370074 State of Nevada Public Employees' Benefits Program

Life Performance Guarantees 2026 Q3 – 1/01/2026 – 3/31/2026)

Service	Metric	Measurement	How Measured	Fee at Risk	Results Details	Guarantee Achieved?
Claim Processing	Life Insurance - Complete Life Claim Decision	A. Basic Life Claim Determination 97% of claims processed within 10 days of receipt of complete information	Claim Turn Around Reports	.3% of quarterly Basic Life Insurance Premium	100%	Yes
	Life Insurance - Timeliness of Claim Payments	A. Timeliness of Claim Payment 97% of claims approved and payment issued, or claims denied, and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Quarterly claim decision report	.3% of quarterly Basic Life Insurance Premium	100%	Yes
	Life Insurance - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of quarterly Basic Life Insurance Premium	100%	Yes
Claim Customer Service	Average Speed of Answer	80% of Calls will be answered in less than 30 seconds	Call Center Statistics	.3% of quarterly Basic Life Insurance Premium	84.06%	Yes
	Abandonment Rate	Less than 5% of calls will be abandoned	Call Center Statistics	.3% of quarterly Basic Life Insurance Premium	1.00%	Yes

14.5

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

Nevada PEBP FY26 Q3 Report

7/1/2024 – 3/31/2026

Report Includes:

- CDHP Comparison Data from Q3 FY26 to Q3 FY25
- EPO Comparison Data from Q3 FY26 to Q3 FY25
- PPO Comparison Data from Q3 FY26 to Q3 FY25
- CDHP, EPO, PPO Breakout Data from Q3 FY26
- Summary Comparison Data from FY26
- Key Metric Breakout Data from FY26

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

Mathew Gehrin (mgehrin@express-scripts.com)

5/28/2026

Express Scripts

By **EVERNORTH**
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q3 FY26 to Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	52,503	51,421	2.1%
Utilizing Member Count (Patients)	37,513	36,778	2.0%
Percent Utilizing (Utilization)	71.4%	71.5%	-0.1

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	631,612	606,595	4.1%
Claims per Elig Member per Month (Claims PMPM)	1.34	1.31	2.0%
Total Claims for Generic (Generic ARx)	548,537	525,668	4.4%
Total Claims for Brand (Brand ARx)	83,075	80,927	2.7%
Total Claims for Multisource Brand Claims (MSB ARx)	1,176	1,504	-21.8%
Total Non-Specialty Claims	622,097	598,816	3.9%
Total Specialty Claims	9,515	7,779	22.3%
Generic % of Total Claims (GFR)	86.8%	86.7%	0.2
Generic Effective Rate (GCR)	99.8%	99.7%	0.1
Mail Order Claims	147,367	158,237	-6.9%
Mail Penetration Rate*	26.3%	29.6%	-3.3

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	\$102,935,809	\$90,299,433	14.0%
Total Generic Gross Cost	\$9,332,528	\$9,256,851	0.8%
Total Brand Gross Cost	\$93,603,281	\$81,042,582	15.5%
Total MSB Gross Cost	\$963,368	\$930,684	3.5%
Total Ingredient Cost	\$100,164,624	\$87,676,708	14.2%
Total Dispensing Fee	\$2,747,353	\$2,576,287	6.6%
Total Other (e.g. tax)	\$23,833	\$46,437	-48.7%
Avg Total Cost per Claim (Gross Cost/ARx)	\$162.97	\$148.86	9.5%
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	\$17.01	\$17.61	-3.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	\$1,126.73	\$1,001.43	12.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	\$819.19	\$618.81	32.4%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q3 FY26 to Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	\$16,296,338	\$16,218,797	0.5%
Generic Cost Share	\$3,289,930	\$3,659,288	-10.1%
Brand Cost Share	\$13,006,408	\$12,559,509	3.6%
MSB Cost Share	\$133,397	\$171,705	-22.3%
Total Copay	\$14,743,196	\$14,566,111	1.2%
Total Deductible	\$1,553,142	\$1,652,686	-6.0%
Avg Copay per Claim (Member Cost Share/ARx)	\$25.80	\$26.74	-3.5%
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	\$6.00	\$6.96	-13.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	\$156.56	\$155.20	0.9%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	\$113.43	\$114.17	-0.6%
Copay % of Total Prescription Cost (Member Cost Share %)	15.8%	18.0%	-2.1
Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	\$86,639,471	\$74,080,635	17.0%
Generic Plan Cost	\$6,042,598	\$5,597,563	8.0%
Brand Plan Cost	\$80,596,873	\$68,483,073	17.7%
MSB Plan Cost	\$829,971	\$758,979	9.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	\$39,710,230	\$36,649,149	8.4%
Total Specialty Drug Cost (Specialty Plan Cost)	\$46,929,241	\$37,431,486	25.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	\$137.17	\$122.13	12.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	\$11.02	\$10.65	3.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	\$970.17	\$846.23	14.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	\$705.76	\$504.64	39.9%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	\$63.83	\$61.20	4.3%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	\$4,932.13	\$4,811.86	2.5%
Plan Cost PMPM	\$183.35	\$160.07	14.5%
Non-Specialty Plan Cost PMPM	\$84.04	\$79.19	6.1%
Specialty Plan Cost PMPM	\$99.32	\$80.88	22.8%
Specialty % of Plan Cost	54.2%	50.5%	3.6
Net Plan Cost PMPM (factoring Rebates)	\$121.32	\$99.78	21.6%
Non-Specialty Plan Cost PMPM	\$47.41	\$44.22	7.2%
Specialty Plan Cost PMPM	\$73.91	\$55.56	33.0%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q3 FY26 to Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	22,407	22,979	-2.5%
Utilizing Member Count (Patients)	14,990	15,478	-3.2%
Percent Utilizing (Utilization)	66.9%	67.4%	-0.5

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	244,808	250,970	-2.5%
Claims per Elig Member per Month (Claims PMPM)	1.21	1.21	0.0%
Total Claims for Generic (Generic ARx)	215,076	220,267	-2.4%
Total Claims for Brand (Brand ARx)	29,732	30,703	-3.2%
Total Claims for Multisource Brand Claims (MSB ARx)	327	407	-19.7%
Total Non-Specialty Claims	241,208	247,881	-2.7%
Total Specialty Claims	3,600	3,089	16.5%
Generic % of Total Claims (GFR)	87.9%	87.8%	0.1
Generic Effective Rate (GCR)	99.8%	99.8%	0.0
Mail Order Claims	57,380	63,722	-10.0%
Mail Penetration Rate*	26.4%	28.8%	-2.4

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	\$37,423,470	\$34,225,980	9.3%
Total Generic Gross Cost	\$2,917,664	\$3,479,654	-16.2%
Total Brand Gross Cost	\$34,505,806	\$30,746,325	12.2%
Total MSB Gross Cost	\$297,800	\$255,775	16.4%
Total Ingredient Cost	\$36,325,101	\$33,130,168	9.6%
Total Dispensing Fee	\$1,089,513	\$1,079,135	1.0%
Total Other (e.g. tax)	\$8,855	\$16,677	-46.9%
Avg Total Cost per Claim (Gross Cost/ARx)	\$152.87	\$136.37	12.1%
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	\$13.57	\$15.80	-14.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	\$1,160.56	\$1,001.41	15.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	\$910.70	\$628.44	44.9%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q3 FY26 to Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	\$7,782,834	\$7,812,777	-0.4%
Generic Cost Share	\$1,329,220	\$1,564,601	-15.0%
Brand Cost Share	\$6,453,614	\$6,248,176	3.3%
MSB Cost Share	\$79,038	\$121,917	-35.2%
Total Copay	\$6,233,335	\$6,163,234	1.1%
Total Deductible	\$1,549,499	\$1,649,543	-6.1%
Avg Copay per Claim (Member Cost Share/ARx)	\$31.79	\$31.13	2.1%
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	\$6.18	\$7.10	-13.0%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	\$217.06	\$203.50	6.7%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	\$241.71	\$299.55	-19.3%
Copay % of Total Prescription Cost (Member Cost Share %)	20.8%	22.8%	-2.0
Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	\$29,640,636	\$26,413,203	12.2%
Generic Plan Cost	\$1,588,444	\$1,915,053	-17.1%
Brand Plan Cost	\$28,052,192	\$24,498,150	14.5%
MSB Plan Cost	\$218,762	\$133,858	63.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	\$10,739,662	\$10,959,668	-2.0%
Total Specialty Drug Cost (Specialty Plan Cost)	\$18,900,974	\$15,453,535	22.3%
Avg Plan Cost per Claim (Plan Cost/ARx)	\$121.08	\$105.24	15.0%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	\$7.39	\$8.69	-15.1%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	\$943.50	\$797.91	18.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	\$669.00	\$328.89	103.4%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	\$44.52	\$44.21	0.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	\$5,250.27	\$5,002.76	4.9%
Plan Cost PMPM	\$146.98	\$127.72	15.1%
Non-Specialty Plan Cost PMPM	\$53.26	\$52.99	0.5%
Specialty Plan Cost PMPM	\$93.73	\$74.72	25.4%
Specialty % of Plan Cost	63.8%	58.5%	5.3
Net Plan Cost PMPM (factoring Rebates)	\$98.22	\$78.31	25.4%
Non-Specialty Plan Cost PMPM	\$27.19	\$27.08	0.4%
Specialty Plan Cost PMPM	\$71.03	\$51.22	38.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q3 FY26 vs Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	4,486	5,208	-13.9%
Utilizing Member Count (Patients)	3,625	4,168	-13.0%
Percent Utilizing (Utilization)	80.8%	80.0%	0.8

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	81,599	90,724	-10.1%
Claims per Elig Member per Month (Claims PMPM)	2.02	1.94	4.4%
Total Claims for Generic (Generic ARx)	70,030	78,048	-10.3%
Total Claims for Brand (Brand ARx)	11,569	12,676	-8.7%
Total Claims for Multisource Brand Claims (MSB ARx)	184	323	-43.0%
Total Non-Specialty Claims	80,226	89,383	-10.2%
Total Specialty Claims	1,373	1,341	2.4%
Generic % of Total Claims (GFR)	85.8%	86.0%	-0.2
Generic Effective Rate (GCR)	99.7%	99.6%	0.2
Mail Order Claims	21,222	25,562	-17.0%
Mail Penetration Rate*	28.6%	31.1%	-2.6

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	\$14,396,498	\$15,520,767	-7.2%
Total Generic Gross Cost	\$1,296,471	\$1,377,757	-5.9%
Total Brand Gross Cost	\$13,100,027	\$14,143,010	-7.4%
Total MSB Gross Cost	\$197,389	\$336,015	-41.3%
Total Ingredient Cost	\$14,027,408	\$15,122,314	-7.2%
Total Dispensing Fee	\$366,028	\$391,041	-6.4%
Total Other (e.g. tax)	\$3,062	\$7,412	-58.7%
Avg Total Cost per Claim (Gross Cost/ARx)	\$176.43	\$171.08	3.1%
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	\$18.51	\$17.65	4.9%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	\$1,132.34	\$1,115.73	1.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	\$1,072.77	\$1,040.29	3.1%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q3 FY26 vs Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	\$1,888,422	\$2,364,028	-20.1%
Generic Cost Share	\$421,705	\$533,034	-20.9%
Brand Cost Share	\$1,466,717	\$1,830,995	-19.9%
MSB Cost Share	\$25,430	\$22,430	13.4%
Total Copay	\$1,884,779	\$2,360,885	-20.2%
Total Deductible	\$3,643	\$3,143	15.9%
Avg Copay per Claim (Member Cost Share/ARx)	\$23.14	\$26.06	-11.2%
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	\$6.02	\$6.83	-11.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	\$126.78	\$144.45	-12.2%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	\$138.21	\$69.44	99.0%
Copay % of Total Prescription Cost (Member Cost Share %)	13.1%	15.2%	-2.1
Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	\$12,508,076	\$13,156,738	-4.9%
Generic Plan Cost	\$874,766	\$844,723	3.6%
Brand Plan Cost	\$11,633,310	\$12,312,016	-5.5%
MSB Plan Cost	\$171,959	\$313,585	-45.2%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	\$6,153,521	\$6,496,594	-5.3%
Total Specialty Drug Cost (Specialty Plan Cost)	\$6,354,555	\$6,660,144	-4.6%
Avg Plan Cost per Claim (Plan Cost/ARx)	\$153.29	\$145.02	5.7%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	\$12.49	\$10.82	15.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	\$1,005.56	\$971.29	3.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	\$934.56	\$970.85	-3.7%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	\$76.70	\$72.68	5.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	\$4,628.23	\$4,966.55	-6.8%
Plan Cost PMPM	\$309.81	\$280.70	10.4%
Non-Specialty Plan Cost PMPM	\$152.41	\$138.60	10.0%
Specialty Plan Cost PMPM	\$157.39	\$142.09	10.8%
Specialty % of Plan Cost	50.8%	50.6%	0.2
Net Plan Cost PMPM (factoring Rebates)	\$200.47	\$176.60	13.5%
Non-Specialty Plan Cost PMPM	\$84.42	\$77.17	9.4%
Specialty Plan Cost PMPM	\$116.06	\$99.43	16.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q3 FY26 vs Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	25,612	23,237	10.2%
Utilizing Member Count (Patients)	18,956	17,195	10.2%
Percent Utilizing (Utilization)	74.0%	74.0%	0.0

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	305,205	264,901	15.2%
Claims per Elig Member per Month (Claims PMPM)	1.32	1.27	4.5%
Total Claims for Generic (Generic ARx)	263,431	227,353	15.9%
Total Claims for Brand (Brand ARx)	41,774	37,548	11.3%
Total Claims for Multisource Brand Claims (MSB ARx)	665	774	-14.1%
Total Non-Specialty Claims	300,663	261,552	15.0%
Total Specialty Claims	4,542	3,349	35.6%
Generic % of Total Claims (GFR)	86.3%	85.8%	0.5
Generic Effective Rate (GCR)	99.7%	99.7%	0.1
Mail Order Claims	68,765	68,953	-0.3%
Mail Penetration Rate*	25.5%	29.8%	-4.3

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	\$51,115,842	\$40,552,686	26.0%
Total Generic Gross Cost	\$5,118,393	\$4,399,440	16.3%
Total Brand Gross Cost	\$45,997,448	\$36,153,246	27.2%
Total MSB Gross Cost	\$468,179	\$338,894	38.1%
Total Ingredient Cost	\$49,812,114	\$39,424,226	26.3%
Total Dispensing Fee	\$1,291,812	\$1,106,112	16.8%
Total Other (e.g. tax)	\$11,916	\$22,348	-46.7%
Avg Total Cost per Claim (Gross Cost/ARx)	\$167.48	\$153.09	9.4%
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	\$19.43	\$19.35	0.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	\$1,101.10	\$962.85	14.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	\$704.03	\$437.85	60.8%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q3 FY26 vs Q3 FY25

Express Scripts

By EVERNORTH
Confidential Information

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	\$6,625,082	\$6,041,992	9.7%
Generic Cost Share	\$1,539,006	\$1,561,653	-1.5%
Brand Cost Share	\$5,086,077	\$4,480,339	13.5%
MSB Cost Share	\$28,929	\$27,358	5.7%
Total Copay	\$6,625,082	\$6,041,992	9.7%
Total Deductible	\$0	\$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	\$21.71	\$22.81	-4.8%
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	\$5.84	\$6.87	-14.9%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	\$121.75	\$119.32	2.0%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	\$43.50	\$35.35	23.1%
Copay % of Total Prescription Cost (Member Cost Share %)	13.0%	14.9%	-1.9
Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	\$44,490,759	\$34,510,694	28.9%
Generic Plan Cost	\$3,579,388	\$2,837,787	26.1%
Brand Plan Cost	\$40,911,372	\$31,672,907	29.2%
MSB Plan Cost	\$439,250	\$311,536	41.0%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	\$22,817,047	\$19,192,887	18.9%
Total Specialty Drug Cost (Specialty Plan Cost)	\$21,673,713	\$15,317,807	41.5%
Avg Plan Cost per Claim (Plan Cost/ARx)	\$145.77	\$130.28	11.9%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	\$13.59	\$12.48	8.9%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	\$979.35	\$843.53	16.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	\$660.53	\$402.50	64.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	\$75.89	\$73.38	3.4%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	\$4,771.84	\$4,573.85	4.3%
Plan Cost PMPM	\$193.01	\$165.02	17.0%
Non-Specialty Plan Cost PMPM	\$98.99	\$91.77	7.9%
Specialty Plan Cost PMPM	\$94.03	\$73.24	28.4%
Specialty % of Plan Cost	48.7%	44.4%	4.3
Net Plan Cost PMPM (factoring Rebates)	\$127.65	\$103.77	23.0%
Non-Specialty Plan Cost PMPM	\$58.60	\$53.77	9.0%
Specialty Plan Cost PMPM	\$69.04	\$50.01	38.1%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q3 FY26

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	52,503	4,486	22,407	25,612
Utilizing Member Count (Patients)	37,513	3,625	14,990	18,956
Percent Utilizing (Utilization)	71.4%	80.8%	66.9%	74.0%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	631,612	81,599	244,808	305,205
Claims per Elig Member per Month (Claims PMPM)	1.34	2.02	1.21	1.32
Total Claims for Generic (Generic Rx)	548,537	70,030	215,076	263,431
Total Claims for Brand (Brand Rx)	83,075	11,569	29,732	41,774
Total Claims for Multisource Brand Claims (MSB Rx)	1,176	184	327	665
Total Non-Specialty Claims	622,097	80,226	241,208	300,663
Total Specialty Claims	9,515	1,373	3,600	4,542
Generic % of Total Claims (GFR)	86.8%	85.8%	87.9%	86.3%
Generic Effective Rate (GCR)	99.8%	99.7%	99.8%	99.7%
Mail Order Claims	147,367	21,222	57,380	68,765
Mail Penetration Rate*	26.3%	28.6%	26.4%	25.5%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	\$102,935,809	\$14,396,498	\$37,423,470	\$51,115,842
Total Generic Gross Cost	\$9,332,528	\$1,296,471	\$2,917,664	\$5,118,393
Total Brand Gross Cost	\$93,603,281	\$13,100,027	\$34,505,806	\$45,997,448
Total MSB Gross Cost	\$963,368	\$197,389	\$297,800	\$468,179
Total Ingredient Cost	\$100,164,624	\$14,027,408	\$36,325,101	\$49,812,114
Total Dispensing Fee	\$1,455,541	\$366,028	\$1,089,513	\$1,291,812
Total Other (e.g. tax)	\$23,833	\$3,062	\$8,855	\$11,916
Avg Total Cost per Claim (Gross Cost/Rx)	\$162.97	\$176.43	\$152.87	\$167.48
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	\$17.01	\$18.51	\$13.57	\$19.43
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	\$1,126.73	\$1,132.34	\$1,160.56	\$1,101.10
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	\$819.19	\$1,072.77	\$910.70	\$704.03

Express Scripts

By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN
+ Q3 FY26

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	\$16,296,338	\$1,888,422	\$7,782,834	\$6,625,082
Generic Cost Share	\$3,289,930	\$421,705	\$1,329,220	\$1,539,006
Brand Cost Share	\$13,006,408	\$1,466,717	\$6,453,614	\$5,086,077
MSB Cost Share	\$133,397	\$25,430	\$79,038	\$28,929
Total Copay	\$14,743,196	\$1,884,779	\$6,233,335	\$6,625,082
Total Deductible	\$1,553,142	\$3,643	\$1,549,499	\$0
Avg Copay per Claim (Member Cost Share/Rx)	\$25.80	\$23.14	\$31.79	\$21.71
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	\$6.00	\$6.02	\$6.18	\$5.84
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	\$156.56	\$126.78	\$217.06	\$121.75
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	\$113.43	\$138.21	\$241.71	\$43.50
Copay % of Total Prescription Cost (Member Cost Share %)	15.8%	13.1%	20.8%	13.0%

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	\$86,639,471	\$12,508,076	\$29,640,636	\$44,490,759
Generic Plan Cost	\$6,042,598	\$874,766	\$1,588,444	\$3,579,388
Brand Plan Cost	\$80,596,873	\$11,633,310	\$28,052,192	\$40,911,372
MSB Plan Cost	\$829,971	\$171,959	\$218,762	\$439,250
Total Non-Specialty Cost (Non-Specialty Plan Cost)	\$39,710,230	\$6,153,521	\$10,739,662	\$22,817,047
Total Specialty Drug Cost (Specialty Plan Cost)	\$46,929,241	\$6,354,555	\$18,900,974	\$21,673,713
Avg Plan Cost per Claim (Plan Cost/Rx)	\$137.17	\$153.29	\$121.08	\$145.77
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	\$11.02	\$12.49	\$7.39	\$13.59
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	\$970.17	\$1,005.56	\$943.50	\$979.35
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	\$705.76	\$934.56	\$669.00	\$660.53
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	\$63.83	\$76.70	\$44.52	\$75.89
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	\$4,932.13	\$4,628.23	\$5,250.27	\$4,771.84
Plan Cost PMPM	\$183.35	\$309.81	\$146.98	\$193.01
Non-Specialty Plan Cost PMPM	\$84.04	\$152.41	\$53.26	\$98.99
Specialty Plan Cost PMPM	\$99.32	\$157.39	\$93.73	\$94.03
Specialty % of Plan Cost	54.2%	50.8%	63.8%	48.7%
Net Plan Cost PMPM (factoring Rebates)	\$121.32	\$200.47	\$98.22	\$127.65
Non-Specialty Net Plan Cost PMPM	\$47.41	\$84.42	\$27.19	\$58.60
Specialty Net Plan Cost PMPM	\$73.91	\$116.06	\$71.03	\$69.04

Express Scripts

By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q3 FY26

State of Nevada PEBP				
FY2026 Q3				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	52,503	4,486	22,407	25,612
Pct Members Utilizing Benefit	71.4%	80.8%	66.9%	74.0%
Total Plan Cost	\$ 86,639,471	\$ 12,508,076	\$ 29,640,636	\$ 44,490,759
Total Days	16,652,283	2,208,325	6,456,451	7,987,507
Total Adjusted Rxs	631,612	81,599	244,808	305,205
Plan Cost PMPM	\$ 183.35	\$ 309.81	\$ 146.98	\$ 193.01
Plan Cost Net PMPM	\$ 121.32	\$ 200.47	\$ 98.22	\$ 127.65
Plan Cost/Day	\$ 5.20	\$ 5.66	\$ 4.59	\$ 5.57
Plan Cost per Adjusted Rx	\$ 137.17	\$ 153.29	\$ 121.08	\$ 145.77
Nbr Rxs PMPM	1.34	2.02	1.21	1.32
Generic Fill Rate	86.8%	85.8%	87.9%	86.3%
Home Delivery Utilization	26.3%	28.6%	26.4%	25.5%
Member Cost %	15.8%	13.1%	20.8%	13.0%
Specialty Percent of Plan Cost	54.2%	50.8%	63.8%	48.7%
Specialty Plan Cost PMPM	\$ 99.32	\$ 157.39	\$ 93.73	\$ 94.03
Formulary Compliance Rate	99.5%	99.4%	99.8%	99.3%

STATE OF NEVADA PEBP:

**PRESCRIPTION
DRUG UTILIZATION**
+ TOTAL PLAN
+ Q3 FY26

State of Nevada PEBP					
FY2026 Q3 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	52,503	46,696	5,401	16	392
Pct Members Utilizing Benefit	71.4%	70.0%	87.2%	81.3%	92.1%
Total Plan Cost	\$ 86,639,471	\$ 69,813,342	\$ 15,662,952	\$ 35,844	\$ 1,127,334
Total Days	16,652,283	12,972,363	3,254,250	8,322	417,348
Total Adjusted Rxs	631,612	497,652	118,651	295	15,014
Plan Cost PMPM	\$ 183.35	\$ 166.12	\$ 322.22	\$ 248.92	\$ 319.54
Plan Cost Net PMPM	\$ 121.32	\$ 109.47	\$ 219.08	\$ 132.28	\$ 184.24
Plan Cost/Day	\$ 5.20	\$ 5.38	\$ 4.81	\$ 4.31	\$ 2.70
Plan Cost per Adjusted Rx	\$ 137.17	\$ 140.29	\$ 132.01	\$ 121.51	\$ 75.09
Nbr Rxs PMPM	1.34	1.18	2.44	2.05	4.26
Generic Fill Rate	86.8%	86.6%	87.7%	79.7%	87.9%
Home Delivery Utilization	26.3%	24.0%	34.2%	69.7%	34.2%
Member Cost %	15.8%	15.8%	15.9%	7.6%	17.0%
Specialty Percent of Plan Cost	54.2%	53.5%	58.9%	0.0%	33.8%
Specialty Plan Cost PMPM	\$ 99.32	\$ 88.81	\$ 189.77	\$ -	\$ 107.96
Formulary Compliance Rate	99.5%	99.5%	99.7%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q3 FY26

State of Nevada PEBP					
FY2026 Q3 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	22,407	19,114	2,983	9	301
Pct Members Utilizing Benefit	66.9%	64.2%	84.8%	77.8%	92.0%
Total Plan Cost	\$ 29,640,636	\$ 21,740,077	\$ 7,049,681	\$ 1,720	\$ 849,158
Total Days	6,456,451	4,437,683	1,689,764	680	328,324
Total Adjusted Rxs	244,808	171,474	61,522	27	11,785
Plan Cost PMPM	\$ 146.98	\$ 126.38	\$ 262.59	\$ 21.24	\$ 313.46
Plan Cost Net PMPM	\$ 98.22	\$ 84.34	\$ 180.82	\$ 12.42	\$ 163.94
Plan Cost/Day	\$ 4.59	\$ 4.90	\$ 4.17	\$ 2.53	\$ 2.59
Plan Cost per Adjusted Rx	\$ 121.08	\$ 126.78	\$ 114.59	\$ -	\$ 72.05
Nbr Rxs PMPM	1.21	1.00	2.29	0.33	4.35
Generic Fill Rate	87.9%	87.5%	88.9%	66.7%	87.6%
Home Delivery Utilization	26.4%	23.0%	34.0%	0.0%	33.3%
Member Cost %	20.8%	21.4%	19.1%	15.8%	19.5%
Specialty Percent of Plan Cost	63.8%	64.1%	65.9%	0.0%	37.3%
Specialty Plan Cost PMPM	\$ 93.73	\$ 81.02	\$ 173.06	\$ -	\$ 116.96
Formulary Compliance Rate	99.8%	99.7%	99.8%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN
+ Q3 FY26

State of Nevada PEBP					
FY2026 Q3 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	4,486	3,796	629	3	58
Pct Members Utilizing Benefit	80.8%	79.2%	94.1%	66.7%	89.7%
Total Plan Cost	\$ 12,508,076	\$ 8,958,718	\$ 3,411,776	\$ 15,077	\$ 122,506
Total Days	2,208,325	1,655,998	498,884	2,967	50,476
Total Adjusted Rxs	81,599	61,664	18,014	104	1,817
Plan Cost PMPM	\$ 309.81	\$ 262.23	\$ 602.68	\$ 558.39	\$ 234.69
Plan Cost Net PMPM	\$ 200.47	\$ 161.95	\$ 436.04	\$ 196.02	\$ 167.12
Plan Cost/Day	\$ 5.66	\$ 5.41	\$ 6.84	\$ 5.08	\$ 2.43
Plan Cost per Adjusted Rx	\$ 153.29	\$ 145.28	\$ 189.40	\$ 144.97	\$ 67.42
Nbr Rxs PMPM	2.02	1.80	3.18	3.85	4.26
Generic Fill Rate	85.8%	85.6%	86.2%	81.7%	90.9%
Home Delivery Utilization	28.6%	26.9%	33.3%	63.5%	34.6%
Member Cost %	13.1%	13.0%	13.4%	5.6%	10.6%
Specialty Percent of Plan Cost	50.8%	47.1%	61.3%	0.0%	37.6%
Specialty Plan Cost PMPM	\$ 157.39	\$ 123.46	\$ 369.31	\$ -	\$ 88.15
Formulary Compliance Rate	99.4%	99.4%	99.6%	100.0%	99.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q3 FY26

State of Nevada PEBP					
FY2026 Q3 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	25,612	23,786	1,789	5	32
Pct Members Utilizing Benefit	74.0%	73.3%	89.0%	80.0%	100.0%
Total Plan Cost	\$ 44,490,759	\$ 39,114,547	\$ 5,201,495	\$ 19,047	\$ 155,669
Total Days	7,987,507	6,878,682	1,065,602	4,675	38,548
Total Adjusted Rxs	305,205	264,514	39,115	164	1,412
Plan Cost PMPM	\$ 193.01	\$ 182.72	\$ 323.05	\$ 423.28	\$ 540.52
Plan Cost Net PMPM	\$ 127.65	\$ 121.29	\$ 206.60	\$ 283.31	\$ 411.94
Plan Cost/Day	\$ 5.57	\$ 5.69	\$ 4.88	\$ 4.07	\$ 4.04
Plan Cost per Adjusted Rx	\$ 145.77	\$ 147.87	\$ 132.98	\$ 116.14	\$ 110.25
Nbr Rxs PMPM	1.32	1.24	2.43	3.64	4.90
Generic Fill Rate	86.3%	86.3%	86.5%	80.5%	86.8%
Home Delivery Utilization	25.5%	24.0%	35.0%	83.7%	41.1%
Member Cost %	13.0%	13.0%	12.9%	8.4%	6.4%
Specialty Percent of Plan Cost	48.7%	49.0%	47.8%	0.0%	11.6%
Specialty Plan Cost PMPM	\$ 94.03	\$ 89.54	\$ 154.49	\$ -	\$ 62.56
Formulary Compliance Rate	99.3%	99.3%	99.5%	100.0%	99.9%

14.6

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

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Nevada PEBP

Q3 FY2026

Prepared by Client Analytics

Mathew Gehrin (mgehrin@express-scripts.com)

5/28/2026

**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 Q3 FY26 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 | | \$98.22 |
| Utilization | \$0.61 | 0.8% |
| Unit Cost | \$13.38 | 17.1% |
| Member Share | \$5.93 | 7.6% |
| Total Change in Plan Cost Net PMPM | | \$19.92 |
| | | 25.4% |
| Previous Period - Plan Cost Net PMPM | | \$78.31 |

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

- **Inflammatory Conditions:** Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net ↑ \$864k (37.3%) to current \$3.2M.
 - Plan Cost Net PMPM ↑ \$4.57 (40.8%) to current \$15.77.
 - Patient Count ↑ 19 to current count of 252.
 - Adjusted Rx's ↑ 118 to current count of 1,862.
- **Notable Drug Changes within Indication:**
 - **Rinvoq:**
 - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$115k (44.9%) to current \$370k.
 - Plan Cost Net PMPM ↑ \$.60 (48.6%) to current \$1.84.
 - Patient Count ↑ 3 to current count of 15.
 - Adjusted Rx's ↑ 19 to current count of 99.
 - **Ilaris:**
 - New, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net: New, current \$320k.
 - Plan Cost Net PMPM: New, current \$1.59.
 - Patient Count: New, current count of 3.
 - Adjusted Rx's: New, current count of 24.

- **Bimzelx Autoinjector:**
 - Previously ranked 11th, currently ranked 6th by Plan Cost Net.
 - Plan Cost Net ↑ \$86k (104.1%) to current \$169k.
 - Plan Cost Net PMPM ↑ \$.44 (109.3%) to current \$.84.
 - Patient Count ↑ 2 to current count of 5.
 - Adjusted Rxs ↑ 19 to current count of 26.
- **Pulmonary Hypertension:** Previously ranked 13th, currently ranked 8th by Plan Cost Net.
 - Plan Cost Net ↑ \$677k (238.6%) to current \$961k.
 - Plan Cost Net PMPM ↑ \$3.39 (247.2%) to current \$4.77.
 - Patient Count ↑ 3 to current count of 6.
 - Adjusted Rxs ↑ 53 to current count of 90.
- **Notable Drug Changes within Indication:**
 - **Tyvaso DPI:**
 - New, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net: New, current 427k.
 - Plan Cost Net PMPM: New, current \$2.12.
 - Patient Count: New, current count of 2.
 - Adjusted Rxs: New, current count of 21.
 - **Opsynvi:**
 - New, currently ranked 3rd by Plan Cost Net.
 - Plan Cost Net: New, current 164k.
 - Plan Cost Net PMPM: New, current \$.81.
 - Patient Count: New, current count of 2.
 - Adjusted Rxs: New, current count of 18.
 - **Winrevair:**
 - New, currently ranked 5th by Plan Cost Net.
 - Plan Cost Net: New, current 75k.
 - Plan Cost Net PMPM: New, current \$.37.
 - Patient Count: New, current count of 1.
 - Adjusted Rxs: New, current count of 5.
- **Ophthalmic Conditions:** Previous ranked 26th, currently ranked 12th by Plan Cost Net.
 - Plan Cost Net ↑ \$455k (349.3%) to current \$586k.
 - Plan Cost Net PMPM ↑ \$2.27 (360.8%) to current \$2.91.
 - Patient Count ↓ 29 to current count of 261.
 - Adjusted Rxs ↓ 84 to current count of 630.
- **Notable Drug Changes within Indication:**
 - **Tepezza:**

- New, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net: New, current \$430k.
 - Plan Cost Net PMPM: New, current \$2.13.
 - Patient Count: New, current count of 1.
 - Adjusted Rxs: New, current count of 8.
- **Other drug changes in this indication were not notable.**
- **Enzyme Deficiencies:** Previously ranked 47th, currently ranked 13th by Plan Cost Net.
 - Plan Cost Net ↑ \$380k (1,582.6%) to current \$404k.
 - Plan Cost Net PMPM ↑ \$1.88 (1,625.5%) to current \$4.10.
 - Patient Count ↑ 3 to current count of 4.
 - Adjusted Rxs ↑ 15 to current count of 20.
- **Notable Drug Changes within Indication:**
 - **Fabrazyme:**
 - New, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net: New, current \$327k.
 - Plan Cost Net PMPM: New, current \$1.62.
 - Patient Count: New, current count of 1.
 - Adjusted Rxs: New, current count of 9.
 - **Sucraid:**
 - Previously ranked 1st, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net ↑ \$48k (200.8%) to current \$72k.
 - Plan Cost Net PMPM ↑ \$.24 (208.5%) to current \$.36.
 - Patient Count ↑ 1 to current count of 2.
 - Adjusted Rxs ↑ 4 to current count of 9.

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer in Plan Cost Net PMPM but has a higher trend.
- Peer experienced Plan Cost Net PMPM of \$108.81 compared to CDHP PEBP of \$98.22.
- Peer experienced Trend of 16.8%, compared to CDHP PEBP Trend of 25.4%

EPO Overall Trend Summaries:

| EPO Overall Trend | | % Change |
|---|----------------|-----------------|
| Current Period - Plan Cost Net PMPM | | \$200.47 |
| Utilization | \$9.29 | 5.3% |
| Unit Cost | \$6.43 | 3.6% |
| Member Share | \$8.15 | 4.6% |
| Total Change in Plan Cost Net PMPM | \$23.87 | 13.5% |
| Previous Period - Plan Cost Net PMPM | | \$176.60 |

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

- **Gout:** Previous ranked 14th, currently ranked 53rd by Plan Cost Net.
 - Plan Cost Net ↓ \$172k (-98.2%) to current \$3k.
 - Plan Cost Net PMPM ↓ \$3.65 (-97.9%) to current \$.08.
 - Patient Count ↓ 17 to current count of 113.
 - Adjusted Rx's ↓ 45 to current count of 695.
- **Notable Drug Changes within Indication:**
 - **Krystexxa:**
 - Previously ranked 1st, not currently utilized.
 - Plan Cost Net: Previous, \$167k.
 - Plan Cost Net PMPM: Previous, \$3.56.
 - Patient Count: Previous count of 2.
 - Adjusted Rx's: Previous count of 4.
 - **Other drug changes in this indication were not notable.**
- **Multiple Sclerosis:** Previous ranked 10th, currently ranked 5th by Plan Cost Net.
 - Plan Cost Net ↑ \$142k (57.1%) to current \$390k.
 - Plan Cost Net PMPM ↑ \$4.36 (82.3%) to current \$9.65.
 - Patient Count ↑ 1 to current count of 8.
 - Adjusted Rx's ↑ 4 to current count of 63.
- **Notable Drug Changes within Indication:**
 - **Mavenclad:**
 - New, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net: New, current \$86k.
 - Plan Cost Net PMPM: New, current \$2.13.
 - Patient Count: New, current count of 1.
 - Adjusted Rx's: New, current count of 1.

- **Kesimpta Pen:**
 - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$86k (114.1%) to current \$161k.
 - Plan Cost Net PMPM ↑ \$2.39 (148.5%) to current \$4.00.
 - Patient Count: Remains at 2.
 - Adjusted Rxs ↑ 9 to current count of 20.

- **Endocrine Disorders:** Previously ranked 12th, currently ranked 24th by Plan Cost Net.
 - Plan Cost Net ↓ \$125k (-60.0%) to current \$83k.
 - Plan Cost Net PMPM ↓ \$2.37 (-53.5%) to current \$2.06.
 - Patient Count ↓ 8 to current count of 23.
 - Adjusted Rxs ↓ 35 to current count of 141.

- **Notable Drug Changes within Indication:**
 - **Korlym:**
 - No Longer utilized, previously ranked 1st by Plan Cost Net.
 - Plan Cost Net: Previously \$80k.
 - Plan Cost Net PMPM: Previously \$1.71.
 - Patient Count: Previous count of 2.
 - Adjusted Rxs: Previous count of 2.

 - **Supprelin LA:**
 - No Longer utilized, previously ranked 3rd by Plan Cost Net.
 - Plan Cost Net: Previously \$49k.
 - Plan Cost Net PMPM: Previously \$1.04.
 - Patient Count: Previous count of 1.
 - Adjusted Rxs: Previous count of 12.

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

- **Muscle Relaxant:** Previously ranked 57th, currently ranked 19th by Plan Cost Net.
 - Plan Cost Net ↑ \$117k (2,920.8%) to current \$118k.
 - Plan Cost Net PMPM ↑ \$2.92 (3,407.0%) to current \$3.00.
 - Patient Count: Remains at 404.
 - Adjusted Rxs ↑ 9 to current count of 1,391.

- **Notable Drug Changes within Indication:**
 - **Skyclarys:**
 - New, Currently ranked 1st by Plan Cost Net.
 - Plan Cost Net: New, current \$118k.
 - Plan Cost Net PMPM: New, current \$2.92.
 - Patient Count: New, current count of 1.

- Adjusted Rxs: New, current count of 4.
- **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 PEBP EPO plan has a significantly lower trend.
- Peer experienced Plan Cost Net PMPM of \$172.15 compared to PEBP EPO of \$200.47
- Peer experienced Trend of 21.5%, compared to PEBP EPO of 13.5%

PPO Overall Trend Summaries:

| PPO Overall Trend | | % Change |
|--|---------|-----------------|
| Current Period - Plan Cost Net PMPM | | \$127.65 |
| Utilization | \$5.83 | 5.6% |
| Unit Cost | \$12.73 | 12.3% |
| Member Share | \$5.32 | 5.1% |
| Total Change in Plan Cost Net PMPM | | \$23.87 |
| | | 23.0% |

Previous Period - Plan Cost Net PMPM **\$103.77**

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 ↑ \$1.7M (53.4%) to current \$4.8M.
 - Plan Cost Net PMPM ↑ \$5.80 (39.2%) to current \$20.62.
 - Patient Count ↑ 53 to current count of 387.
 - Adjusted Rxs ↑ 446 to current count of 2,855.
- **Notable Drug Changes within Indication:**
 - **Rinvoq:**
 - Previously ranked 1st, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$194k (44.5%) to current \$631k.
 - Plan Cost Net PMPM ↑ \$.65 (31.1%) to current \$2.74.
 - Patient Count ↑ 4 to current count of 23.
 - Adjusted Rxs ↑ 38 to current count of 172.
 - **Skyrizi On-Body:**
 - Previously ranked 14th, currently ranked 4th by Plan Cost Net.
 - Plan Cost Net ↑ \$153k (249.0%) to current \$214k.
 - Plan Cost Net PMPM ↑ \$.64 (216.7%) to current \$.93.

- Patient Count ↑ 5 to current count of 7.
- Adjusted Rxs ↑ 32 to current count of 42.
- **Bimzelx Autoinjector:**
 - Previously ranked 23rd, currently ranked 6th by Plan Cost Net.
 - Plan Cost Net ↑ \$151k (471.9%) to current \$183k.
 - Plan Cost Net PMPM ↑ \$.64 (418.9%) to current \$.79.
 - Patient Count ↑ 3 to current count of 52.
 - Adjusted Rxs ↑ 18 to current count of 24.
- **Adalimumab-ADB(MCF) Pen (Humira Biosimilar):**
 - New, currently ranked 7th by Plan Cost Net.
 - Plan Cost Net: New, current \$176k.
 - Plan Cost Net PMPM: New, current \$.77.
 - Patient Count: New, current count of 31.
 - Adjusted Rxs: New, current count of 171.
- **Enzyme Deficiencies:** Previously ranked 4th, currently ranked 5th by Plan Cost Net.
 - Plan Cost Net ↑ \$827k (82.6%) to current \$1.8M.
 - Plan Cost Net PMPM ↑ \$3.14 (65.7%) to current \$7.93.
 - Patient Count ↓ 1 to current count of 10.
 - Adjusted Rxs ↑ 41 to current count of 79.
- **Notable Drug Changes within Indication:**
 - **Yorvipath:**
 - Previously ranked 6th, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$834k (1,254.2%) to current \$901k.
 - Plan Cost Net PMPM ↑ \$3.59 (1,128.6%) to current \$3.91.
 - Patient Count ↑ 5 to current count of 6.
 - Adjusted Rxs ↑ 43 to current count of 46.
 - **Imcivree:**
 - New, currently ranked 3rd by Plan Cost Net.
 - Plan Cost Net: New, current \$272k.
 - Plan Cost Net PMPM: New, current \$1.18.
 - Patient Count: New, current count of 1.
 - Adjusted Rxs: New, current count of 9.
 - **Nexvazyme:**
 - No Longer utilized, previously ranked 2nd by Plan Cost Net.
 - Plan Cost Net: Previously \$151k.
 - Plan Cost Net PMPM: Previously \$.72.
 - Patient Count: Previous count of 1.
 - Adjusted Rxs: Previous count of 2.
 - **Galafold:**
 - No Longer utilized, previously ranked 3rd by Plan Cost Net.
 - Plan Cost Net: Previously \$119k.

- Plan Cost Net PMPM: Previously \$.57.
 - Patient Count: Previous count of 1.
 - Adjusted Rxs: Previous count of 4.
- **Diabetes:** Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net ↑ \$753k (26.5%) to current \$3.6M.
 - Plan Cost Net PMPM ↑ \$2.00 (14.7%) to current \$15.61.
 - Patient Count ↑ 190 to current count of 2068.
 - Adjusted Rxs ↑ 1,717 to current count of 24,601.
- **Notable Drug Changes within Indication:**
 - **Mounjaro:**
 - Previously ranked 1st, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$682k (71.6%) to current \$1.6M.
 - Plan Cost Net PMPM ↑ \$2.54 (55.7%) to current \$7.10.
 - Patient Count ↑ 230 to current count of 619.
 - Adjusted Rxs ↑ 1,672 to current count of 4,488.
 - **Other drug changes in this indication were not notable.**
- **Cancer:** Previously ranked 3rd, currently ranked 3rd by Plan Cost Net.
 - Plan Cost Net ↑ \$616k (35.1%) to current \$2.4Mk.
 - Plan Cost Net PMPM ↑ \$1.89 (22.5%) to current \$10.30.
 - Patient Count ↑ 36 to current count of 237.
 - Adjusted Rxs ↑ 208 to current count of 1,449.
- **Notable Drug Changes within Indication:**
 - **Idihifa:**
 - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
 - Plan Cost Net ↑ \$107k (48.8%) to current \$327k.
 - Plan Cost Net PMPM ↑ \$.37 (35.0%) to current \$1.42.
 - Patient Count remains at 2.
 - Adjusted Rxs ↑ 3 to current count of 10.
 - **Tibsovo:**
 - New, currently ranked 2nd by Plan Cost Net.
 - Plan Cost Net: New, current \$259k.
 - Plan Cost Net PMPM: New, current \$1.12.
 - Patient Count: New, current count of 1.
 - Adjusted Rxs: New, current count of 8.
 - **Kisqali:**
 - Previously ranked 20th, currently ranked 5th by Plan Cost Net.

- Plan Cost Net ↑ \$218k (1,157.8%) to current \$237k.
- Plan Cost Net PMPM ↑ \$.94 (1,041.2%) to current \$1.03.
- Patient Count ↑ 1 to current count of 2.
- Adjusted Rxs ↑ 16 to current count of 20.

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP PPO plan)
- PEBP PPO is outperforming the peer in Plan Cost Net PMPM, however PEBP PPO plan has a slightly higher trend.
- PEBP PPO experienced Plan Cost Net PMPM of \$127.65 compared to peer of \$172.15.
- Peer experienced Trend of 21.5%, compared to PEBP PPO of 23.0%.

| Total Overall Trend | | % Change |
|--------------------------------------|---------|---------------|
| Current Period - Plan Cost Net PMPM | | \$121.32 |
| Utilization | \$2.78 | 2.8% |
| Unit Cost | \$12.75 | 12.8% |
| Member Share | \$6.01 | 6.0% |
| Total Change in Plan Cost Net PMPM | | \$21.54 21.6% |
| Previous Period - Plan Cost Net PMPM | | \$99.78 |

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 16.9% in Specialty patients. This resulted in a 21.2% increase in Specialty Days of Therapy.

Trend was mitigated by increased rebates of 5.0%. Which reduced combine Unit Cost Trend to 12.8%.

Member Cost contributed to Trend on both Specialty and Non-Specialty drugs. This is due to increased Utilization on Specialty drugs and Drug Mix on Non-Specialty drugs. Primarily driven by utilization of more expensive drugs (exchanging utilization of a brand drug for a more expensive brand drug).

Key Statistics:

| Nevada PEBP Total | | | |
|-------------------------------------|--------------|--------------|--------|
| Description | Q3 FY26 | Q3 FY25 | Change |
| Average Members per Month | 52,503 | 51,421 | 2.1% |
| Number of Unique patients | 37,513 | 36,778 | 2.0% |
| Members Utilizing the Benefit | 71.4% | 71.5% | -0.1 |
| Gross Cost/Adjusted Rx | \$162.97 | \$148.86 | 9.5% |
| Plan Spend | \$86,639,471 | \$74,080,635 | 17.0% |
| Rebates (estimated) | \$29,313,774 | \$27,905,130 | 5.0% |
| Plan Cost Net | \$57,325,697 | \$46,175,506 | 24.1% |
| Plan Cost Net PMPM | \$121.32 | \$99.78 | 21.6% |
| Non-Specialty Plan Cost Net PMPM | \$84.04 | \$79.19 | 6.1% |
| Specialty Plan Cost Net PMPM | \$99.32 | \$80.88 | 22.8% |
| Generic Fill Rate | 86.8% | 86.7% | 0.2 |
| 90 Day Utilization | 59.6% | 59.9% | -0.3 |
| Retail - Maintenance 90 Utilization | 32.2% | 29.5% | 2.7 |
| Home Delivery Utilization | 26.3% | 29.6% | -3.3 |
| Member Cost Net % | 15.8% | 18.0% | -2.1 |

END OF REPORT

14.7

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

14.7 Q3 CDHP Performance Report



PEBP

Public Employees' Benefits Program

Quarterly Plan Performance Review HDHP Plan • 2026-3Q



A UnitedHealthcare Company

Report Criteria & Contents

Experience Periods*

➤ 2026 Plan Year (Current)

2026-3Q. 1st three Quarters: Claims Paid 7/1/2025 - 3/31/2026

➤ 2025 Plan Year

2025-3Q. 1st three Quarters: Claims Paid 7/1/2024 - 3/31/2025

2025 Full Year: Claims paid 7/1/2024 - 6/30/2025

➤ 2024 Plan Year

2024-3Q. 1st three Quarters: Claims Paid 7/1/2023 - 3/31/2024

2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

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 InfoPortSM
- Composition: 5,293 groups with approximately 8.8 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 3/31/2026

* Additional date ranges for specific figures are defined on the page if applicable

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Executive Summary



Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: +14.0%
- High-Cost Claimants Paid PMPM trend: +29.3%; Non HCCs trend: +7.5%
- Top Paid Diagnostic Chapters: Health Status & Services (+16.2% Paid PMPM), Neoplasms (Cancer) (+38.2%), Musculoskeletal (+9.3%)



Membership & Demographics

- Total membership is 2.7% lower than prior period
- Employees decreased 2.8%, while Dependents were down 2.6%
- 86.2% of members had < \$2,500 medical paid, with 24.1% having no claims paid at all during the reporting period



Utilization Key Indicators

- Paid per IP Admit was \$27,410, which is 3.2% higher than 2025-3Q
- Paid per ER Visit was \$2,425, which is 2.3% higher than 2025-3Q



Network Utilization & Savings

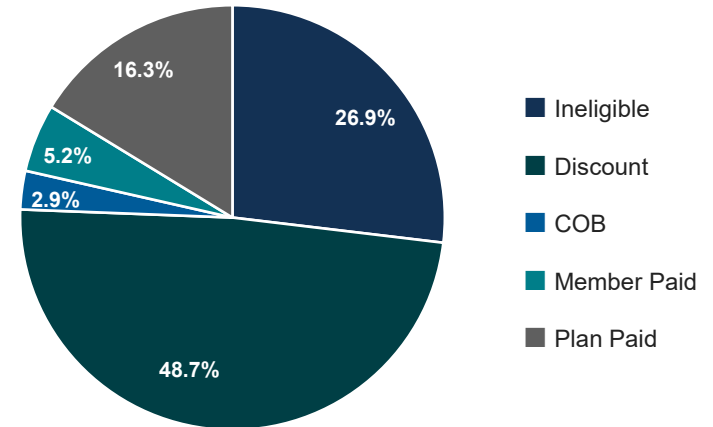
- 97.6% of all Medical spend dollars were to In Network providers
- The average In Network discount was 70.1%, which is 0.7 pts above the 2025 average discount of 69.4%

Medical Total Savings Summary

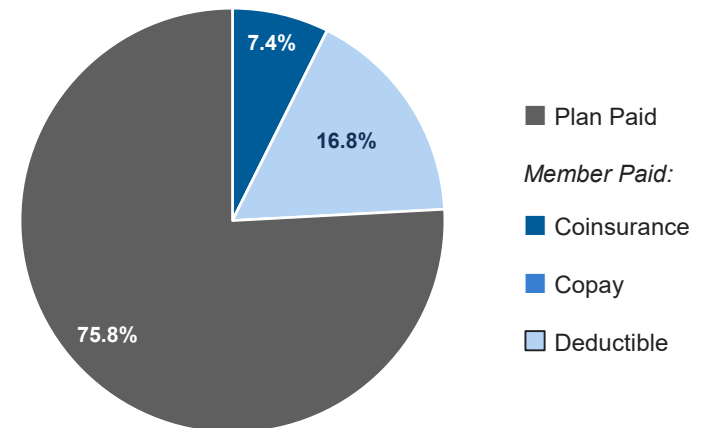
Dollar Chain: Billed to Paid Dollars

| Dollar Amount | 2026-3Q
Total Dollars | 2026-3Q
PMPM* | 2025
PMPM* | Trend |
|-------------------|--------------------------|------------------|---------------|--------|
| Medical Billed | \$442,833,040 | \$2,190 | \$1,981 | 10.6% |
| (-) Ineligible | \$118,946,829 | \$588 | \$588 | 0.0% |
| Medical Covered | \$323,886,210 | \$1,602 | \$1,393 | 15.0% |
| (-) Discount | \$215,502,753 | \$1,066 | \$902 | 18.1% |
| Medical Allowed | \$108,383,457 | \$536 | \$490 | 9.3% |
| (-) COB | \$12,975,364 | \$64 | \$70 | -8.8% |
| (-) Coinsurance | \$6,983,652 | \$35 | \$33 | 4.2% |
| (-) Copay | \$160 | \$0 | \$0 | -88.9% |
| (-) Deductible | \$15,932,064 | \$79 | \$66 | 19.8% |
| Total Member Paid | \$22,915,876 | \$113 | \$99 | 14.6% |
| Total Plan Paid | \$71,973,362 | \$356 | \$320 | 11.4% |

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 | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | | 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 | \$2,086,478 | \$1,978 | \$8,504 | \$8 | \$2,094,982 | \$1,986 | \$2,452,886 | \$2,604 | \$1,220 | \$1 | \$2,454,106 | \$2,605 | 17.1% | 31.2% |
| 1 | \$142,966 | \$154 | \$217 | \$0 | \$143,183 | \$154 | \$148,863 | \$135 | \$210 | \$0 | \$149,073 | \$135 | 4.1% | -12.1% |
| 2 - 4 | \$762,966 | \$179 | \$47,030 | \$11 | \$809,996 | \$190 | \$711,404 | \$183 | \$35,620 | \$9 | \$747,023 | \$192 | -7.8% | 0.7% |
| 5 - 9 | \$1,159,400 | \$124 | \$339,865 | \$36 | \$1,499,264 | \$161 | \$1,069,601 | \$117 | \$321,638 | \$35 | \$1,391,240 | \$152 | -7.2% | -5.3% |
| 10 - 14 | \$1,050,118 | \$88 | \$210,927 | \$18 | \$1,261,045 | \$105 | \$1,743,096 | \$147 | \$360,429 | \$30 | \$2,103,525 | \$178 | 66.8% | 68.4% |
| 15 - 19 | \$2,442,554 | \$176 | \$393,429 | \$28 | \$2,835,983 | \$204 | \$2,742,636 | \$204 | \$512,304 | \$38 | \$3,254,940 | \$242 | 14.8% | 19.0% |
| 20 - 24 | \$2,245,893 | \$130 | \$1,210,610 | \$70 | \$3,456,503 | \$200 | \$2,049,058 | \$122 | \$719,216 | \$43 | \$2,768,273 | \$165 | -19.9% | -17.7% |
| 25 - 29 | \$1,600,049 | \$135 | \$592,699 | \$50 | \$2,192,748 | \$184 | \$1,922,259 | \$155 | \$602,540 | \$49 | \$2,524,799 | \$204 | 15.1% | 10.4% |
| 30 - 34 | \$3,884,159 | \$278 | \$824,988 | \$59 | \$4,709,147 | \$337 | \$5,201,269 | \$391 | \$853,712 | \$64 | \$6,054,981 | \$456 | 28.6% | 35.3% |
| 35 - 39 | \$3,952,763 | \$262 | \$1,158,900 | \$77 | \$5,111,663 | \$339 | \$3,912,285 | \$256 | \$1,772,829 | \$116 | \$5,685,113 | \$372 | 11.2% | 9.8% |
| 40 - 44 | \$3,153,492 | \$187 | \$1,393,098 | \$83 | \$4,546,590 | \$270 | \$3,834,154 | \$227 | \$1,863,579 | \$110 | \$5,697,733 | \$337 | 25.3% | 24.8% |
| 45 - 49 | \$4,438,650 | \$286 | \$2,626,059 | \$169 | \$7,064,709 | \$456 | \$5,751,801 | \$367 | \$2,776,465 | \$177 | \$8,528,266 | \$545 | 20.7% | 19.5% |
| 50 - 54 | \$5,783,580 | \$330 | \$3,329,241 | \$190 | \$9,112,821 | \$520 | \$7,962,463 | \$489 | \$3,095,469 | \$190 | \$11,057,932 | \$679 | 21.3% | 30.7% |
| 55 - 59 | \$9,221,609 | \$487 | \$3,616,879 | \$191 | \$12,838,488 | \$678 | \$8,828,854 | \$482 | \$4,318,762 | \$236 | \$13,147,616 | \$718 | 2.4% | 5.9% |
| 60 - 64 | \$13,347,609 | \$592 | \$5,199,220 | \$230 | \$18,546,829 | \$822 | \$13,851,838 | \$669 | \$6,313,903 | \$305 | \$20,165,741 | \$973 | 8.7% | 18.4% |
| 65+ | \$9,670,144 | \$578 | \$5,152,942 | \$308 | \$14,823,087 | \$886 | \$9,790,895 | \$605 | \$5,561,690 | \$343 | \$15,352,585 | \$948 | 3.6% | 7.0% |
| Total | \$64,942,432 | \$313 | \$26,104,606 | \$126 | \$91,047,038 | \$438 | \$71,973,362 | \$356 | \$29,109,584 | \$144 | \$101,082,946 | \$500 | 11.0% | 14.1% |

Financial Summary – YTD Trend

Total Plan & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|---------------|--------------|---------------|--------------|---------------|-----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 8,183 | 74.5% | 14,278 | -2.8% | 13,884 | | |
| Spouses | 1,530 | 66.8% | 2,553 | -3.4% | 2,466 | | |
| Children | 3,703 | 68.9% | 6,254 | -2.2% | 6,114 | | |
| Tot. Members | 13,417 | 72.1% | 23,086 | -2.7% | 22,464 | | |
| Avg. Family Size | 1.6 | -1.4% | 1.6 | 0.1% | 1.6 | 1.9 | -15.7% |
| Financial Summary | | | | | | | |
| Allowed | \$56,308,501 | 80.7% | \$101,745,192 | 6.5% | \$108,383,457 | | |
| Plan Paid | \$39,675,856 | 63.7% | \$64,942,432 | 10.8% | \$71,973,362 | | |
| Member Paid (OOP) | \$11,014,850 | 101.1% | \$22,150,925 | 3.5% | \$22,915,876 | | |
| Paid PEPY | \$6,464 | -6.2% | \$6,064 | 14.0% | \$6,912 | \$10,453 | -33.9% |
| Paid PMPY | \$3,943 | -4.9% | \$3,751 | 13.9% | \$4,272 | \$5,447 | -21.6% |
| Paid PEPM | \$539 | -6.2% | \$505 | 14.0% | \$576 | \$871 | -33.9% |
| Paid PMPM | \$329 | -4.9% | \$313 | 13.9% | \$356 | \$454 | -21.6% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 104 | -10.6% | 93 | 6.5% | 99 | | |
| HCCs per 1000 | 7.8 | -48.0% | 4.0 | 9.4% | 4.4 | 4.9 | -9.4% |
| Paid per HCC | \$219,549 | -6.8% | \$204,554 | 18.2% | \$241,812 | \$219,275 | 10.3% |
| HCC Paid % of Tot | 57.5% | -28.3 pts | 29.3% | 4.0 pts | 33.3% | 27.8% | 5.5 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$1,398 | -27.9% | \$1,009 | 16.9% | \$1,179 | \$1,303 | -9.5% |
| Outpatient | \$1,081 | 15.9% | \$1,253 | 14.3% | \$1,432 | \$1,587 | -9.8% |
| Physician | \$1,411 | 1.0% | \$1,425 | 13.0% | \$1,610 | \$2,457 | -34.5% |
| Ancillary | \$52 | 23.0% | \$64 | -21.6% | \$51 | \$100 | -49.3% |

- With \$51.9M paid, the State Active population is 72.1% of total 2026-3Q med spend
- On a Paid PMPM basis, State Actives are up 8.1% compared to prior year
- Total HDHP Plan Paid PMPM trend is +13.9%

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 | | | | |
|--|---------------|--------------|---------------|--------------|---------------|------------------|---------------|------------|--------------|------------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 6,649 | 76.7% | 11,747 | -1.3% | 11,595 | 2 | 116.7% | 4 | 50.9% | 7 |
| Spouses | 1,164 | 68.1% | 1,958 | -1.8% | 1,922 | 0 | 100.0% | 1 | 130.6% | 2 |
| Children | 3,391 | 69.8% | 5,758 | -1.5% | 5,670 | 1 | -27.3% | 1 | 12.5% | 1 |
| Tot. Members | 11,205 | 73.7% | 19,462 | -1.4% | 19,187 | 4 | 65.6% | 6 | 54.1% | 9 |
| Avg. Family Size | 1.7 | -1.7% | 1.7 | -0.1% | 1.7 | 1.8 | -23.6% | 1.4 | 2.1% | 1.4 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$39,260,159 | 74.9% | \$68,660,881 | 7.3% | \$73,704,506 | \$57,058 | -43.3% | \$32,332 | 215.6% | \$102,038 |
| Plan Paid | \$30,526,108 | 59.5% | \$48,680,071 | 6.6% | \$51,871,701 | \$45,865 | -48.9% | \$23,450 | 214.8% | \$73,811 |
| Member Paid (OOP) | \$8,370,434 | 103.0% | \$16,992,318 | 5.6% | \$17,940,039 | \$11,193 | -20.6% | \$8,882 | 83.2% | \$16,269 |
| Paid PEPY | \$6,121 | -9.7% | \$5,526 | 7.9% | \$5,965 | \$30,577 | -76.4% | \$7,215 | 108.7% | \$15,055 |
| Paid PMPY | \$3,632 | -8.2% | \$3,335 | 8.1% | \$3,605 | \$17,199 | -69.1% | \$5,309 | 104.3% | \$10,846 |
| Paid PEPM | \$510 | -9.7% | \$460 | 7.9% | \$497 | \$2,548 | -76.4% | \$601 | 108.7% | \$1,255 |
| Paid PMPM | \$303 | -8.2% | \$278 | 8.1% | \$300 | \$1,433 | -69.1% | \$442 | 104.3% | \$904 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 75 | -16.0% | 63 | 1.6% | 64 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 6.7 | -51.6% | 3.2 | 3.0% | 3.3 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$237,156 | -8.6% | \$216,728 | 4.1% | \$225,596 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 58.3% | -30.2 pts | 28.0% | -0.2 pts | 27.8% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,318 | -30.4% | \$918 | 2.7% | \$943 | \$0 | - | \$0 | - | \$6,248 |
| Outpatient | \$979 | 13.3% | \$1,109 | 11.9% | \$1,241 | \$14,270 | -72.7% | \$3,893 | -38.1% | \$2,411 |
| Physician | \$1,292 | -1.5% | \$1,273 | 8.0% | \$1,374 | \$2,923 | -51.5% | \$1,417 | -16.0% | \$1,190 |
| Ancillary | \$44 | -18.6% | \$36 | 28.5% | \$46 | \$7 | -100.0% | \$0 | - | \$998 |

Financial Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|--------------|--------------|--------------|--------------------|--------------|-------------|---------------|-------------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 1,357 | 64.9% | 2,237 | -9.9% | 2,016 | 175 | 65.4% | 290 | -8.1% | 267 |
| Spouses | 346 | 63.3% | 565 | -7.9% | 520 | 19 | 51.7% | 29 | -25.0% | 22 |
| Children | 303 | 59.7% | 484 | -10.3% | 434 | 8 | 56.5% | 12 | -20.4% | 10 |
| Tot. Members | 2,006 | 63.8% | 3,286 | -9.6% | 2,970 | 202 | 63.7% | 331 | -10.0% | 298 |
| Avg. Family Size | 1.5 | -0.6% | 1.5 | 0.3% | 1.5 | 1.2 | -1.0% | 1.1 | -2.1% | 1.1 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$14,066,832 | 93.6% | \$27,228,563 | 7.9% | \$29,380,852 | \$2,924,453 | 99.1% | \$5,823,415 | -10.8% | \$5,196,062 |
| Plan Paid | \$8,172,730 | 76.8% | \$14,452,400 | 25.9% | \$18,190,106 | \$931,153 | 91.9% | \$1,786,510 | 2.9% | \$1,837,743 |
| Member Paid (OOP) | \$2,264,572 | 98.2% | \$4,489,383 | -4.0% | \$4,308,768 | \$368,651 | 79.1% | \$660,343 | -1.4% | \$650,800 |
| Paid PEPY | \$8,030 | 7.2% | \$8,613 | 39.7% | \$12,033 | \$7,077 | 16.0% | \$8,211 | 11.9% | \$9,189 |
| Paid PMPY | \$5,432 | 7.9% | \$5,864 | 39.3% | \$8,167 | \$6,133 | 17.2% | \$7,187 | 14.3% | \$8,216 |
| Paid PEPM | \$669 | 7.2% | \$718 | 39.7% | \$1,003 | \$590 | 16.0% | \$684 | 11.9% | \$766 |
| Paid PMPM | \$453 | 7.9% | \$489 | 39.3% | \$681 | \$511 | 17.2% | \$599 | 14.3% | \$685 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 26 | -3.8% | 25 | 28.0% | 32 | 3 | 66.7% | 5 | -40.0% | 3 |
| HCCs per 1000 | 13.0 | -41.3% | 7.6 | 41.6% | 10.8 | 14.8 | 1.8% | 15.1 | -33.3% | 10.1 |
| Paid per HCC | \$170,464 | 11.9% | \$190,749 | 44.2% | \$275,067 | \$168,611 | -28.7% | \$120,195 | 43.7% | \$172,716 |
| HCC Paid % of Tot | 54.2% | -21.2 pts | 33.0% | 15.4 pts | 48.4% | 54.3% | -20.7 pts | 33.6% | -5.4 pts | 28.2% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,657 | -25.3% | \$1,238 | 94.1% | \$2,402 | \$3,314 | 23.7% | \$4,098 | -1.1% | \$4,054 |
| Outpatient | \$1,605 | 31.3% | \$2,107 | 21.1% | \$2,552 | \$1,351 | -10.5% | \$1,209 | 110.0% | \$2,539 |
| Physician | \$2,079 | 9.9% | \$2,284 | 37.6% | \$3,144 | \$1,360 | 35.2% | \$1,838 | -17.8% | \$1,510 |
| Ancillary | \$92 | 155.1% | \$235 | -70.7% | \$69 | \$108 | -62.2% | \$41 | 175.5% | \$112 |

Financial Summary – Full Year Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|---------------|--------------|---------------|--------------|---------------|------------|---------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 9,842 | 45.4% | 14,312 | -3.0% | 13,884 | | |
| Spouses | 1,827 | 39.6% | 2,550 | -3.3% | 2,466 | | |
| Children | 4,428 | 41.1% | 6,250 | -2.2% | 6,114 | | |
| Tot. Members | 16,097 | 43.6% | 23,112 | -2.8% | 22,464 | | |
| Avg. Family Size | 1.6 | -1.3% | 1.6 | 0.2% | 1.6 | 1.9 | -15.7% |
| Financial Summary | | | | | | | |
| Allowed | \$93,151,002 | 46.0% | \$135,998,902 | -20.3% | \$108,383,457 | | |
| Plan Paid | \$66,404,990 | 33.5% | \$88,624,170 | -18.8% | \$71,973,362 | | |
| Member Paid (OOP) | \$16,404,762 | 67.3% | \$27,441,813 | -16.5% | \$22,915,876 | | |
| Paid PEPY | \$6,747 | -8.2% | \$6,192 | 11.6% | \$6,912 | \$10,453 | -33.9% |
| Paid PMPY | \$4,125 | -7.0% | \$3,835 | 11.4% | \$4,272 | \$5,447 | -21.6% |
| Paid PEPM | \$562 | -8.2% | \$516 | 11.6% | \$576 | \$871 | -33.9% |
| Paid PMPM | \$344 | -7.0% | \$320 | 11.4% | \$356 | \$454 | -21.6% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 148 | -13.5% | 128 | -22.7% | 99 | | |
| HCCs per 1000 | 9.2 | -39.8% | 5.5 | -20.4% | 4.4 | 4.9 | -9.4% |
| Paid per HCC | \$230,303 | -11.6% | \$203,621 | 18.8% | \$241,812 | \$219,275 | 10.3% |
| HCC Paid % of Tot | 51.3% | -21.9 pts | 29.4% | 3.9 pts | 33.3% | 27.8% | 5.5 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$1,348 | -29.3% | \$953 | 23.7% | \$1,179 | \$1,303 | -9.5% |
| Outpatient | \$1,195 | 9.3% | \$1,306 | 9.7% | \$1,432 | \$1,587 | -9.8% |
| Physician | \$1,530 | -1.2% | \$1,512 | 6.5% | \$1,610 | \$2,457 | -34.5% |
| Ancillary | \$52 | 21.9% | \$64 | -20.9% | \$51 | \$100 | -49.3% |

- Total plan paid amount for the first three quarters of 2024 was 73.3% of the full year
- Annualizing 2025 paid dollars using the same ratio would result in a total paid of \$98.2 M

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 for the 2024 Plan Year.

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 – Full Year Trend

Active Members

| Measure | State Active | | | | | Non-State Active | | | | |
|--|---------------|--------------|---------------|--------------|---------------|------------------|--------------|----------|--------------|-----------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 8,019 | 47.2% | 11,806 | -1.8% | 11,595 | 3 | 106.7% | 5 | 26.5% | 7 |
| Spouses | 1,394 | 40.6% | 1,960 | -2.0% | 1,922 | 0 | 266.7% | 1 | 67.7% | 2 |
| Children | 4,058 | 41.9% | 5,758 | -1.5% | 5,670 | 1 | -21.4% | 1 | 9.1% | 1 |
| Tot. Members | 13,471 | 44.9% | 19,525 | -1.7% | 19,187 | 4 | 78.7% | 7 | 29.6% | 9 |
| Avg. Family Size | 1.7 | -1.6% | 1.7 | 0.1% | 1.7 | 1.6 | -13.5% | 1.4 | 2.5% | 1.4 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$65,852,974 | 39.0% | \$91,514,620 | -19.5% | \$73,704,506 | \$72,947 | -54.1% | \$33,497 | 204.6% | \$102,038 |
| Plan Paid | \$51,498,861 | 28.4% | \$66,141,692 | -21.6% | \$51,871,701 | \$61,402 | -61.5% | \$23,665 | 211.9% | \$73,811 |
| Member Paid (OOP) | \$12,585,988 | 68.6% | \$21,217,588 | -15.4% | \$17,940,039 | \$11,545 | -14.8% | \$9,832 | 65.5% | \$16,269 |
| Paid PEPY | \$6,422 | -12.8% | \$5,602 | 6.5% | \$5,965 | \$24,561 | -81.4% | \$4,580 | 228.7% | \$15,055 |
| Paid PMPY | \$3,823 | -11.4% | \$3,388 | 6.4% | \$3,605 | \$15,677 | -78.4% | \$3,381 | 220.8% | \$10,846 |
| Paid PEPM | \$535 | -12.8% | \$467 | 6.5% | \$497 | \$2,047 | -81.4% | \$382 | 228.7% | \$1,255 |
| Paid PMPM | \$319 | -11.4% | \$282 | 6.4% | \$300 | \$1,306 | -78.4% | \$282 | 220.8% | \$904 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 110 | -20.9% | 87 | -26.4% | 64 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 8.2 | -45.4% | 4.5 | -25.1% | 3.3 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$245,319 | -14.3% | \$210,234 | 7.3% | \$225,596 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 52.4% | -24.7 pts | 27.7% | 0.2 pts | 27.8% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,279 | -32.1% | \$868 | 8.6% | \$943 | \$0 | - | \$0 | - | \$6,248 |
| Outpatient | \$1,090 | 4.8% | \$1,142 | 8.6% | \$1,241 | \$9,953 | -75.3% | \$2,456 | -1.8% | \$2,411 |
| Physician | \$1,410 | -5.3% | \$1,336 | 2.9% | \$1,374 | \$5,720 | -84.0% | \$916 | 29.8% | \$1,190 |
| Ancillary | \$44 | -6.7% | \$41 | 12.2% | \$46 | \$5 | 77.1% | \$9 | 11539.5% | \$998 |

Financial Summary – Full Year Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|--------------|--------------|--------------|--------------------|--------------|-------------|--------------|-------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 1,613 | 37.2% | 2,213 | -8.9% | 2,016 | 208 | 38.5% | 288 | -7.3% | 267 |
| Spouses | 410 | 36.6% | 560 | -7.0% | 520 | 23 | 26.7% | 29 | -23.7% | 22 |
| Children | 360 | 33.1% | 479 | -9.6% | 434 | 9 | 32.7% | 12 | -19.2% | 10 |
| Tot. Members | 2,383 | 36.5% | 3,252 | -8.7% | 2,970 | 239 | 37.2% | 328 | -9.2% | 298 |
| Avg. Family Size | 1.5 | -0.5% | 1.5 | 0.3% | 1.5 | 1.2 | -1.0% | 1.1 | -2.0% | 1.1 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$22,711,677 | 62.4% | \$36,877,665 | -20.3% | \$29,380,852 | \$4,513,404 | 67.8% | \$7,573,121 | -31.4% | \$5,196,062 |
| Plan Paid | \$13,599,461 | 49.1% | \$20,280,083 | -10.3% | \$18,190,106 | \$1,245,265 | 75.0% | \$2,178,730 | -15.7% | \$1,837,743 |
| Member Paid (OOP) | \$3,280,740 | 65.5% | \$5,428,023 | -20.6% | \$4,308,768 | \$526,489 | 49.4% | \$786,370 | -17.2% | \$650,800 |
| Paid PEPY | \$8,431 | 8.7% | \$9,166 | 31.3% | \$12,033 | \$5,996 | 26.3% | \$7,574 | 21.3% | \$9,189 |
| Paid PMPY | \$5,707 | 9.3% | \$6,237 | 30.9% | \$8,167 | \$5,203 | 27.5% | \$6,636 | 23.8% | \$8,216 |
| Paid PEPM | \$703 | 8.7% | \$764 | 31.3% | \$1,003 | \$500 | 26.3% | \$631 | 21.3% | \$766 |
| Paid PMPM | \$476 | 9.3% | \$520 | 30.9% | \$681 | \$434 | 27.5% | \$553 | 23.8% | \$685 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 37 | -5.4% | 35 | -8.6% | 32 | 3 | 100.0% | 6 | -50.0% | 3 |
| HCCs per 1000 | 15.5 | -30.7% | 10.8 | 0.1% | 10.8 | 12.5 | 45.8% | 18.3 | -45.0% | 10.1 |
| Paid per HCC | \$175,418 | 14.4% | \$200,660 | 37.1% | \$275,067 | \$175,672 | -28.8% | \$125,018 | 38.2% | \$172,716 |
| HCC Paid % of Tot | 47.7% | -13.1 pts | 34.6% | 13.8 pts | 48.4% | 42.3% | -7.9 pts | 34.4% | -6.2 pts | 28.2% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,634 | -25.2% | \$1,222 | 96.5% | \$2,402 | \$2,441 | 37.8% | \$3,364 | 20.5% | \$4,054 |
| Outpatient | \$1,784 | 27.5% | \$2,274 | 12.2% | \$2,552 | \$1,105 | 26.9% | \$1,403 | 81.0% | \$2,539 |
| Physician | \$2,199 | 15.5% | \$2,540 | 23.8% | \$3,144 | \$1,517 | 19.3% | \$1,810 | -16.6% | \$1,510 |
| Ancillary | \$90 | 122.4% | \$200 | -65.7% | \$69 | \$139 | -57.9% | \$59 | 92.0% | \$112 |

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

| Claim Type | 2025-3Q (7/1/2024 - 3/31/2025) | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | Trend |
|--------------------------|--------------------------------|-----------------------|--------------------|---------------------|--------------------------------|-----------------------|--------------------|---------------------|--------------|
| | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Total |
| State Members | | | | | | | | | |
| Inpatient | \$13,396,753 | \$2,010,662 | \$1,039,604 | \$16,447,019 | \$13,570,553 | \$3,844,453 | \$1,505,673 | \$18,920,680 | 15.0% |
| Outpatient | \$16,182,760 | \$4,384,925 | \$806,981 | \$21,374,665 | \$17,856,590 | \$4,984,837 | \$698,633 | \$23,540,060 | 10.1% |
| Physician | \$18,574,651 | \$4,700,936 | \$929,248 | \$24,204,835 | \$19,778,342 | \$5,949,119 | \$1,054,060 | \$26,781,521 | 10.6% |
| Ancillary | \$525,908 | \$118,086 | \$461,959 | \$1,105,953 | \$666,216 | \$120,409 | \$32,922 | \$819,547 | -25.9% |
| Total | \$48,680,071 | \$11,214,609 | \$3,237,791 | \$63,132,472 | \$51,871,701 | \$14,898,819 | \$3,291,287 | \$70,061,807 | 11.0% |
| PMPM | \$277.92 | \$511.39 | \$423.42 | \$308.36 | \$300.39 | \$768.12 | \$448.99 | \$351.35 | 13.9% |
| Non-State Members | | | | | | | | | |
| Inpatient | \$0 | \$141,870 | \$876,937 | \$1,018,807 | \$42,520 | \$21,835 | \$885,000 | \$949,355 | -6.8% |
| Outpatient | \$17,192 | \$172,840 | \$127,706 | \$317,738 | \$16,406 | \$174,002 | \$393,952 | \$584,360 | 83.9% |
| Physician | \$6,257 | \$138,571 | \$318,448 | \$463,276 | \$8,096 | \$110,073 | \$227,745 | \$345,913 | -25.3% |
| Ancillary | \$0 | \$7,714 | \$2,426 | \$10,140 | \$6,790 | \$5,318 | \$19,818 | \$31,925 | 214.8% |
| Total | \$23,450 | \$460,994 | \$1,325,516 | \$1,809,960 | \$73,811 | \$311,228 | \$1,526,515 | \$1,911,554 | 5.6% |
| PMPM | \$442.45 | \$775.66 | \$554.92 | \$596.17 | \$903.81 | \$762.34 | \$670.78 | \$691.17 | 15.9% |
| All Members | | | | | | | | | |
| Inpatient | \$13,396,753 | \$2,152,532 | \$1,916,541 | \$17,465,825 | \$13,613,073 | \$3,866,288 | \$2,390,674 | \$19,870,035 | 13.8% |
| Outpatient | \$16,199,952 | \$4,557,765 | \$934,686 | \$21,692,403 | \$17,872,995 | \$5,158,840 | \$1,092,585 | \$24,124,420 | 11.2% |
| Physician | \$18,580,909 | \$4,839,506 | \$1,247,696 | \$24,668,111 | \$19,786,438 | \$6,059,192 | \$1,281,804 | \$27,127,434 | 10.0% |
| Ancillary | \$525,908 | \$125,800 | \$464,385 | \$1,116,093 | \$673,006 | \$125,727 | \$52,740 | \$851,472 | -23.7% |
| Total | \$48,703,521 | \$11,675,603 | \$4,563,307 | \$64,942,432 | \$51,945,513 | \$15,210,047 | \$4,817,802 | \$71,973,362 | 10.8% |
| PMPM | \$277.97 | \$518.36 | \$454.72 | \$312.57 | \$300.67 | \$768.00 | \$501.53 | \$355.99 | 13.9% |

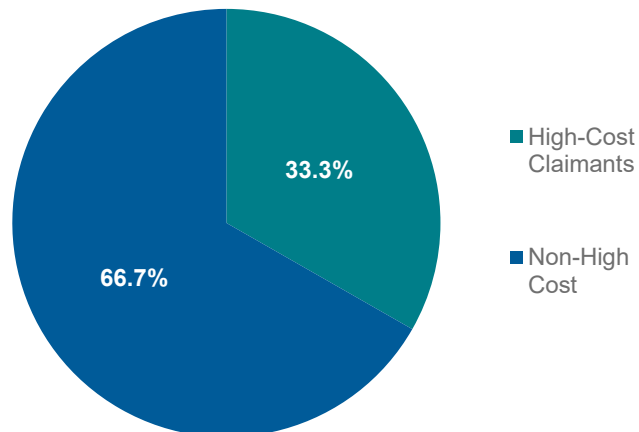
Medical Cost Distribution

Distribution by Member Cost

| Member Total Paid Range | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | |
|----------------------------------|--------------------------------|------------------|---------------------|-------------------|-------------------------|---------------|--------------------------------|------------------|---------------------|-------------------|-------------------------|---------------|
| | *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 | 6,732 | 24.9% | \$0 | 0.0% | \$0 | 0.0% | 6,285 | 24.1% | \$0 | 0.0% | \$0 | 0.0% |
| < \$0 - \$0 | 5,458 | 20.2% | -\$499,817 | -0.8% | \$2,038,368 | 9.2% | 5,303 | 20.4% | -\$659,378 | -0.9% | \$2,012,091 | 8.8% |
| > \$0 - \$2,500 | 11,465 | 42.5% | \$6,400,022 | 9.9% | \$8,846,053 | 39.9% | 10,868 | 41.7% | \$6,127,726 | 8.5% | \$8,717,582 | 38.0% |
| > \$2,500 - \$5,000 | 1,312 | 4.9% | \$4,638,005 | 7.1% | \$3,026,372 | 13.7% | 1,397 | 5.4% | \$4,949,409 | 6.9% | \$3,315,826 | 14.5% |
| > \$5,000 - \$10,000 | 885 | 3.3% | \$6,199,219 | 9.5% | \$2,905,508 | 13.1% | 948 | 3.6% | \$6,640,863 | 9.2% | \$3,000,344 | 13.1% |
| > \$10,000 - \$25,000 | 650 | 2.4% | \$10,056,752 | 15.5% | \$2,859,781 | 12.9% | 717 | 2.8% | \$11,279,827 | 15.7% | \$3,073,761 | 13.4% |
| > \$25,000 - \$50,000 | 250 | 0.9% | \$8,679,399 | 13.4% | \$1,198,045 | 5.4% | 278 | 1.1% | \$9,564,225 | 13.3% | \$1,387,223 | 6.1% |
| > \$50,000 - \$100,000 | 150 | 0.6% | \$10,445,299 | 16.1% | \$801,109 | 3.6% | 148 | 0.6% | \$10,131,317 | 14.1% | \$802,028 | 3.5% |
| > \$100,000 | 93 | 0.3% | \$19,023,552 | 29.3% | \$475,689 | 2.1% | 99 | 0.4% | \$23,939,374 | 33.3% | \$607,020 | 2.6% |
| Total | 26,995 | 100.0% | \$64,942,432 | 100.0% | \$22,150,925 | 100.0% | 26,043 | 100.0% | \$71,973,362 | 100.0% | \$22,915,876 | 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 | 45 | \$4,928,417 | 20.6% |
| 2 | Health Status & Health Services | 90 | \$4,666,348 | 19.5% |
| 3 | Circulatory System | 69 | \$2,424,575 | 10.1% |
| 4 | Musculoskeletal System | 66 | \$1,593,904 | 6.7% |
| 5 | Injury, Poisoning & External Causes | 52 | \$1,574,889 | 6.6% |
| 6 | Nervous System | 55 | \$1,259,499 | 5.3% |
| 7 | Perinatal Originating Conditions | 7 | \$1,206,625 | 5.0% |
| 8 | Respiratory System | 51 | \$1,176,849 | 4.9% |
| 9 | Digestive System | 44 | \$1,078,721 | 4.5% |
| 10 | Infectious & Parasitic Diseases | 31 | \$1,045,556 | 4.4% |
| ... | All Others | | \$2,983,993 | 12.5% |
| = | Total | 99 | \$23,939,374 | 100.0% |

Utilization Summary – YTD Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|------------------------------|------------|----------|----------|----------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Inpatient Admissions | | | | | | | |
| # of Admits | 788 | -11.0% | 701 | 6.0% | 743 | | |
| # of Admit Days | 5,784 | -39.9% | 3,477 | 7.6% | 3,742 | | |
| Paid per Admit | \$32,820 | -19.1% | \$26,561 | 3.2% | \$27,410 | \$28,343 | -3.3% |
| Paid per Admit Day | \$4,471 | 19.8% | \$5,355 | 1.6% | \$5,442 | \$5,770 | -5.7% |
| Admits per 1000 | 78.3 | -48.3% | 40.5 | 8.9% | 44.1 | 45.7 | -3.5% |
| Average LOS | 7.3 | -32.4% | 5.0 | 1.5% | 5.0 | 4.9 | 2.5% |
| Emergency Room Visits | | | | | | | |
| # of ER Visits | 3,511 | -2.6% | 3,418 | 13.0% | 3,863 | | |
| ~ % resulting in Admit | 14.2% | -1.6 pts | 12.6% | -0.1 pts | 12.5% | 10.5% | 2.0 pts |
| ER Visits per Patient | 1.4 | -0.2% | 1.4 | 6.5% | 1.5 | | |
| ER Visits per 1000 | 348.9 | -43.4% | 197.4 | 16.1% | 229.3 | 220.4 | 4.0% |
| Paid per ER Visit | \$2,218 | 6.9% | \$2,371 | 2.3% | \$2,425 | \$2,447 | -0.9% |
| Urgent Care Visits | | | | | | | |
| # of UC Visits | 5,681 | 1.3% | 5,756 | -10.7% | 5,138 | | |
| UC Visits per Patient | 1.4 | 1.0% | 1.5 | -2.5% | 1.4 | | - |
| UC Visits per 1000 | 564.6 | -41.1% | 332.4 | -8.3% | 305.0 | 249.2 | 22.4% |
| Paid per UC Visit | \$40 | 15.9% | \$46 | 7.1% | \$50 | \$121 | -58.9% |
| Office Visits | | | | | | | |
| Off Visits per Patient | 3.8 | 4.5% | 4.0 | 4.1% | 4.2 | | |
| Paid per Office Visit | \$41 | 8.2% | \$45 | 10.8% | \$49 | \$98 | -49.3% |
| Office Visits Paid PMPY | \$270 | -38.0% | \$167 | 15.4% | \$193 | \$379 | -49.1% |
| Services | | | | | | | |
| Radiology Svcs per 1000 | 6,589.8 | -41.3% | 3,868.2 | 9.1% | 4,218.3 | 3,555.6 | 18.6% |
| Radiology Paid PMPY | \$452 | -37.7% | \$282 | 12.3% | \$316 | | |
| Lab Services per 1000 | 17,122.9 | -40.9% | 10,118.9 | 9.3% | 11,059.5 | 9,761.3 | 13.3% |
| Labs Paid PMPY | \$286 | -35.1% | \$185 | 14.0% | \$211 | | |

- Inpatient Admission rate per 1000 increased 8.9%, and amount paid per Admission is 3.2% higher than prior period
- ER utilization increased significantly (+16.1%), and amount paid per ER visit is 2.3% 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 | | | | |
|------------------------------|--------------|----------|----------|----------|----------|------------------|---------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 589 | -9.2% | 535 | 5.0% | 562 | 0 | - | 0 | - | 2 |
| # of Admit Days | 4,352 | -39.1% | 2,651 | 0.6% | 2,667 | 0 | - | 0 | - | 10 |
| Paid per Admit | \$34,020 | -17.3% | \$28,146 | -7.0% | \$26,162 | \$0 | - | \$0 | - | \$21,737 |
| Paid per Admit Day | \$4,604 | 23.4% | \$5,680 | -2.9% | \$5,513 | \$0 | - | \$0 | - | \$4,347 |
| Admits per 1000 | 70.1 | -47.7% | 36.7 | 6.6% | 39.1 | 0.0 | - | 0.0 | - | 293.9 |
| Average LOS | 7.4 | -32.9% | 5.0 | -4.2% | 4.7 | 0.0 | - | 0.0 | - | 5.0 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 2,790 | 0.8% | 2,813 | 9.2% | 3,073 | 4 | -75.0% | 1 | 400.0% | 5 |
| ~ % resulting in Admit | 12.8% | -1.7 pts | 11.1% | -0.3 pts | 10.8% | 0.0% | 0.0 pts | 0.0% | 40.0 pts | 40.0% |
| ER Visits per Patient | 1.4 | 0.3% | 1.4 | 3.7% | 1.4 | 2.0 | -50.0% | 1.0 | 66.7% | 1.7 |
| ER Visits per 1000 | 332.0 | -42.0% | 192.7 | 10.8% | 213.5 | 1,500.0 | -84.9% | 226.4 | 224.5% | 734.7 |
| Paid per ER Visit | \$2,350 | 2.1% | \$2,399 | 5.3% | \$2,526 | \$5,162 | 254.0% | \$18,276 | -89.4% | \$1,938 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 4,968 | 1.8% | 5,058 | -10.7% | 4,516 | 2 | -50.0% | 1 | 200.0% | 3 |
| UC Visits per Patient | 1.4 | 1.5% | 1.5 | -3.8% | 1.4 | 1.0 | 0.0% | 1.0 | 50.0% | 1.5 |
| UC Visits per 1000 | 591.2 | -41.4% | 346.5 | -9.4% | 313.8 | 750.0 | -69.8% | 226.4 | 94.7% | 440.8 |
| Paid per UC Visit | \$40 | 14.2% | \$46 | 7.4% | \$49 | \$130 | -4.6% | \$124 | -39.2% | \$75 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 3.6 | 4.6% | 3.8 | 4.0% | 3.9 | 2.8 | -46.4% | 1.5 | 77.8% | 2.7 |
| Paid per Office Visit | \$42 | 7.2% | \$45 | 9.7% | \$49 | \$122 | -52.3% | \$58 | -9.1% | \$53 |
| Office Visits Paid PMPY | \$249 | -38.8% | \$153 | 14.1% | \$174 | \$639 | -87.7% | \$79 | 135.9% | \$186 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 5,740.3 | -41.4% | 3,361.8 | 13.3% | 3,807.2 | 7,500.0 | -84.9% | 1,132.1 | 107.7% | 2,351.0 |
| Radiology Paid PMPY | \$414 | -44.7% | \$229 | 7.7% | \$247 | \$4,510 | -71.3% | \$1,296 | -36.2% | \$827 |
| Lab Services per 1000 | 15,927.9 | -41.0% | 9,403.9 | 9.1% | 10,256.5 | 8,625.0 | -73.7% | 2,264.2 | 471.1% | 12,930.6 |
| Labs Paid PMPY | \$268 | -34.9% | \$174 | 11.6% | \$194 | \$408 | 2.1% | \$417 | 168.5% | \$1,119 |

Utilization Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|------------------------------|----------------|---------|----------|----------|----------|--------------------|----------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 159 | -19.5% | 128 | 8.6% | 139 | 40 | -5.0% | 38 | 5.3% | 40 |
| # of Admit Days | 1,175 | -46.2% | 632 | 37.5% | 869 | 257 | -24.5% | 194 | 1.0% | 196 |
| Paid per Admit | \$29,927 | -17.1% | \$24,824 | 47.9% | \$36,707 | \$26,650 | -62.1% | \$10,095 | 27.9% | \$12,914 |
| Paid per Admit Day | \$4,050 | 24.1% | \$5,028 | 16.8% | \$5,871 | \$4,148 | -52.3% | \$1,977 | 33.3% | \$2,636 |
| Admits per 1000 | 105.7 | -50.9% | 51.9 | 20.2% | 62.4 | 263.4 | -42.0% | 152.9 | 17.0% | 178.8 |
| Average LOS | 7.4 | -33.2% | 4.9 | 26.6% | 6.3 | 6.4 | -20.5% | 5.1 | -4.0% | 4.9 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 586 | -15.7% | 494 | 22.5% | 605 | 131 | -16.0% | 110 | 63.6% | 180 |
| ~ % resulting in Admit | 17.9% | 1.7 pts | 19.6% | -0.3 pts | 19.3% | 28.2% | -9.2 pts | 19.1% | -1.3 pts | 17.8% |
| ER Visits per Patient | 1.4 | 1.0% | 1.4 | 10.8% | 1.6 | 2.0 | -7.6% | 1.8 | 48.8% | 2.7 |
| ER Visits per 1000 | 389.5 | -48.5% | 200.4 | 35.5% | 271.6 | 862.8 | -48.7% | 442.5 | 81.9% | 804.8 |
| Paid per ER Visit | \$1,918 | 32.3% | \$2,537 | -4.6% | \$2,420 | \$647 | 16.6% | \$755 | -3.5% | \$728 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 641 | -1.6% | 631 | -17.1% | 523 | 70 | -5.7% | 66 | 45.5% | 96 |
| UC Visits per Patient | 1.4 | -1.1% | 1.4 | -0.3% | 1.4 | 1.6 | -13.7% | 1.4 | 70.9% | 2.4 |
| UC Visits per 1000 | 426.1 | -39.9% | 256.0 | -8.3% | 234.8 | 461.0 | -42.4% | 265.5 | 61.7% | 429.2 |
| Paid per UC Visit | \$39 | 28.1% | \$50 | 6.3% | \$53 | \$27 | 41.7% | \$38 | 9.1% | \$41 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 4.5 | 5.2% | 4.8 | 4.3% | 5.0 | 7.2 | 4.8% | 7.5 | 10.0% | 8.3 |
| Paid per Office Visit | \$43 | 10.0% | \$47 | 16.0% | \$54 | \$23 | 27.4% | \$30 | 5.9% | \$31 |
| Office Visits Paid PMPY | \$373 | -34.5% | \$244 | 24.0% | \$303 | \$374 | -27.8% | \$270 | 18.2% | \$319 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 9,833.5 | -37.3% | 6,165.0 | -0.5% | 6,131.8 | 21,451.2 | -49.3% | 10,877.6 | 7.3% | 11,669.2 |
| Radiology Paid PMPY | \$656 | -10.4% | \$588 | 30.6% | \$768 | \$439 | -30.6% | \$304 | -10.4% | \$273 |
| Lab Services per 1000 | 21,082.8 | -37.2% | 13,242.6 | 7.0% | 14,165.9 | 44,180.0 | -51.9% | 21,268.5 | 49.2% | 31,734.7 |
| Labs Paid PMPY | \$386 | -35.4% | \$249 | 23.9% | \$309 | \$294 | -32.4% | \$199 | 53.0% | \$304 |

On Demand Care Summary

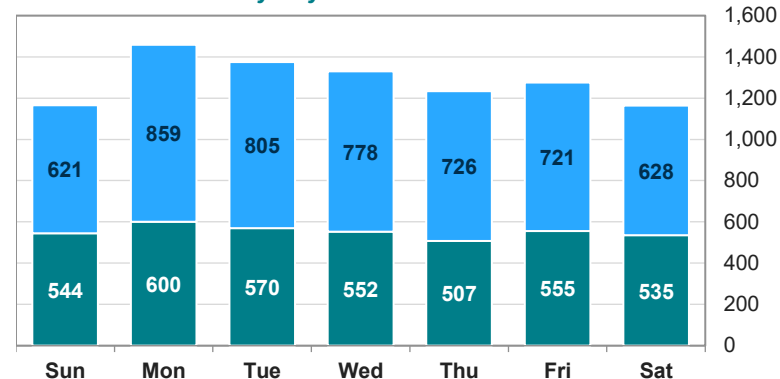
Emergency Room & Urgent Care

| Measure | 2025-3Q | 2026-3Q | Change | UMR Norm | Variance |
|--------------------------------|-------------|-------------|----------|----------|-----------|
| Emergency Room | | | | | |
| # of Visits | 3,418 | 3,863 | 13.0% | | |
| # of Patients | 2,445 | 2,595 | 6.1% | | |
| Total Plan Paid | \$8,102,841 | \$9,366,532 | 15.6% | | |
| Total Mem Paid | \$4,087,701 | \$4,272,186 | 4.5% | | |
| Visits per 1000 | 197.4 | 229.3 | 16.1% | 220.4 | 4.0% |
| Paid per Visit | \$2,371 | \$2,425 | 2.3% | \$2,447 | -0.9% |
| Paid PMPM | \$39 | \$46 | 18.8% | \$45 | 3.1% |
| % ER Patients w/ Office Visit* | 90.2% | 90.3% | 0.0 pts | | |
| % Potentially Avoidable** | 17.1% | 15.9% | -1.2 pts | 82.2% | -66.3 pts |
| Urgent Care | | | | | |
| # of Visits | 5,756 | 5,138 | -10.7% | | |
| # of Patients | 3,945 | 3,612 | -8.4% | | |
| Total Plan Paid | \$266,325 | \$254,499 | -4.4% | | |
| Total Mem Paid | \$777,007 | \$693,019 | -10.8% | | |
| Visits per 1000 | 332.4 | 305.0 | -8.3% | 249.2 | 22.4% |
| Paid per Visit | \$46 | \$50 | 7.1% | \$121 | -58.9% |
| Paid PMPM | \$1 | \$1 | -1.8% | \$3 | -49.8% |

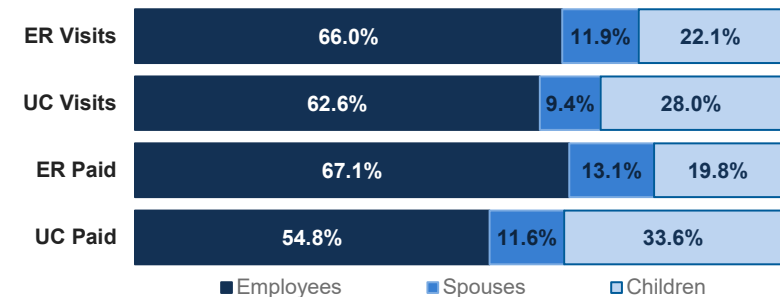
* Office Visit within prior 12 months..

** 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.

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



| | # of Visits | | | Total Paid | | |
|----------|-------------|-------|-------|-------------|-----------|-------------|
| | ER | UC | Total | ER | UC | Total |
| Employee | 2,551 | 3,215 | 5,766 | \$6,289,105 | \$139,491 | \$6,428,596 |
| Spouse | 458 | 483 | 941 | \$1,226,986 | \$29,433 | \$1,256,420 |
| Child | 854 | 1,440 | 2,294 | \$1,850,440 | \$85,574 | \$1,936,014 |
| Total | 3,863 | 5,138 | 9,001 | \$9,366,532 | \$254,499 | \$9,621,030 |

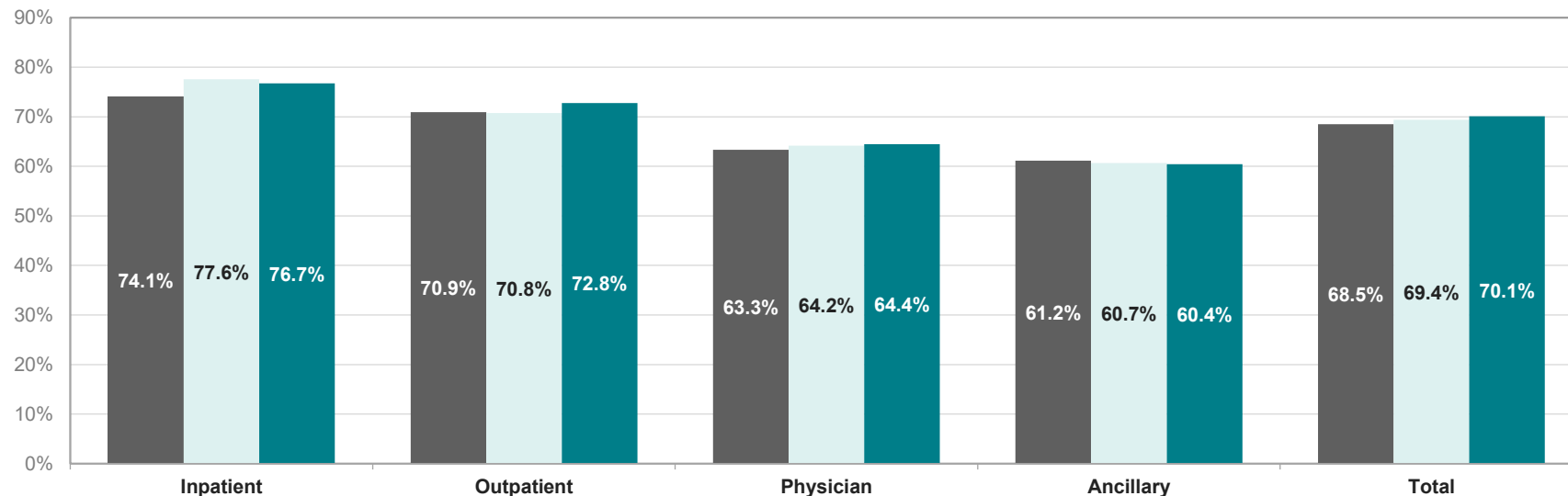


Network Summary

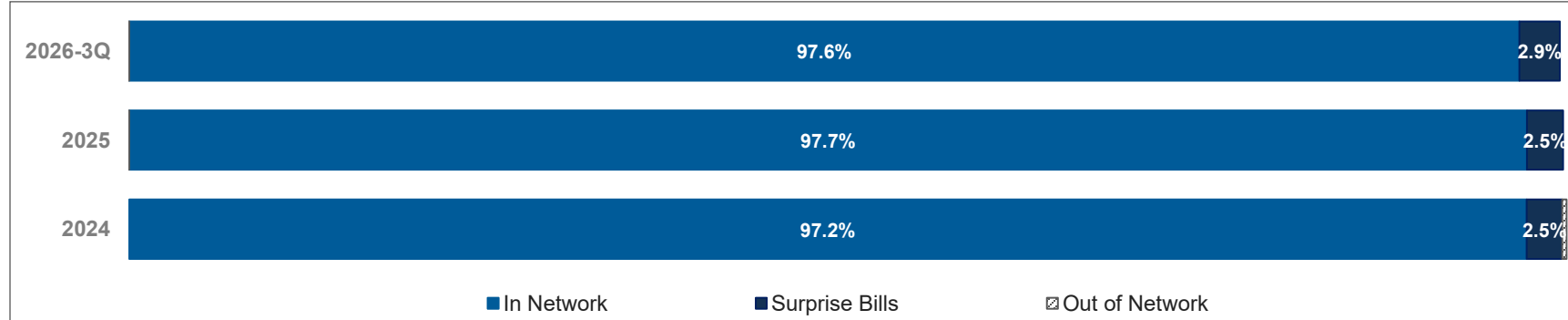
Discount Percentage & Network Utilization

Discount Percentage* by Claim Type

Plan Year: ■ 2024 ■ 2025 ■ 2026-3Q



Network Utilization*



* Network Discounts and Utilization exclude COB Claims, and Network Discounts additionally exclude Surprise Bills.

Clinical Classification Summary

Breakout by Diagnostic Chapter

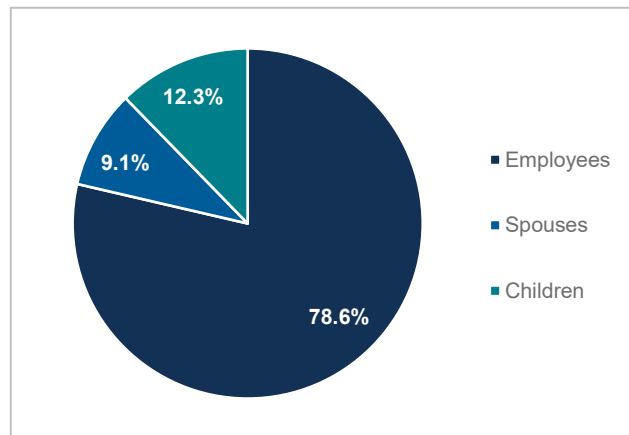
| Diagnostic Chapter | 2025 (Full Year) | | 2026-3Q | | CYTD Paid by Relationship | | | CYTD Paid by Sex | |
|--|------------------|---------------------|---------------|---------------------|---------------------------|---------------------|---------------------|---------------------|---------------------|
| | Patients | Total Paid | Patients | Total Paid | Employee | Spouse | Child | Male | Female |
| Health Status & Health Services | 13,867 | \$12,290,366 | 11,433 | \$10,409,540 | \$8,184,918 | \$945,076 | \$1,279,547 | \$4,409,429 | \$6,000,111 |
| Neoplasms | 3,177 | \$8,496,372 | 2,441 | \$8,561,675 | \$6,547,427 | \$1,842,228 | \$172,020 | \$4,864,324 | \$3,697,351 |
| Musculoskeletal System | 6,235 | \$9,614,034 | 5,108 | \$7,657,432 | \$5,742,281 | \$1,421,868 | \$493,284 | \$4,268,397 | \$3,389,035 |
| Circulatory System | 4,249 | \$9,533,462 | 3,408 | \$7,084,246 | \$5,790,273 | \$989,297 | \$304,676 | \$4,352,167 | \$2,732,079 |
| Injury, Poisoning & External Causes | 2,881 | \$7,432,651 | 2,369 | \$5,236,952 | \$2,714,162 | \$985,602 | \$1,537,188 | \$2,985,349 | \$2,251,603 |
| Symptoms, Signs & Findings, NEC | 8,856 | \$5,378,622 | 7,127 | \$4,391,694 | \$3,152,668 | \$531,998 | \$707,027 | \$2,040,879 | \$2,350,814 |
| Digestive System | 2,875 | \$5,633,027 | 2,238 | \$4,382,656 | \$2,858,118 | \$734,054 | \$790,484 | \$2,032,541 | \$2,350,115 |
| Nervous System | 3,005 | \$3,876,394 | 2,600 | \$3,602,365 | \$2,381,888 | \$523,087 | \$697,389 | \$1,577,747 | \$2,024,618 |
| Respiratory System | 5,262 | \$3,232,126 | 3,903 | \$3,057,125 | \$2,289,594 | \$228,568 | \$538,963 | \$1,322,368 | \$1,734,757 |
| Mental, Behavioral & Neurodevelopmental | 3,387 | \$3,746,998 | 3,000 | \$2,957,796 | \$1,271,276 | \$419,475 | \$1,267,046 | \$1,319,471 | \$1,638,325 |
| Genitourinary System | 4,241 | \$4,467,616 | 3,450 | \$2,938,618 | \$2,190,593 | \$510,256 | \$237,770 | \$1,087,272 | \$1,851,346 |
| Endocrine, Nutritional & Metabolic | 6,461 | \$3,685,436 | 5,453 | \$2,458,695 | \$2,075,706 | \$237,743 | \$145,246 | \$1,319,382 | \$1,139,313 |
| Pregnancy, Childbirth & the Puerperium | 410 | \$2,314,674 | 351 | \$2,052,959 | \$1,509,054 | \$398,395 | \$145,509 | \$5,478 | \$2,047,481 |
| Infectious & Parasitic Diseases | 1,624 | \$2,894,059 | 1,145 | \$2,048,440 | \$1,586,422 | \$296,339 | \$165,678 | \$1,618,832 | \$429,607 |
| Perinatal Originating Conditions | 190 | \$2,082,861 | 157 | \$1,943,927 | \$157 | \$0 | \$1,943,770 | \$1,571,301 | \$371,219 |
| Skin & Subcutaneous Tissue | 4,810 | \$1,242,481 | 3,843 | \$817,020 | \$626,942 | \$129,180 | \$60,898 | \$443,354 | \$373,666 |
| Eye and Adnexa | 4,098 | \$895,465 | 2,939 | \$810,672 | \$569,147 | \$194,817 | \$46,708 | \$355,261 | \$455,411 |
| Blood & Immune Disorders | 967 | \$752,337 | 849 | \$638,216 | \$538,230 | \$54,509 | \$45,477 | \$294,351 | \$343,865 |
| Ear and Mastoid Process | 1,596 | \$513,866 | 1,141 | \$562,858 | \$190,307 | \$169,877 | \$202,674 | \$115,922 | \$446,936 |
| Congenital Malformations & Abnormalities | 271 | \$541,322 | 236 | \$360,474 | \$99,733 | \$11,259 | \$249,481 | \$244,940 | \$115,534 |
| External Causes of Morbidity | 0 | \$0 | 10 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Total | 21,073 | \$88,624,170 | 18,940 | \$71,973,362 | \$50,318,897 | \$10,623,628 | \$11,030,837 | \$36,228,767 | \$35,743,187 |

Health Status & Health Services

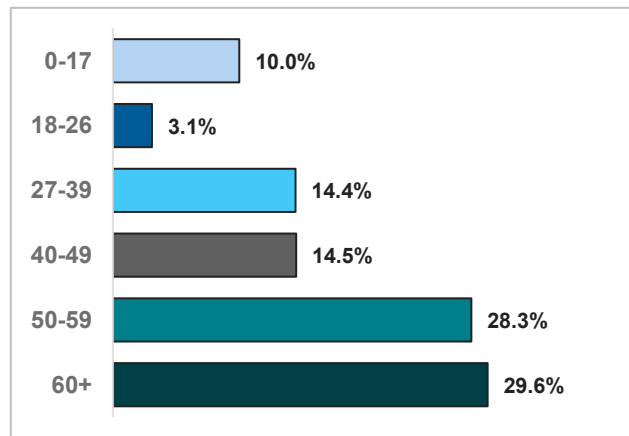
Breakout by Diagnostic Grouping & Demographics

| # | Health Status & Services Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--|---------------|---------------|---------------------|---------------|
| 1 | Encounter for antineoplastic therapies | 67 | 629 | \$4,822,071 | 46.3% |
| 2 | Neoplasm-related encounters | 3,225 | 5,694 | \$1,781,805 | 17.1% |
| 3 | Medical examination/evaluation | 7,644 | 12,491 | \$1,453,246 | 14.0% |
| 4 | Exposure, enc, screen or contact w infectious dz | 3,499 | 4,816 | \$847,744 | 8.1% |
| 5 | Contraceptive & procreative management | 476 | 749 | \$397,842 | 3.8% |
| 6 | Other aftercare encounter | 451 | 1,020 | \$298,530 | 2.9% |
| 7 | Implant, device or graft related encounter | 383 | 1,114 | \$143,241 | 1.4% |
| 8 | Encount for obs & exam for conds ruled out | 1,448 | 1,878 | \$123,548 | 1.2% |
| 9 | Other specified status | 585 | 1,200 | \$114,502 | 1.1% |
| 10 | Family history of disease | 111 | 160 | \$82,098 | 0.8% |
| 11 | Acquired absence of limb or organ | 48 | 72 | \$71,277 | 0.7% |
| 12 | Organ transplant status | 34 | 270 | \$52,354 | 0.5% |
| 13 | Enc for prophylactic measures (ex immuniz) | 79 | 178 | \$49,451 | 0.5% |
| 14 | Personal history of other disease | 242 | 330 | \$39,947 | 0.4% |
| 15 | Genetic susceptibility to disease | 14 | 37 | \$26,168 | 0.3% |
| 16 | Other specified encounters & counseling | 174 | 350 | \$24,429 | 0.2% |
| 17 | Personal history of malignant neoplasm | 101 | 128 | \$22,007 | 0.2% |
| 18 | Encounter for administrative purposes | 36 | 49 | \$15,265 | 0.1% |
| 19 | Encounter for prophylactic or oth procedures | 36 | 43 | \$14,769 | 0.1% |
| 20 | Lifestyle/life management factors | 47 | 81 | \$9,756 | 0.1% |
| ... | All Others | 1,359 | 1,692 | \$19,494 | 0.2% |
| = | Total | 11,433 | 34,606 | \$10,409,540 | 100.0% |

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range

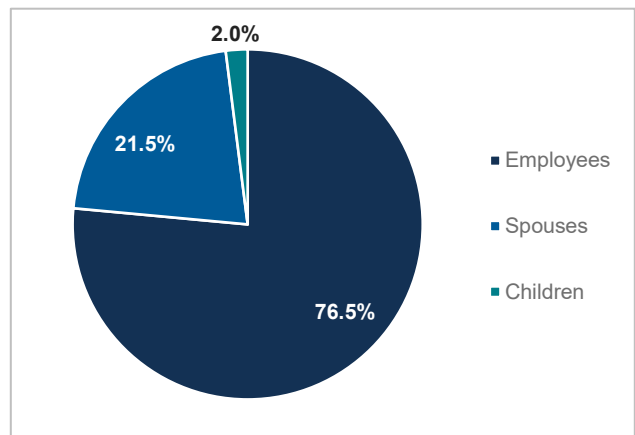


Neoplasms (Cancer)

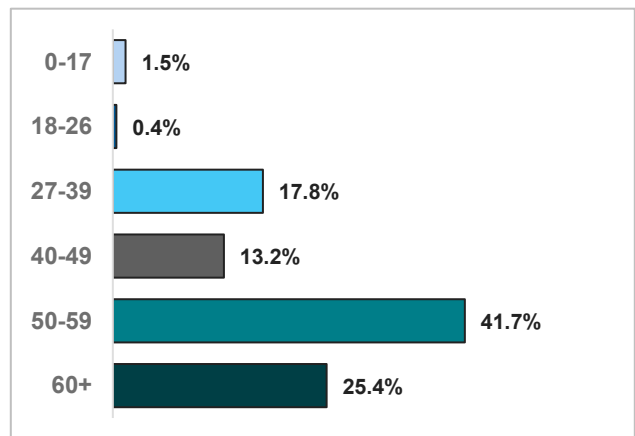
Breakout by Diagnostic Grouping & Demographics

| # | Neoplasms (Cancer) Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--------------------------------|--------------|---------------|--------------------|---------------|
| 1 | Benign neoplasms | 1,471 | 2,373 | \$1,199,800 | 14.0% |
| 2 | Breast cancer | 153 | 1,562 | \$1,174,478 | 13.7% |
| 3 | Leukemia | 36 | 430 | \$1,154,103 | 13.5% |
| 4 | Prostate cancer | 101 | 888 | \$1,108,239 | 12.9% |
| 5 | Secondary malignancies | 51 | 300 | \$679,943 | 7.9% |
| 6 | Lymphoma | 36 | 368 | \$493,309 | 5.8% |
| 7 | Colorectal cancer | 40 | 635 | \$412,359 | 4.8% |
| 8 | Ovarian cancer | 15 | 164 | \$405,132 | 4.7% |
| 9 | Other cancer | 49 | 283 | \$328,664 | 3.8% |
| 10 | Multiple myeloma | 8 | 288 | \$233,609 | 2.7% |
| 11 | Pancreatic cancer | 10 | 306 | \$200,333 | 2.3% |
| 12 | Thyroid cancer | 44 | 245 | \$191,559 | 2.2% |
| 13 | Head & neck cancers | 17 | 181 | \$184,540 | 2.2% |
| 14 | Other gastrointestinal cancers | 19 | 163 | \$154,428 | 1.8% |
| 15 | Neoplasms of unspec nature | 908 | 1,418 | \$132,282 | 1.5% |
| 16 | Skin cancer | 239 | 697 | \$118,249 | 1.4% |
| 17 | Respiratory cancers | 14 | 126 | \$90,017 | 1.1% |
| 18 | Female reproductive | 13 | 181 | \$67,355 | 0.8% |
| 19 | Brain cancer | 6 | 15 | \$62,038 | 0.7% |
| 20 | Other urinary system cancer | 15 | 65 | \$52,245 | 0.6% |
| ... | All Others | 53 | 357 | \$118,996 | 1.4% |
| = | Total | 2,441 | 12,214 | \$8,561,675 | 100.0% |

Neoplasms (Cancer) Paid by Relationship



Neoplasms (Cancer) Paid by Age Range



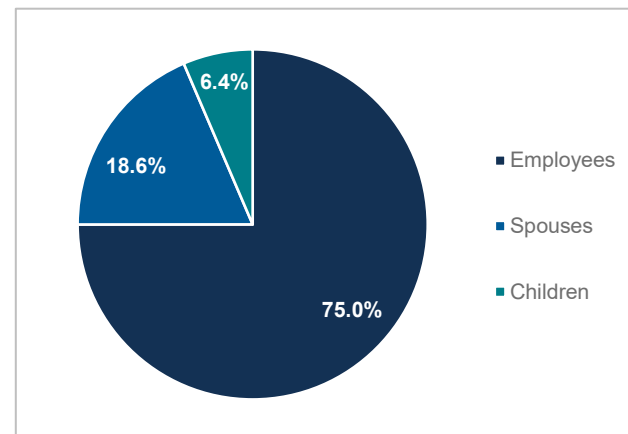
Note: there are additional cancer-related costs for encounters and therapy, totaling \$6,603,876 – see Health Status for more details

Musculoskeletal System

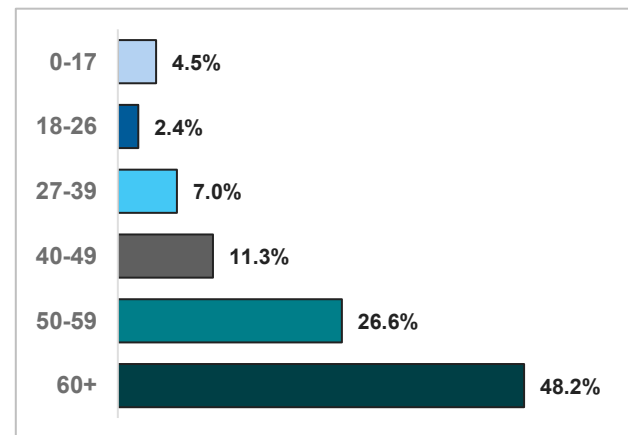
Breakout by Diagnostic Grouping & Demographics

| # | Musculoskeletal Dx Grouping | Patients | Claims | Total Paid | % Paid |
|----|--|--------------|---------------|--------------------|---------------|
| 1 | Spondylopathies & arthropathy | 1,430 | 6,513 | \$2,235,022 | 29.2% |
| 2 | Osteoarthritis & osteoporosis | 917 | 2,821 | \$1,648,214 | 21.5% |
| 3 | Tendon, tissue, muscle disorders | 1,144 | 3,278 | \$904,870 | 11.8% |
| 4 | Joint disorders & fractures | 352 | 822 | \$747,668 | 9.8% |
| 5 | Other musculoskeletal pain | 2,745 | 10,296 | \$744,166 | 9.7% |
| 6 | Scoliosis & oth deformities | 460 | 932 | \$469,326 | 6.1% |
| 7 | Other MSK | 96 | 477 | \$294,679 | 3.8% |
| 8 | Lupus | 107 | 374 | \$197,479 | 2.6% |
| 9 | Low back pain | 654 | 2,216 | \$191,487 | 2.5% |
| 10 | Rheumatoid arthritis & related disease | 135 | 553 | \$186,060 | 2.4% |
| 11 | Biomechanical lesions | 395 | 1,690 | \$25,552 | 0.3% |
| 12 | Gout & crystal arthropathies | 114 | 258 | \$12,908 | 0.2% |
| = | Total | 5,108 | 33,022 | \$7,657,432 | 100.0% |

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

| Mental & Behavioral
Diagnostic Grouping | 2024 (Full Year) | | 2025 (Full Year) | | 2026-3Q | | 2026-3Q Paid by Claim Type | | | |
|--|------------------|--------------------|------------------|--------------------|--------------|--------------------|----------------------------|------------------|--------------------|----------------|
| | Patients | Total Paid | Patients | Total Paid | Patients | Total Paid | Inpatient | Outpatient | Physician | Ancillary |
| Neurodevelopmental disorders | 502 | \$1,242,281 | 532 | \$1,247,192 | 508 | \$742,418 | \$0 | \$0 | \$741,367 | \$1,051 |
| Alcohol-related disorders | 124 | \$806,533 | 137 | \$565,545 | 81 | \$592,562 | \$332,933 | \$103,858 | \$148,663 | \$7,108 |
| Depressive disorders | 1,005 | \$728,698 | 972 | \$640,203 | 820 | \$559,125 | \$156,007 | \$8,880 | \$394,238 | \$0 |
| Anxiety & related Disorders | 1,199 | \$362,534 | 1,284 | \$382,098 | 1,108 | \$316,321 | \$41,293 | \$30,661 | \$244,368 | \$0 |
| Trauma & stressor disorders | 760 | \$288,426 | 836 | \$376,394 | 757 | \$253,663 | \$0 | \$22,015 | \$231,602 | \$46 |
| Other mental health | 258 | \$121,588 | 311 | \$82,352 | 234 | \$106,950 | \$0 | \$45,715 | \$61,045 | \$190 |
| Suicidal ideation, attempt or self-harm | 51 | \$205,797 | 44 | \$79,221 | 33 | \$100,879 | \$2,094 | \$89,902 | \$8,883 | \$0 |
| Bipolar & related Disorders | 172 | \$99,260 | 174 | \$152,956 | 134 | \$87,764 | \$57,208 | \$3,029 | \$27,527 | \$0 |
| Schizophrenia spectrum disorders | 48 | \$121,142 | 41 | \$59,034 | 37 | \$66,277 | \$18,778 | \$34,201 | \$13,298 | \$0 |
| Eating disorders | 30 | \$83,704 | 23 | \$16,533 | 16 | \$52,693 | \$0 | \$0 | \$52,693 | \$0 |
| Obsessive compulsive disorders | 54 | \$72,146 | 57 | \$70,219 | 40 | \$23,091 | \$0 | \$0 | \$23,091 | \$0 |
| Cannabis-related disorders | 24 | \$15,571 | 28 | \$13,141 | 20 | \$22,761 | \$0 | \$16,161 | \$6,600 | \$0 |
| Opiod disorders | 35 | \$37,710 | 37 | \$36,077 | 27 | \$18,150 | \$7,125 | \$2,129 | \$8,895 | \$0 |
| Other substance use | 106 | \$12,377 | 114 | \$19,144 | 101 | \$14,068 | \$0 | \$4,866 | \$9,203 | \$0 |
| Stimulant disorders | 7 | \$21,155 | 12 | \$6,892 | 7 | \$1,074 | \$0 | \$0 | \$1,074 | \$0 |
| Total | 3,269 | \$4,218,922 | 3,387 | \$3,746,998 | 3,000 | \$2,957,796 | \$615,439 | \$361,417 | \$1,972,546 | \$8,395 |

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 | 52 | 2.3 | 4.0% | 36 | 1.6 | 12.5% | \$7,954 | 76.9 | 269.2 |
| Asthma | 570 | 24.9 | -7.9% | 219 | 9.6 | -11.3% | \$6,857 | 57.9 | 473.7 |
| Atrial Fibrillation | 239 | 10.5 | 8.6% | 164 | 7.2 | 4.5% | \$40,606 | 330.5 | 665.3 |
| Blood Disorders | 991 | 43.4 | 10.7% | 443 | 19.4 | 11.6% | \$21,707 | 193.7 | 515.6 |
| CAD | 382 | 16.7 | -2.3% | 201 | 8.8 | -4.7% | \$19,766 | 172.8 | 366.5 |
| COPD | 86 | 3.8 | -28.9% | 53 | 2.3 | -26.4% | \$29,193 | 418.6 | 837.2 |
| Cancer | 1,699 | 74.3 | -5.6% | 880 | 38.5 | -4.1% | \$18,884 | 95.4 | 219.0 |
| Chronic Pain | 120 | 5.3 | -11.1% | 53 | 2.3 | -22.1% | \$37,494 | 466.7 | 833.3 |
| CHF | 95 | 4.2 | 4.4% | 56 | 2.5 | 12.0% | \$34,768 | 494.7 | 884.2 |
| Demyelinating Diseases | 60 | 2.6 | -3.2% | 43 | 1.9 | 16.2% | \$21,665 | 133.3 | 700.0 |
| Depression | 940 | 41.1 | 1.4% | 642 | 28.1 | 4.2% | \$11,234 | 157.4 | 362.8 |
| Diabetes | 1,501 | 65.7 | 0.0% | 1,020 | 44.6 | -0.3% | \$11,876 | 92.6 | 267.2 |
| ESRD | 115 | 5.0 | -4.2% | 79 | 3.5 | -9.2% | \$57,972 | 1,173.9 | 2,382.6 |
| Eating Disorders | 21 | 0.9 | -8.7% | 12 | 0.5 | -25.0% | \$18,685 | 190.5 | 190.5 |
| HIV/AIDS | 41 | 1.8 | 10.8% | 33 | 1.4 | 10.0% | \$7,136 | 170.7 | 439.0 |
| Hyperlipidemia | 950 | 41.6 | 17.1% | 306 | 13.4 | 9.3% | \$3,979 | 23.2 | 82.1 |
| Hypertension | 2,325 | 101.7 | -4.8% | 1,124 | 49.2 | -4.7% | \$8,698 | 94.2 | 272.7 |
| Immune Disorders | 46 | 2.0 | 0.0% | 22 | 1.0 | -8.3% | \$27,000 | 217.4 | 587.0 |
| IBD | 68 | 3.0 | 36.0% | 19 | 0.8 | 58.3% | \$5,611 | 29.4 | 176.5 |
| Liver Disease | 11 | 0.5 | 83.3% | 8 | 0.4 | 33.3% | \$113,251 | 1,636.4 | 2,363.6 |
| Morbid Obesity | 248 | 10.9 | -5.0% | 113 | 4.9 | -7.4% | \$9,650 | 76.6 | 201.6 |
| Osteoarthritis | 914 | 40.0 | 4.2% | 408 | 17.9 | 6.8% | \$13,865 | 62.4 | 240.7 |
| Peripheral Vascular Disease | 111 | 4.9 | -14.6% | 38 | 1.7 | 15.2% | \$17,559 | 153.2 | 333.3 |
| Rheumatoid Arthritis | 138 | 6.0 | 6.2% | 98 | 4.3 | 5.4% | \$36,817 | 87.0 | 347.8 |

- Most prevalent chronic condition is Hypertension, with 2,325 members
- Hypertension is also the condition with the most moderate/high risk members (1,124)
- Members with mod/high risk Cancer have the highest combined cost: 880 members totaling \$16.6M

Date Range: Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

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:** \$5,817
- **Admits per 1000:** 42.7
- **ER Visits per 1000:** 210.5

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

| Preventive Service | Population | 2024 | | | 2025 | | | Rate Change | UMR Norm | |
|----------------------|--|----------|--------|---------|----------|--------|---------|-------------|----------|----------|
| | | Eligible | Actual | Rate | Eligible | Actual | Rate | | Rate | 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 | 142.1 | 828 | 5,825.8 | 139.4 | 717 | 5,145.3 | -11.7% | 5,373.2 | -4.2% |
| Well Child Visit | 3 - 6 years | 743.6 | 558 | 750.4 | 710.5 | 516 | 726.2 | -3.2% | 806.3 | -9.9% |
| Adults w/ Well Visit | Adults 18+ | 19,513 | 7,172 | 36.8% | 18,950 | 6,942 | 36.6% | -0.1 pts | 44.9% | -8.2 pts |
| Screenings | Rate for all screenings is the percentage of eligible population who had the screening during the period. | | | | | | | | | |
| Mammogram | Females 40 - 69 | 6,030 | 2,641 | 43.8% | 5,674 | 2,551 | 45.0% | 1.2 pts | 51.6% | -6.7 pts |
| Cervical Cancer | Females 21 - 64 | 8,716 | 2,109 | 24.2% | 8,357 | 1,981 | 23.7% | -0.5 pts | 24.8% | -1.1 pts |
| Prostate Cancer | Males 50 - 70 | 3,741 | 1,573 | 42.0% | 3,527 | 1,448 | 41.1% | -1.0 pts | 46.7% | -5.7 pts |
| Colorectal Cancer | Members 45 - 75 | 10,049 | 1,586 | 15.8% | 9,503 | 1,561 | 16.4% | 0.6 pts | 17.7% | -1.3 pts |
| Cholesterol | Female 45+ Male 35+ | 12,134 | 5,865 | 48.3% | 11,650 | 5,788 | 49.7% | 1.3 pts | 51.2% | -1.5 pts |
| Condition-specific | Screening | | | | | | | | | |
| Asthma | Office Visit for Asthma | 619 | 498 | 80.5% | 570 | 452 | 79.3% | -1.2 pts | | |
| COPD | Spirometry Test | 121 | 23 | 19.0% | 86 | 17 | 19.8% | 0.8 pts | | |
| Type 2 Diabetes | A1c Test | 1,426 | 1,221 | 85.6% | 1,421 | 1,230 | 86.6% | 0.9 pts | 84.5% | 2.1 pts |
| | Eye Exam | - | - | - | 0 | 0 | 0 | - | 0 | 0 |
| | Lipid Panel | 1,426 | 1,090 | 76.4% | 1,421 | 1,101 | 77.5% | 1.0 pts | 72.9% | 4.6 pts |
| | Urine Protein Test | 1,426 | 895 | 62.8% | 1,421 | 932 | 65.6% | 2.8 pts | 66.2% | -0.7 pts |
| | Any Diabetes Screen | 1,426 | 1,263 | 88.6% | 1,421 | 1,280 | 90.1% | 1.5 pts | 88.4% | 1.6 pts |
| Hyperlipidemia | Lipid Profile | 811 | 404 | 49.8% | 950 | 448 | 47.2% | -2.7 pts | | |
| Hypertension | Creatinine Test | 2,441 | 475 | 19.5% | 2,325 | 447 | 19.2% | -0.2 pts | | |
| | Lipid Profile | 2,441 | 575 | 23.6% | 2,325 | 585 | 25.2% | 1.6 pts | | |

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.



14.8

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

14.7 Q3 CDHP Performance Report

14.8 Q3 LD PPO Performance Report



PEBP

Public Employees' Benefits Program

Quarterly Plan Performance Review

Low Ded Plan • 2026-3Q



A UnitedHealthcare Company

Report Criteria & Contents

Experience Periods*

➤ 2026 Plan Year (Current)

2026-3Q. 1st three Quarters: Claims Paid 7/1/2025 - 3/31/2026

➤ 2025 Plan Year

2025-3Q. 1st three Quarters: Claims Paid 7/1/2024 - 3/31/2025

2025 Full Year: Claims paid 7/1/2024 - 6/30/2025

➤ 2024 Plan Year

2024-3Q. 1st three Quarters: Claims Paid 7/1/2023 - 3/31/2024

2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

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 InfoPortSM
- Composition: 5,293 groups with approximately 8.8 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 3/31/2026

* Additional date ranges for specific figures are defined on the page if applicable

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| Chronic Conditions | 24 |
| Prevention, Wellness, & Maintenance | 25 |



Executive Summary



Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: +10.9%
- High-Cost Claimants Paid PMPM trend: +17.1%; Non HCCs trend: +9.5%
- Top Paid Diagnostic Chapters: Health Status & Services (+3.1% Paid PMPM), Musculoskeletal (+18.4%), Neoplasms (Cancer) (+3.9%)



Membership & Demographics

- Total membership is 10.0% higher than prior period
- Employees increased 10.5%, while Dependents were up 9.5%
- 78.6% of members had < \$2,500 medical paid, with 17.1% having no claims paid at all during the reporting period



Utilization Key Indicators

- Paid per IP Admit was \$27,304, which is 10.5% lower than 2025-3Q
- Paid per ER Visit was \$3,324, which is 5.6% higher than 2025-3Q



Network Utilization & Savings

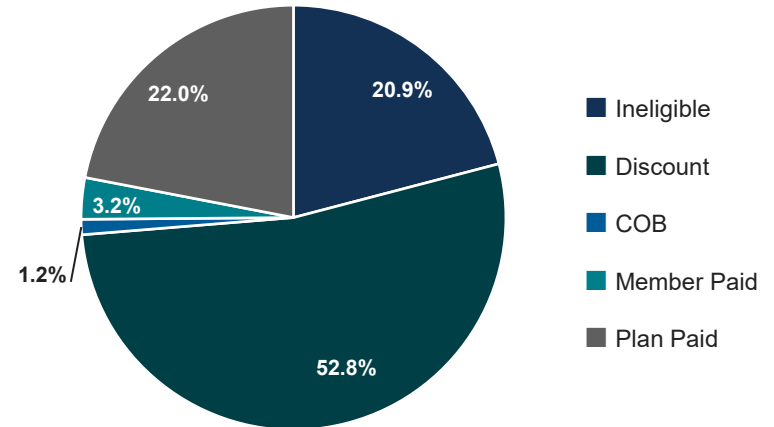
- 98.2% of all Medical spend dollars were to In Network providers
- The average In Network discount was 67.9%, which is 0.8 pts above the 2025 average discount of 67.1%

Medical Total Savings Summary

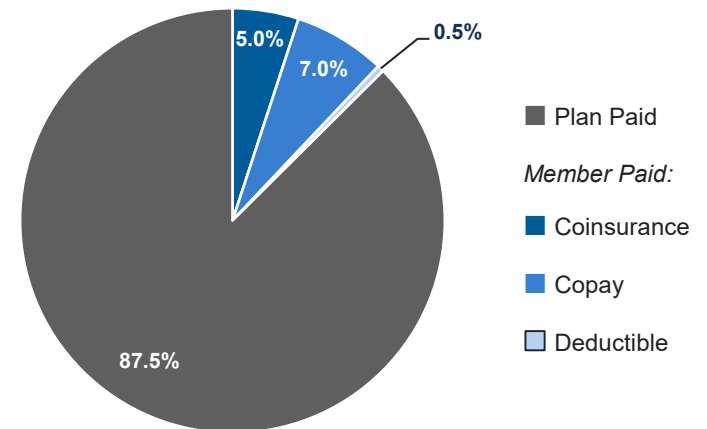
Dollar Chain: Billed to Paid Dollars

| Dollar Amount | 2026-3Q
Total Dollars | 2026-3Q
PMPM* | 2025
PMPM* | Trend |
|-------------------|--------------------------|------------------|---------------|-------|
| Medical Billed | \$474,215,629 | \$2,059 | \$1,796 | 14.6% |
| (-) Ineligible | \$99,134,522 | \$430 | \$344 | 25.1% |
| Medical Covered | \$375,081,107 | \$1,628 | \$1,452 | 12.2% |
| (-) Discount | \$250,098,847 | \$1,086 | \$958 | 13.3% |
| Medical Allowed | \$124,982,259 | \$543 | \$494 | 9.9% |
| (-) COB | \$5,512,981 | \$24 | \$20 | 17.4% |
| (-) Coinsurance | \$5,998,429 | \$26 | \$24 | 10.0% |
| (-) Copay | \$8,341,574 | \$36 | \$33 | 10.4% |
| (-) Deductible | \$598,810 | \$3 | \$2 | 4.1% |
| Total Member Paid | \$14,938,813 | \$65 | \$59 | 10.0% |
| Total Plan Paid | \$104,110,928 | \$452 | \$414 | 9.2% |

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 | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | | 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 | \$4,734,658 | \$2,218 | \$24,955 | \$12 | \$4,759,613 | \$2,230 | \$5,856,462 | \$2,437 | \$31,843 | \$13 | \$5,888,305 | \$2,450 | 23.7% | 9.9% |
| 1 | \$685,151 | \$304 | \$12,177 | \$5 | \$697,328 | \$309 | \$611,016 | \$247 | \$37,205 | \$15 | \$648,221 | \$262 | -7.0% | -15.3% |
| 2 - 4 | \$1,472,906 | \$196 | \$77,102 | \$10 | \$1,550,008 | \$206 | \$1,825,031 | \$233 | \$124,751 | \$16 | \$1,949,783 | \$249 | 25.8% | 20.7% |
| 5 - 9 | \$1,788,652 | \$127 | \$745,968 | \$53 | \$2,534,620 | \$180 | \$2,599,677 | \$174 | \$337,953 | \$23 | \$2,937,630 | \$196 | 15.9% | 9.2% |
| 10 - 14 | \$2,325,304 | \$157 | \$301,524 | \$20 | \$2,626,827 | \$177 | \$3,130,841 | \$190 | \$910,959 | \$55 | \$4,041,799 | \$245 | 53.9% | 38.3% |
| 15 - 19 | \$3,792,327 | \$219 | \$1,007,338 | \$58 | \$4,799,665 | \$277 | \$3,776,051 | \$200 | \$1,226,986 | \$65 | \$5,003,037 | \$265 | 4.2% | -4.5% |
| 20 - 24 | \$3,286,309 | \$197 | \$1,248,733 | \$75 | \$4,535,041 | \$272 | \$4,474,248 | \$242 | \$1,801,340 | \$97 | \$6,275,588 | \$339 | 38.4% | 25.0% |
| 25 - 29 | \$4,534,178 | \$314 | \$1,824,049 | \$126 | \$6,358,227 | \$440 | \$5,780,266 | \$369 | \$2,075,651 | \$132 | \$7,855,917 | \$501 | 23.6% | 14.0% |
| 30 - 34 | \$6,009,079 | \$362 | \$2,587,072 | \$156 | \$8,596,150 | \$518 | \$6,535,968 | \$378 | \$3,365,663 | \$195 | \$9,901,631 | \$572 | 15.2% | 10.4% |
| 35 - 39 | \$7,113,326 | \$387 | \$2,993,817 | \$163 | \$10,107,143 | \$549 | \$9,031,249 | \$437 | \$3,391,422 | \$164 | \$12,422,671 | \$601 | 22.9% | 9.4% |
| 40 - 44 | \$7,703,221 | \$430 | \$3,276,586 | \$183 | \$10,979,807 | \$612 | \$9,450,244 | \$475 | \$4,777,325 | \$240 | \$14,227,569 | \$715 | 29.6% | 16.7% |
| 45 - 49 | \$6,471,992 | \$410 | \$3,763,702 | \$238 | \$10,235,695 | \$648 | \$9,115,207 | \$498 | \$4,991,385 | \$273 | \$14,106,593 | \$771 | 37.8% | 19.1% |
| 50 - 54 | \$8,066,246 | \$475 | \$4,592,489 | \$271 | \$12,658,736 | \$746 | \$9,082,799 | \$505 | \$6,182,109 | \$344 | \$15,264,907 | \$848 | 20.6% | 13.8% |
| 55 - 59 | \$9,993,962 | \$646 | \$4,810,655 | \$311 | \$14,804,618 | \$956 | \$12,593,099 | \$723 | \$5,884,642 | \$338 | \$18,477,741 | \$1,061 | 24.8% | 10.9% |
| 60 - 64 | \$11,183,994 | \$834 | \$4,608,808 | \$344 | \$15,792,802 | \$1,177 | \$13,951,607 | \$918 | \$5,794,744 | \$381 | \$19,746,351 | \$1,299 | 25.0% | 10.3% |
| 65+ | \$5,838,789 | \$1,064 | \$2,222,077 | \$405 | \$8,060,867 | \$1,469 | \$6,297,162 | \$1,002 | \$2,929,670 | \$466 | \$9,226,833 | \$1,469 | 14.5% | 0.0% |
| Total | \$85,000,092 | \$406 | \$34,097,054 | \$163 | \$119,097,146 | \$569 | \$104,110,928 | \$452 | \$43,863,648 | \$190 | \$147,974,576 | \$642 | 24.2% | 13.0% |

Financial Summary – YTD Trend

Total Plan & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|---------------|---------------|---------------|--------------|---------------|-----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 5,573 | 118.9% | 12,201 | 10.5% | 13,477 | | |
| Spouses | 1,362 | 110.9% | 2,871 | 9.3% | 3,137 | | |
| Children | 3,774 | 117.2% | 8,199 | 9.5% | 8,979 | | |
| Tot. Members | 10,709 | 117.3% | 23,271 | 10.0% | 25,594 | | |
| Avg. Family Size | 1.9 | -0.7% | 1.9 | -0.4% | 1.9 | 1.9 | -1.0% |
| Financial Summary | | | | | | | |
| Allowed | \$43,296,528 | 135.5% | \$101,979,426 | 22.6% | \$124,982,259 | | |
| Plan Paid | \$36,649,777 | 131.9% | \$85,000,092 | 22.5% | \$104,110,928 | | |
| Member Paid (OOP) | \$5,434,307 | 129.6% | \$12,478,429 | 19.7% | \$14,938,813 | | |
| Paid PEPY | \$8,769 | 5.9% | \$9,289 | 10.9% | \$10,300 | \$10,453 | -1.5% |
| Paid PMPY | \$4,563 | 6.7% | \$4,870 | 11.4% | \$5,424 | \$5,447 | -0.4% |
| Paid PEPM | \$731 | 5.9% | \$774 | 10.9% | \$858 | \$871 | -1.5% |
| Paid PMPM | \$380 | 6.7% | \$406 | 11.4% | \$452 | \$454 | -0.4% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 54 | 64.8% | 89 | 31.5% | 117 | | |
| HCCs per 1000 | 5.0 | -24.2% | 3.8 | 19.5% | 4.6 | 4.9 | -6.0% |
| Paid per HCC | \$247,264 | -3.2% | \$239,246 | -2.0% | \$234,383 | \$219,275 | 6.9% |
| HCC Paid % of Tot | 36.4% | -11.4 pts | 25.1% | 1.3 pts | 26.3% | 27.8% | -1.4 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$929 | 12.4% | \$1,044 | 10.2% | \$1,150 | \$1,303 | -11.8% |
| Outpatient | \$1,283 | 8.2% | \$1,388 | 17.1% | \$1,626 | \$1,587 | 2.5% |
| Physician | \$2,270 | 4.1% | \$2,362 | 6.4% | \$2,512 | \$2,457 | 2.3% |
| Ancillary | \$82 | -7.3% | \$76 | 78.4% | \$136 | \$100 | 36.1% |

- With \$92.4M paid, the State Active population is 88.7% of total 2026-3Q med spend
- On a Paid PMPM basis, State Actives are up 11.1% compared to prior year
- Total Low Ded Plan Paid PMPM trend is +11.4%

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 | | | | |
|--|--------------|---------------|---------------|-------------|---------------|------------------|---------------|----------|--------------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 5,099 | 120.7% | 11,254 | 10.1% | 12,392 | 1 | 214.3% | 2 | 22.7% | 3 |
| Spouses | 1,210 | 112.4% | 2,571 | 8.9% | 2,799 | 1 | 85.7% | 1 | 38.5% | 2 |
| Children | 3,601 | 118.3% | 7,861 | 9.2% | 8,582 | 0 | - | 0 | - | 0 |
| Tot. Members | 9,910 | 118.8% | 21,685 | 9.6% | 23,773 | 2 | 150.0% | 4 | 28.6% | 5 |
| Avg. Family Size | 1.9 | -0.9% | 1.9 | -0.4% | 1.9 | 2.0 | -20.5% | 1.6 | 4.8% | 1.7 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$37,792,147 | 140.4% | \$90,860,894 | 21.8% | \$110,636,879 | \$12,547 | 55.2% | \$19,467 | 225.3% | \$63,319 |
| Plan Paid | \$32,152,396 | 135.9% | \$75,832,194 | 21.8% | \$92,386,212 | \$9,996 | 52.9% | \$15,281 | 272.6% | \$56,933 |
| Member Paid (OOP) | \$4,885,217 | 131.1% | \$11,289,715 | 19.2% | \$13,460,730 | \$2,551 | 64.1% | \$4,187 | 52.5% | \$6,386 |
| Paid PEPY | \$8,408 | 6.9% | \$8,985 | 10.6% | \$9,940 | \$17,136 | -51.4% | \$8,335 | 203.6% | \$25,304 |
| Paid PMPY | \$4,326 | 7.8% | \$4,663 | 11.1% | \$5,182 | \$8,568 | -38.9% | \$5,239 | 189.8% | \$15,182 |
| Paid PEPM | \$701 | 6.9% | \$749 | 10.6% | \$828 | \$1,428 | -51.4% | \$695 | 203.6% | \$2,109 |
| Paid PMPM | \$360 | 7.8% | \$389 | 11.1% | \$432 | \$714 | -38.9% | \$437 | 189.8% | \$1,265 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 42 | 90.5% | 80 | 23.8% | 99 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 4.2 | -13.0% | 3.7 | 12.9% | 4.2 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$259,860 | -9.4% | \$235,305 | 0.0% | \$235,340 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 33.9% | -9.1 pts | 24.8% | 0.4 pts | 25.2% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$887 | 13.0% | \$1,003 | 6.4% | \$1,067 | \$0 | - | \$0 | - | \$0 |
| Outpatient | \$1,170 | 11.0% | \$1,299 | 18.3% | \$1,537 | \$0 | - | \$1,481 | 285.5% | \$5,712 |
| Physician | \$2,186 | 4.5% | \$2,285 | 6.8% | \$2,441 | \$8,568 | -56.1% | \$3,758 | 150.7% | \$9,419 |
| Ancillary | \$83 | -8.1% | \$76 | 79.9% | \$138 | \$0 | - | \$0 | - | \$51 |

Financial Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|--------------|--------------|--------------|--------------------|--------------|------------|---------------|------------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 457 | 101.2% | 920 | 15.2% | 1,060 | 16 | 57.3% | 25 | -10.7% | 22 |
| Spouses | 144 | 100.7% | 288 | 13.4% | 327 | 7 | 57.4% | 11 | -15.6% | 9 |
| Children | 173 | 94.6% | 336 | 17.9% | 397 | 1 | 80.0% | 1 | 0.0% | 1 |
| Tot. Members | 774 | 99.6% | 1,545 | 15.4% | 1,783 | 23 | 57.9% | 37 | -11.8% | 32 |
| Avg. Family Size | 1.7 | -0.8% | 1.7 | 0.2% | 1.7 | 1.5 | 0.4% | 1.5 | -1.3% | 1.4 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$5,257,412 | 104.1% | \$10,730,712 | 26.0% | \$13,519,906 | \$234,421 | 57.1% | \$368,353 | 106.9% | \$762,156 |
| Plan Paid | \$4,378,123 | 104.4% | \$8,947,747 | 25.0% | \$11,184,392 | \$109,262 | 87.5% | \$204,871 | 135.9% | \$483,391 |
| Member Paid (OOP) | \$505,994 | 125.5% | \$1,141,002 | 25.0% | \$1,426,522 | \$40,544 | 7.4% | \$43,526 | 3.8% | \$45,174 |
| Paid PEPY | \$12,765 | 1.6% | \$12,967 | 8.5% | \$14,072 | \$9,169 | 19.2% | \$10,926 | 164.1% | \$28,859 |
| Paid PMPY | \$7,544 | 2.4% | \$7,723 | 8.3% | \$8,362 | \$6,273 | 18.8% | \$7,450 | 167.6% | \$19,934 |
| Paid PEPM | \$1,064 | 1.6% | \$1,081 | 8.5% | \$1,173 | \$764 | 19.2% | \$911 | 164.1% | \$2,405 |
| Paid PMPM | \$629 | 2.4% | \$644 | 8.3% | \$697 | \$523 | 18.8% | \$621 | 167.6% | \$1,661 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 13 | -30.8% | 9 | 88.9% | 17 | 0 | - | 0 | - | 1 |
| HCCs per 1000 | 16.8 | -65.3% | 5.8 | 63.6% | 9.5 | 0.0 | - | 0.0 | - | 30.9 |
| Paid per HCC | \$187,080 | 46.5% | \$274,138 | -19.3% | \$221,164 | \$0 | - | \$0 | - | \$364,353 |
| HCC Paid % of Tot | 55.5% | -28.0 pts | 27.6% | 6.0 pts | 33.6% | 0.0% | - | 0.0% | - | 75.4% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,433 | 15.1% | \$1,650 | 22.2% | \$2,016 | \$1,779 | -100.0% | \$0 | - | \$14,658 |
| Outpatient | \$2,688 | -4.1% | \$2,578 | 8.2% | \$2,790 | \$2,746 | 47.1% | \$4,041 | -44.0% | \$2,263 |
| Physician | \$3,355 | 2.1% | \$3,426 | 0.5% | \$3,444 | \$1,709 | 90.7% | \$3,259 | -10.6% | \$2,913 |
| Ancillary | \$68 | 0.7% | \$69 | 62.4% | \$112 | \$39 | 280.7% | \$149 | -32.8% | \$100 |

Financial Summary – Full Year Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|---------------|--------------|---------------|--------------|---------------|------------|--------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 6,835 | 80.0% | 12,303 | 9.5% | 13,477 | | |
| Spouses | 1,657 | 74.4% | 2,889 | 8.6% | 3,137 | | |
| Children | 4,604 | 79.3% | 8,256 | 8.8% | 8,979 | | |
| Tot. Members | 13,096 | 79.0% | 23,447 | 9.2% | 25,594 | | |
| Avg. Family Size | 1.9 | -0.5% | 1.9 | -0.4% | 1.9 | 1.9 | -1.0% |
| Financial Summary | | | | | | | |
| Allowed | \$71,596,453 | 94.0% | \$138,897,633 | -10.0% | \$124,982,259 | | |
| Plan Paid | \$60,490,825 | 92.4% | \$116,413,291 | -10.6% | \$104,110,928 | | |
| Member Paid (OOP) | \$8,881,598 | 86.8% | \$16,592,748 | -10.0% | \$14,938,813 | | |
| Paid PEPY | \$8,850 | 6.9% | \$9,462 | 8.9% | \$10,300 | \$10,453 | -1.5% |
| Paid PMPY | \$4,619 | 7.5% | \$4,965 | 9.2% | \$5,424 | \$5,447 | -0.4% |
| Paid PEPM | \$738 | 6.9% | \$789 | 8.9% | \$858 | \$871 | -1.5% |
| Paid PMPM | \$385 | 7.5% | \$414 | 9.2% | \$452 | \$454 | -0.4% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 88 | 36.4% | 120 | -2.5% | 117 | | |
| HCCs per 1000 | 6.7 | -23.8% | 5.1 | -10.7% | 4.6 | 4.9 | -6.0% |
| Paid per HCC | \$228,980 | 10.8% | \$253,751 | -7.6% | \$234,383 | \$219,275 | 6.9% |
| HCC Paid % of Tot | 33.3% | -7.2 pts | 26.2% | 0.2 pts | 26.3% | 27.8% | -1.4 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$933 | 11.2% | \$1,038 | 10.8% | \$1,150 | \$1,303 | -11.8% |
| Outpatient | \$1,348 | 5.9% | \$1,428 | 13.8% | \$1,626 | \$1,587 | 2.5% |
| Physician | \$2,251 | 7.4% | \$2,418 | 3.9% | \$2,512 | \$2,457 | 2.3% |
| Ancillary | \$87 | -6.7% | \$81 | 67.4% | \$136 | \$100 | 36.1% |

- Total plan paid amount for the first three quarters of 2024 was 73.0% of the full year
- Annualizing 2025 paid dollars using the same ratio would result in a total paid of \$143 M

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 for the 2024 Plan Year.

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 – Full Year Trend

Active Members

| Measure | State Active | | | | | Non-State Active | | | | |
|--|---------------|--------------|---------------|-------------|---------------|------------------|---------------|----------|--------------|----------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 6,263 | 81.2% | 11,351 | 9.2% | 12,392 | 1 | 181.8% | 3 | 16.1% | 3 |
| Spouses | 1,475 | 75.6% | 2,589 | 8.1% | 2,799 | 1 | 72.7% | 2 | 26.3% | 2 |
| Children | 4,395 | 80.1% | 7,914 | 8.4% | 8,582 | 0 | - | 0 | - | 0 |
| Tot. Members | 12,132 | 80.1% | 21,854 | 8.8% | 23,773 | 2 | 127.3% | 4 | 20.0% | 5 |
| Avg. Family Size | 1.9 | -0.6% | 1.9 | -0.4% | 1.9 | 2.0 | -19.4% | 1.6 | 3.3% | 1.7 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$62,321,732 | 98.5% | \$123,713,482 | -10.6% | \$110,636,879 | \$23,507 | -12.1% | \$20,653 | 206.6% | \$63,319 |
| Plan Paid | \$52,794,401 | 97.1% | \$104,078,363 | -11.2% | \$92,386,212 | \$18,860 | -14.4% | \$16,151 | 252.5% | \$56,933 |
| Member Paid (OOP) | \$8,016,734 | 87.8% | \$15,053,276 | -10.6% | \$13,460,730 | \$4,647 | -3.1% | \$4,503 | 41.8% | \$6,386 |
| Paid PEPY | \$8,430 | 8.8% | \$9,169 | 8.4% | \$9,940 | \$20,574 | -69.6% | \$6,252 | 304.7% | \$25,304 |
| Paid PMPY | \$4,351 | 9.4% | \$4,763 | 8.8% | \$5,182 | \$10,287 | -62.3% | \$3,876 | 291.7% | \$15,182 |
| Paid PEPM | \$702 | 8.8% | \$764 | 8.4% | \$828 | \$1,715 | -69.6% | \$521 | 304.7% | \$2,109 |
| Paid PMPM | \$363 | 9.4% | \$397 | 8.8% | \$432 | \$857 | -62.3% | \$323 | 291.7% | \$1,265 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 70 | 50.0% | 105 | -5.7% | 99 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 5.8 | -16.7% | 4.8 | -13.3% | 4.2 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$230,519 | 11.0% | \$255,813 | -8.0% | \$235,340 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 30.6% | -4.8 pts | 25.8% | -0.6 pts | 25.2% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$893 | 12.6% | \$1,005 | 6.1% | \$1,067 | \$0 | - | \$0 | - | \$0 |
| Outpatient | \$1,246 | 7.0% | \$1,334 | 15.2% | \$1,537 | \$718 | 44.4% | \$1,037 | 450.8% | \$5,712 |
| Physician | \$2,125 | 10.2% | \$2,342 | 4.2% | \$2,441 | \$9,498 | -70.1% | \$2,839 | 231.8% | \$9,419 |
| Ancillary | \$87 | -7.0% | \$81 | 69.5% | \$138 | \$71 | -100.0% | \$0 | - | \$51 |

Financial Summary – Full Year Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|--------------|--------------|--------------|--------------------|--------------|-----------|--------------|-----------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 553 | 67.2% | 925 | 14.6% | 1,060 | 18 | 34.1% | 25 | -9.2% | 22 |
| Spouses | 173 | 66.2% | 288 | 13.5% | 327 | 8 | 29.5% | 10 | -12.2% | 9 |
| Children | 208 | 63.7% | 341 | 16.4% | 397 | 1 | 50.0% | 1 | 0.0% | 1 |
| Tot. Members | 934 | 66.3% | 1,554 | 14.8% | 1,783 | 27 | 33.1% | 36 | -9.8% | 32 |
| Avg. Family Size | 1.7 | -0.6% | 1.7 | 0.2% | 1.7 | 1.5 | -0.7% | 1.5 | -0.7% | 1.4 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$8,832,582 | 65.8% | \$14,647,388 | -7.7% | \$13,519,906 | \$418,633 | 23.3% | \$516,110 | 47.7% | \$762,156 |
| Plan Paid | \$7,453,477 | 61.8% | \$12,059,589 | -7.3% | \$11,184,392 | \$224,086 | 15.7% | \$259,189 | 86.5% | \$483,391 |
| Member Paid (OOP) | \$805,386 | 84.4% | \$1,485,264 | -4.0% | \$1,426,522 | \$54,831 | -9.3% | \$49,705 | -9.1% | \$45,174 |
| Paid PEPY | \$13,479 | -3.2% | \$13,042 | 7.9% | \$14,072 | \$12,223 | -13.7% | \$10,543 | 173.7% | \$28,859 |
| Paid PMPY | \$7,976 | -2.7% | \$7,763 | 7.7% | \$8,362 | \$8,325 | -13.1% | \$7,233 | 175.6% | \$19,934 |
| Paid PEPM | \$1,123 | -3.2% | \$1,087 | 7.9% | \$1,173 | \$1,019 | -13.7% | \$879 | 173.7% | \$2,405 |
| Paid PMPM | \$665 | -2.7% | \$647 | 7.7% | \$697 | \$694 | -13.1% | \$603 | 175.6% | \$1,661 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 18 | -11.1% | 16 | 6.3% | 17 | 1 | -100.0% | 0 | - | 1 |
| HCCs per 1000 | 19.3 | -46.5% | 10.3 | -7.4% | 9.5 | 37.2 | -100.0% | 0.0 | - | 30.9 |
| Paid per HCC | \$216,572 | 3.6% | \$224,337 | -1.4% | \$221,164 | \$109,572 | -100.0% | \$0 | - | \$364,353 |
| HCC Paid % of Tot | 52.3% | -22.5 pts | 29.8% | 3.9 pts | 33.6% | 48.9% | -48.9 pts | 0.0% | - | 75.4% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,369 | 10.4% | \$1,512 | 33.3% | \$2,016 | \$3,938 | -94.7% | \$210 | 6881.4% | \$14,658 |
| Outpatient | \$2,651 | 2.2% | \$2,710 | 3.0% | \$2,790 | \$2,075 | 65.5% | \$3,432 | -34.1% | \$2,263 |
| Physician | \$3,876 | -10.7% | \$3,462 | -0.5% | \$3,444 | \$2,146 | 60.8% | \$3,451 | -15.6% | \$2,913 |
| Ancillary | \$80 | -1.4% | \$79 | 41.9% | \$112 | \$166 | -16.0% | \$139 | -28.1% | \$100 |

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

| Claim Type | 2025-3Q (7/1/2024 - 3/31/2025) | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | Trend |
|--------------------------|--------------------------------|-----------------------|-------------------|--------------|--------------------------------|-----------------------|-------------------|---------------|--------|
| | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Total |
| State Members | | | | | | | | | |
| Inpatient | \$16,307,298 | \$1,832,672 | \$79,332 | \$18,219,301 | \$19,019,642 | \$2,671,663 | \$25,018 | \$21,716,323 | 19.2% |
| Outpatient | \$21,124,702 | \$2,892,919 | \$93,511 | \$24,111,132 | \$27,398,079 | \$3,552,308 | \$179,289 | \$31,129,676 | 29.1% |
| Physician | \$37,156,010 | \$3,771,564 | \$197,953 | \$41,125,527 | \$43,514,171 | \$4,281,098 | \$325,455 | \$48,120,723 | 17.0% |
| Ancillary | \$1,244,185 | \$75,638 | \$4,158 | \$1,323,981 | \$2,454,321 | \$135,123 | \$14,438 | \$2,603,881 | 96.7% |
| Total | \$75,832,194 | \$8,572,793 | \$374,953 | \$84,779,941 | \$92,386,212 | \$10,640,192 | \$544,200 | \$103,570,604 | 22.2% |
| PMPM | \$388.55 | \$680.73 | \$286.46 | \$405.51 | \$431.80 | \$747.50 | \$299.77 | \$450.29 | 11.0% |
| Non-State Members | | | | | | | | | |
| Inpatient | \$0 | \$0 | \$0 | \$0 | \$0 | \$351,894 | \$3,556 | \$355,450 | - |
| Outpatient | \$4,321 | \$12,308 | \$98,819 | \$115,448 | \$21,418 | \$12,136 | \$42,738 | \$76,292 | -33.9% |
| Physician | \$10,960 | \$49,254 | \$40,382 | \$100,596 | \$35,322 | \$19,811 | \$50,823 | \$105,956 | 5.3% |
| Ancillary | \$0 | \$329 | \$3,779 | \$4,108 | \$193 | \$44 | \$2,389 | \$2,625 | -36.1% |
| Total | \$15,281 | \$61,891 | \$142,980 | \$220,151 | \$56,933 | \$383,885 | \$99,505 | \$540,324 | 145.4% |
| PMPM | \$436.59 | \$966.77 | \$537.56 | \$603.15 | \$1,265.18 | \$12,786.85 | \$381.28 | \$1,608.11 | 166.6% |
| All Members | | | | | | | | | |
| Inpatient | \$16,307,298 | \$1,832,672 | \$79,332 | \$18,219,301 | \$19,019,642 | \$3,023,557 | \$28,574 | \$22,071,773 | 21.1% |
| Outpatient | \$21,129,023 | \$2,905,227 | \$192,330 | \$24,226,580 | \$27,419,497 | \$3,564,444 | \$222,027 | \$31,205,969 | 28.8% |
| Physician | \$37,166,970 | \$3,820,818 | \$238,335 | \$41,226,123 | \$43,549,493 | \$4,300,909 | \$376,277 | \$48,226,679 | 17.0% |
| Ancillary | \$1,244,185 | \$75,967 | \$7,937 | \$1,328,088 | \$2,454,513 | \$135,167 | \$16,827 | \$2,606,507 | 96.3% |
| Total | \$75,847,475 | \$8,634,684 | \$517,933 | \$85,000,092 | \$92,443,145 | \$11,024,077 | \$643,705 | \$104,110,928 | 22.5% |
| PMPM | \$388.55 | \$682.18 | \$328.87 | \$405.85 | \$431.97 | \$772.84 | \$310.02 | \$451.98 | 11.4% |

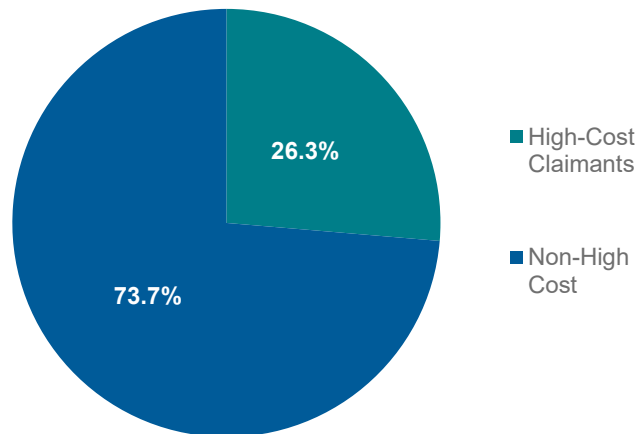
Medical Cost Distribution

Distribution by Member Cost

| Member Total Paid Range | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | |
|----------------------------------|--------------------------------|------------------|---------------------|-------------------|-------------------------|---------------|--------------------------------|------------------|----------------------|-------------------|-------------------------|---------------|
| | *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 | 4,976 | 18.6% | \$0 | 0.0% | \$0 | 0.0% | 5,003 | 17.1% | \$0 | 0.0% | \$0 | 0.0% |
| < \$0 - \$0 | 831 | 3.1% | -\$234,233 | -0.3% | \$27,080 | 0.2% | 1,056 | 3.6% | -\$508,927 | -0.5% | \$58,754 | 0.4% |
| > \$0 - \$2,500 | 15,787 | 59.0% | \$10,958,933 | 12.9% | \$3,801,068 | 30.5% | 16,939 | 57.9% | \$12,301,846 | 11.8% | \$4,170,932 | 27.9% |
| > \$2,500 - \$5,000 | 2,359 | 8.8% | \$8,302,021 | 9.8% | \$2,339,753 | 18.8% | 2,644 | 9.0% | \$9,429,864 | 9.1% | \$2,569,133 | 17.2% |
| > \$5,000 - \$10,000 | 1,359 | 5.1% | \$9,453,474 | 11.1% | \$2,092,264 | 16.8% | 1,758 | 6.0% | \$12,302,056 | 11.8% | \$2,768,943 | 18.5% |
| > \$10,000 - \$25,000 | 908 | 3.4% | \$14,134,954 | 16.6% | \$2,341,849 | 18.8% | 1,171 | 4.0% | \$17,991,760 | 17.3% | \$3,003,107 | 20.1% |
| > \$25,000 - \$50,000 | 309 | 1.2% | \$10,697,894 | 12.6% | \$1,002,616 | 8.0% | 377 | 1.3% | \$12,895,926 | 12.4% | \$1,209,668 | 8.1% |
| > \$50,000 - \$100,000 | 151 | 0.6% | \$10,394,145 | 12.2% | \$525,216 | 4.2% | 177 | 0.6% | \$12,275,621 | 11.8% | \$671,325 | 4.5% |
| > \$100,000 | 89 | 0.3% | \$21,292,905 | 25.1% | \$348,584 | 2.8% | 117 | 0.4% | \$27,422,782 | 26.3% | \$486,950 | 3.3% |
| Total | 26,769 | 100.0% | \$85,000,092 | 100.0% | \$12,478,429 | 100.0% | 29,242 | 100.0% | \$104,110,928 | 100.0% | \$14,938,813 | 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 | Neoplasms | 54 | \$4,652,717 | 17.0% |
| 2 | Health Status & Health Services | 109 | \$2,805,782 | 10.2% |
| 3 | Perinatal Originating Conditions | 12 | \$2,769,410 | 10.1% |
| 4 | Circulatory System | 67 | \$2,414,754 | 8.8% |
| 5 | Endocrine, Nutritional & Metabolic | 61 | \$2,298,321 | 8.4% |
| 6 | Nervous System | 58 | \$1,658,721 | 6.0% |
| 7 | Musculoskeletal System | 65 | \$1,658,466 | 6.0% |
| 8 | Blood & Immune Disorders | 33 | \$1,642,656 | 6.0% |
| 9 | Injury, Poisoning & External Causes | 53 | \$1,514,133 | 5.5% |
| 10 | Respiratory System | 49 | \$1,311,756 | 4.8% |
| ... | All Others | | \$4,696,066 | 17.1% |
| = | Total | 117 | \$27,422,782 | 100.0% |

Utilization Summary – YTD Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|------------------------------|------------|---------|----------|----------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Inpatient Admissions | | | | | | | |
| # of Admits | 549 | 36.2% | 748 | 4.1% | 779 | | |
| # of Admit Days | 2,595 | 34.2% | 3,482 | 2.9% | 3,582 | | |
| Paid per Admit | \$26,262 | 16.1% | \$30,491 | -10.5% | \$27,304 | \$28,343 | -3.7% |
| Paid per Admit Day | \$5,556 | 17.9% | \$6,550 | -9.3% | \$5,938 | \$5,770 | 2.9% |
| Admits per 1000 | 68.4 | -37.3% | 42.9 | -5.3% | 40.6 | 45.7 | -11.2% |
| Average LOS | 4.7 | -1.5% | 4.7 | -1.2% | 4.6 | 4.9 | -6.4% |
| Emergency Room Visits | | | | | | | |
| # of ER Visits | 2,546 | 34.2% | 3,417 | 27.1% | 4,343 | | |
| ~ % resulting in Admit | 10.5% | 0.6 pts | 11.1% | -1.3 pts | 9.8% | 10.5% | -0.6 pts |
| ER Visits per Patient | 1.3 | 2.0% | 1.4 | 2.7% | 1.4 | | |
| ER Visits per 1000 | 317.0 | -38.2% | 195.8 | 15.6% | 226.3 | 220.4 | 2.7% |
| Paid per ER Visit | \$2,943 | 7.0% | \$3,148 | 5.6% | \$3,324 | \$2,447 | 35.9% |
| Urgent Care Visits | | | | | | | |
| # of UC Visits | 5,397 | 29.9% | 7,013 | 3.2% | 7,235 | | |
| UC Visits per Patient | 1.4 | 0.6% | 1.4 | -0.4% | 1.4 | | - |
| UC Visits per 1000 | 672.0 | -40.2% | 401.8 | -6.2% | 376.9 | 249.2 | 51.2% |
| Paid per UC Visit | \$101 | 7.1% | \$108 | 4.9% | \$114 | \$121 | -5.8% |
| Office Visits | | | | | | | |
| Off Visits per Patient | 4.1 | 3.0% | 4.2 | 8.1% | 4.6 | | |
| Paid per Office Visit | \$85 | 5.1% | \$90 | 3.0% | \$92 | \$98 | -5.3% |
| Office Visits Paid PMPY | \$647 | -38.4% | \$398 | 12.6% | \$448 | \$379 | 18.2% |
| Services | | | | | | | |
| Radiology Svcs per 1000 | 6,156.7 | -38.1% | 3,808.8 | 6.6% | 4,059.1 | 3,555.6 | 14.2% |
| Radiology Paid PMPY | \$604 | -35.1% | \$392 | 8.4% | \$425 | | |
| Lab Services per 1000 | 16,996.0 | -37.0% | 10,700.6 | 13.5% | 12,144.3 | 9,761.3 | 24.4% |
| Labs Paid PMPY | \$407 | -33.7% | \$270 | 14.5% | \$309 | | |

- Inpatient Admission rate per 1000 decreased 5.3%, and amount paid per Admission is 10.5% lower than prior period
- ER utilization increased significantly (+15.6%), and amount paid per ER visit is 5.6% 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 | | | | |
|------------------------------|--------------|---------|----------|----------|----------|------------------|---------|----------|---------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 499 | 41.9% | 708 | 1.4% | 718 | 0 | - | 0 | - | 0 |
| # of Admit Days | 2,323 | 41.0% | 3,276 | -0.8% | 3,251 | 0 | - | 0 | - | 0 |
| Paid per Admit | \$25,933 | 16.5% | \$30,218 | -15.9% | \$25,409 | \$0 | - | \$0 | - | \$0 |
| Paid per Admit Day | \$5,571 | 17.2% | \$6,531 | -14.1% | \$5,612 | \$0 | - | \$0 | - | \$0 |
| Admits per 1000 | 67.1 | -35.2% | 43.5 | -7.5% | 40.3 | 0.0 | - | 0.0 | - | 0.0 |
| Average LOS | 4.7 | -0.6% | 4.6 | -2.1% | 4.5 | 0.0 | - | 0.0 | - | 0.0 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 2,332 | 36.7% | 3,189 | 27.5% | 4,067 | 0 | - | 2 | -50.0% | 1 |
| ~ % resulting in Admit | 10.3% | 0.7 pts | 11.0% | -1.4 pts | 9.6% | 0.0% | - | 0.0% | 0.0 pts | 0.0% |
| ER Visits per Patient | 1.3 | 2.6% | 1.4 | 3.2% | 1.4 | 0.0 | - | 2.0 | -50.0% | 1.0 |
| ER Visits per 1000 | 313.8 | -37.5% | 196.1 | 16.3% | 228.1 | 0.0 | - | 685.7 | -61.1% | 266.7 |
| Paid per ER Visit | \$2,970 | 3.5% | \$3,073 | 8.9% | \$3,348 | \$0 | - | \$1,852 | -47.1% | \$980 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 5,102 | 30.6% | 6,664 | 2.5% | 6,831 | 2 | -100.0% | 0 | - | 0 |
| UC Visits per Patient | 1.4 | 0.3% | 1.4 | -0.1% | 1.4 | 1.0 | -100.0% | 0.0 | - | 0.0 |
| UC Visits per 1000 | 686.4 | -40.3% | 409.7 | -6.5% | 383.1 | 1,714.3 | -100.0% | 0.0 | - | 0.0 |
| Paid per UC Visit | \$101 | 7.1% | \$109 | 5.3% | \$114 | \$170 | -100.0% | \$0 | - | \$0 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 4.0 | 3.4% | 4.2 | 8.0% | 4.5 | 9.0 | -38.9% | 5.5 | 136.4% | 13.0 |
| Paid per Office Visit | \$84 | 5.8% | \$89 | 2.6% | \$91 | \$140 | 13.5% | \$159 | -20.6% | \$127 |
| Office Visits Paid PMPY | \$621 | -37.8% | \$386 | 12.1% | \$433 | \$2,168 | -72.3% | \$601 | 192.1% | \$1,756 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 5,696.1 | -37.0% | 3,590.9 | 6.4% | 3,821.4 | 5,142.9 | -13.3% | 4,457.1 | 85.5% | 8,266.7 |
| Radiology Paid PMPY | \$560 | -35.4% | \$361 | 10.1% | \$398 | \$3,311 | -34.9% | \$2,155 | 79.5% | \$3,868 |
| Lab Services per 1000 | 16,540.1 | -36.6% | 10,494.1 | 13.2% | 11,883.6 | 39,428.6 | -59.1% | 16,114.3 | 50.6% | 24,266.7 |
| Labs Paid PMPY | \$397 | -33.7% | \$263 | 15.3% | \$303 | \$304 | -52.7% | \$144 | 294.2% | \$567 |

Utilization Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|------------------------------|----------------|----------|----------|---------|----------|--------------------|---------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 49 | -18.4% | 40 | 40.0% | 56 | 1 | -100.0% | 0 | - | 5 |
| # of Admit Days | 261 | -21.1% | 206 | 36.4% | 281 | 11 | -100.0% | 0 | - | 50 |
| Paid per Admit | \$28,600 | 23.5% | \$35,317 | 33.5% | \$47,138 | \$75,918 | -100.0% | \$0 | - | \$77,242 |
| Paid per Admit Day | \$5,369 | 27.7% | \$6,858 | 37.0% | \$9,394 | \$6,902 | -100.0% | \$0 | - | \$7,724 |
| Admits per 1000 | 84.4 | -59.1% | 34.5 | 21.3% | 41.9 | 57.4 | -100.0% | 0.0 | - | 206.2 |
| Average LOS | 5.3 | -3.3% | 5.2 | -2.6% | 5.0 | 11.0 | -100.0% | 0.0 | - | 10.0 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 206 | 8.3% | 223 | 17.0% | 261 | 8 | -62.5% | 3 | 366.7% | 14 |
| ~ % resulting in Admit | 13.1% | -0.1 pts | 13.0% | 0.4 pts | 13.4% | 0.0% | 0.0 pts | 0.0% | 21.4 pts | 21.4% |
| ER Visits per Patient | 1.5 | -6.0% | 1.4 | -5.4% | 1.3 | 1.1 | 31.3% | 1.5 | 33.3% | 2.0 |
| ER Visits per 1000 | 355.0 | -45.8% | 192.5 | 1.4% | 195.1 | 459.3 | -76.3% | 109.1 | 429.2% | 577.3 |
| Paid per ER Visit | \$2,556 | 66.0% | \$4,242 | -27.1% | \$3,092 | \$5,029 | -44.2% | \$2,805 | -63.0% | \$1,039 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 284 | 19.0% | 338 | 13.9% | 385 | 9 | 22.2% | 11 | 72.7% | 19 |
| UC Visits per Patient | 1.4 | 6.2% | 1.5 | -9.2% | 1.3 | 1.5 | -18.5% | 1.2 | 72.7% | 2.1 |
| UC Visits per 1000 | 489.4 | -40.4% | 291.7 | -1.3% | 287.9 | 516.7 | -22.6% | 400.0 | 95.9% | 783.5 |
| Paid per UC Visit | \$97 | 6.9% | \$104 | -0.6% | \$103 | \$58 | -5.6% | \$55 | -29.5% | \$39 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 5.0 | 0.2% | 5.0 | 6.3% | 5.3 | 6.0 | 26.8% | 7.6 | 7.5% | 8.2 |
| Paid per Office Visit | \$96 | -0.6% | \$95 | 7.3% | \$102 | \$57 | 38.2% | \$79 | -23.7% | \$60 |
| Office Visits Paid PMPY | \$971 | -42.4% | \$559 | 15.3% | \$645 | \$825 | -4.9% | \$785 | -14.7% | \$670 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 11,534.3 | -41.7% | 6,722.3 | 5.4% | 7,084.2 | 23,598.1 | -58.2% | 9,854.5 | 15.1% | 11,340.2 |
| Radiology Paid PMPY | \$1,173 | -30.2% | \$818 | -5.7% | \$772 | \$601 | -9.2% | \$546 | 30.5% | \$712 |
| Lab Services per 1000 | 22,253.6 | -39.6% | 13,451.4 | 15.0% | 15,473.1 | 34,851.7 | -53.0% | 16,363.6 | 12.4% | 18,391.8 |
| Labs Paid PMPY | \$545 | -32.2% | \$370 | 3.7% | \$383 | \$286 | -52.3% | \$136 | 78.4% | \$243 |

On Demand Care Summary

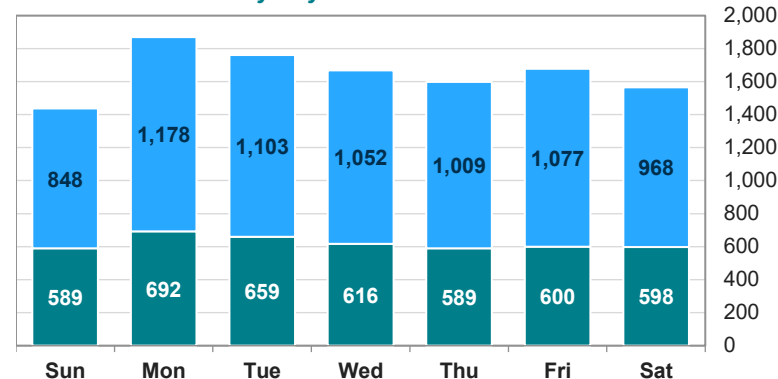
Emergency Room & Urgent Care

| Measure | 2025-3Q | 2026-3Q | Change | UMR Norm | Variance |
|--------------------------------|--------------|--------------|----------|----------|-----------|
| Emergency Room | | | | | |
| # of Visits | 3,417 | 4,343 | 27.1% | | |
| # of Patients | 2,505 | 3,100 | 23.8% | | |
| Total Plan Paid | \$10,757,848 | \$14,438,047 | 34.2% | | |
| Total Mem Paid | \$2,126,468 | \$2,701,809 | 27.1% | | |
| Visits per 1000 | 195.8 | 226.3 | 15.6% | 220.4 | 2.7% |
| Paid per Visit | \$3,148 | \$3,324 | 5.6% | \$2,447 | 35.9% |
| Paid PMPM | \$51 | \$63 | 22.0% | \$45 | 39.5% |
| % ER Patients w/ Office Visit* | 91.4% | 94.0% | 2.7 pts | | |
| % Potentially Avoidable** | 15.9% | 15.4% | -0.5 pts | 82.2% | -66.9 pts |
| Urgent Care | | | | | |
| # of Visits | 7,013 | 7,235 | 3.2% | | |
| # of Patients | 4,888 | 5,065 | 3.6% | | |
| Total Plan Paid | \$759,282 | \$821,782 | 8.2% | | |
| Total Mem Paid | \$510,134 | \$539,610 | 5.8% | | |
| Visits per 1000 | 401.8 | 376.9 | -6.2% | 249.2 | 51.2% |
| Paid per Visit | \$108 | \$114 | 4.9% | \$121 | -5.8% |
| Paid PMPM | \$4 | \$4 | -1.6% | \$3 | 42.4% |

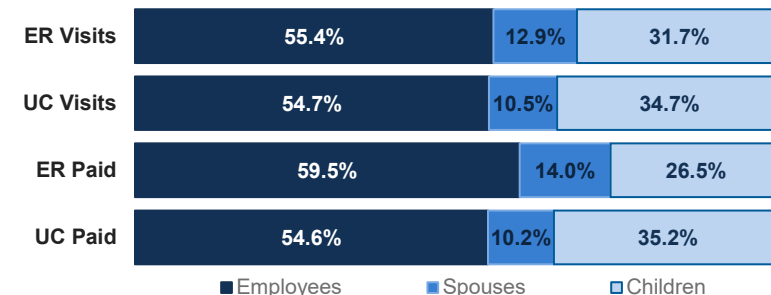
* Office Visit within prior 12 months..

** 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.

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



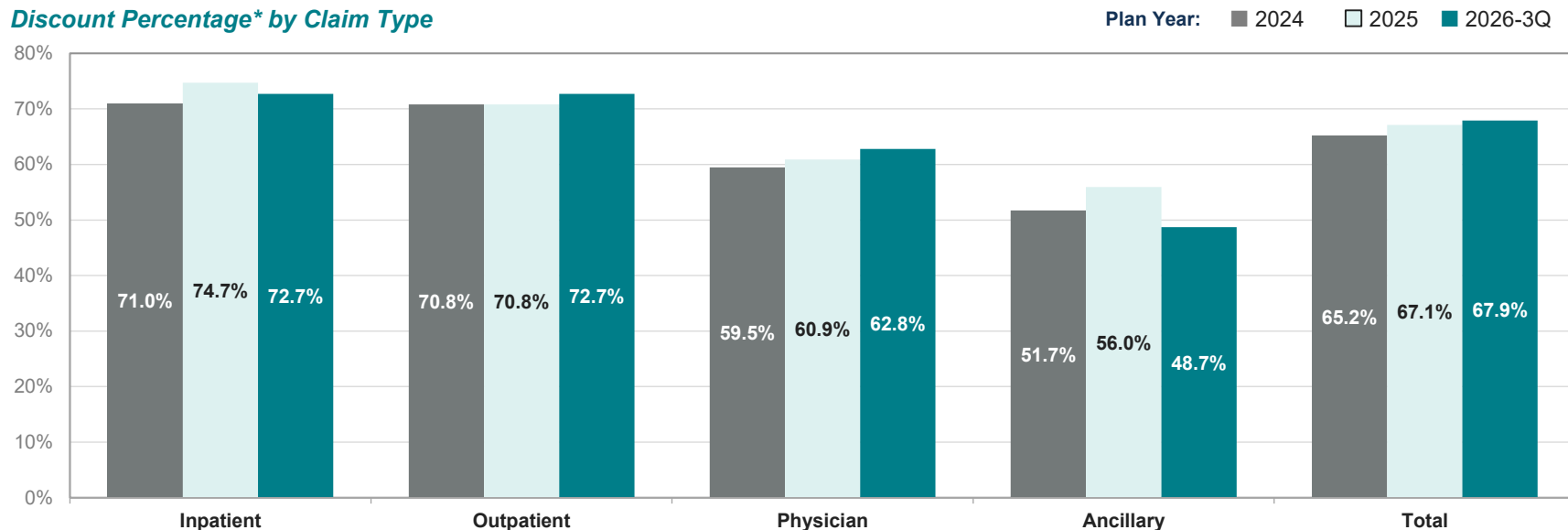
| | # of Visits | | | Total Paid | | |
|----------|-------------|-------|--------|--------------|-----------|--------------|
| | ER | UC | Total | ER | UC | Total |
| Employee | 2,408 | 3,960 | 6,368 | \$8,588,144 | \$448,532 | \$9,036,676 |
| Spouse | 560 | 763 | 1,323 | \$2,025,605 | \$83,831 | \$2,109,436 |
| Child | 1,375 | 2,512 | 3,887 | \$3,824,299 | \$289,419 | \$4,113,718 |
| Total | 4,343 | 7,235 | 11,578 | \$14,438,047 | \$821,782 | \$15,259,829 |



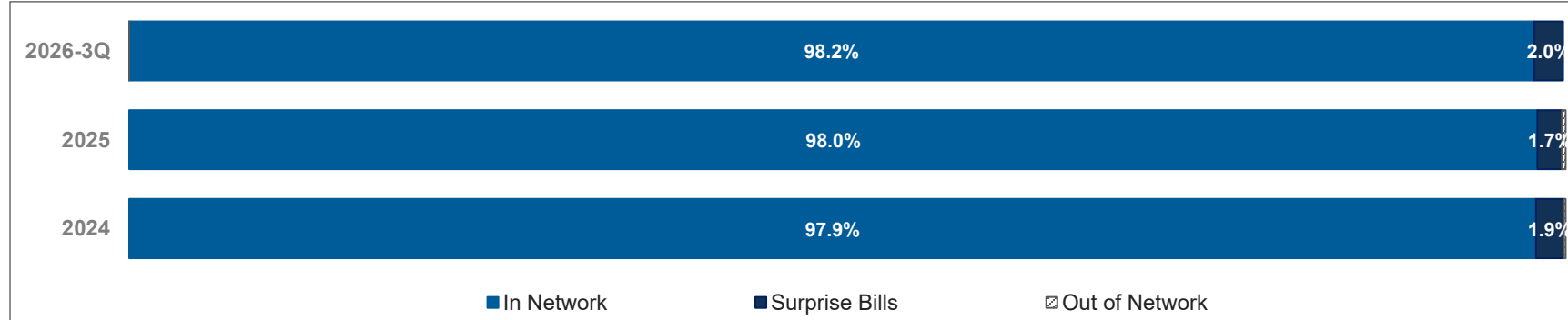
Network Summary

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

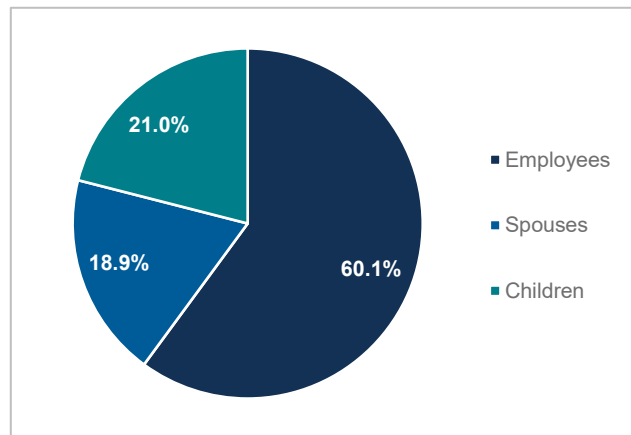
| Diagnostic Chapter | 2025 (Full Year) | | 2026-3Q | | CYTD Paid by Relationship | | | CYTD Paid by Sex | |
|--|------------------|----------------------|---------------|----------------------|---------------------------|---------------------|---------------------|---------------------|---------------------|
| | Patients | Total Paid | Patients | Total Paid | Employee | Spouse | Child | Male | Female |
| Health Status & Health Services | 15,933 | \$13,125,849 | 15,228 | \$11,081,063 | \$6,658,207 | \$2,093,896 | \$2,328,960 | \$3,884,904 | \$7,196,158 |
| Musculoskeletal System | 6,392 | \$9,971,815 | 6,249 | \$9,663,444 | \$6,546,549 | \$2,412,251 | \$704,644 | \$3,976,283 | \$5,687,160 |
| Neoplasms | 3,006 | \$10,454,135 | 2,609 | \$8,893,961 | \$6,912,244 | \$1,419,602 | \$562,115 | \$3,388,173 | \$5,505,788 |
| Mental, Behavioral & Neurodevelopmental | 5,403 | \$9,148,979 | 5,637 | \$8,576,708 | \$4,039,584 | \$631,300 | \$3,905,824 | \$3,725,941 | \$4,850,767 |
| Circulatory System | 3,700 | \$9,265,567 | 3,424 | \$8,111,984 | \$5,756,167 | \$1,932,461 | \$423,356 | \$4,596,413 | \$3,515,571 |
| Injury, Poisoning & External Causes | 3,374 | \$8,521,617 | 3,125 | \$7,041,833 | \$4,626,021 | \$590,207 | \$1,825,605 | \$3,621,891 | \$3,419,943 |
| Symptoms, Signs & Findings, NEC | 10,316 | \$7,524,028 | 9,425 | \$6,807,461 | \$4,430,354 | \$1,022,469 | \$1,354,638 | \$2,366,225 | \$4,441,236 |
| Digestive System | 3,369 | \$6,835,609 | 3,039 | \$6,481,513 | \$4,214,142 | \$1,328,201 | \$939,170 | \$3,037,633 | \$3,443,880 |
| Endocrine, Nutritional & Metabolic | 6,742 | \$5,668,698 | 6,748 | \$5,432,170 | \$4,388,197 | \$699,572 | \$344,401 | \$2,584,760 | \$2,847,410 |
| Nervous System | 3,485 | \$5,995,432 | 3,491 | \$5,332,490 | \$4,171,184 | \$709,727 | \$451,579 | \$1,518,966 | \$3,813,524 |
| Genitourinary System | 5,020 | \$5,876,996 | 4,770 | \$5,013,244 | \$3,599,837 | \$870,009 | \$543,398 | \$1,398,423 | \$3,614,821 |
| Respiratory System | 6,826 | \$5,610,487 | 5,940 | \$4,800,598 | \$2,821,050 | \$525,466 | \$1,454,082 | \$1,983,479 | \$2,817,119 |
| Pregnancy, Childbirth & the Puerperium | 643 | \$5,490,502 | 646 | \$4,517,762 | \$2,964,301 | \$1,062,025 | \$491,436 | \$2,556 | \$4,515,205 |
| Perinatal Originating Conditions | 312 | \$4,049,899 | 303 | \$3,867,723 | \$4,734 | \$0 | \$3,862,989 | \$3,440,364 | \$427,359 |
| Blood & Immune Disorders | 1,041 | \$2,739,481 | 1,006 | \$2,149,141 | \$1,392,282 | \$79,776 | \$677,084 | \$1,798,594 | \$350,546 |
| Infectious & Parasitic Diseases | 1,937 | \$1,811,338 | 1,424 | \$1,827,309 | \$1,073,699 | \$303,086 | \$450,525 | \$835,828 | \$991,481 |
| Eye and Adnexa | 5,230 | \$1,509,643 | 4,460 | \$1,285,264 | \$783,496 | \$215,820 | \$285,948 | \$582,505 | \$702,758 |
| Skin & Subcutaneous Tissue | 5,109 | \$1,235,100 | 4,723 | \$1,271,541 | \$743,674 | \$209,913 | \$317,954 | \$454,221 | \$817,320 |
| Congenital Malformations & Abnormalities | 435 | \$581,437 | 372 | \$1,142,540 | \$205,260 | \$220,485 | \$716,796 | \$534,810 | \$607,731 |
| Ear and Mastoid Process | 2,008 | \$974,018 | 1,724 | \$811,766 | \$449,897 | \$60,538 | \$301,330 | \$346,208 | \$465,558 |
| External Causes of Morbidity | 11 | \$22,660 | 15 | \$1,413 | \$383 | \$49 | \$980 | \$164 | \$1,248 |
| Total | 23,085 | \$116,413,291 | 23,610 | \$104,110,928 | \$65,781,261 | \$16,386,853 | \$21,942,814 | \$44,078,343 | \$60,032,585 |

Health Status & Health Services

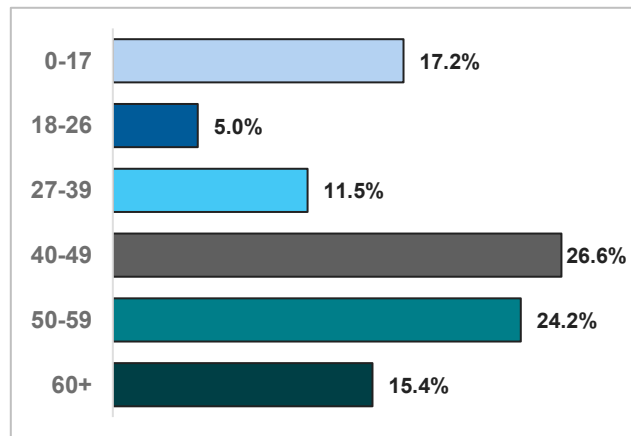
Breakout by Diagnostic Grouping & Demographics

| # | Health Status & Services Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--|---------------|---------------|---------------------|---------------|
| 1 | Encounter for antineoplastic therapies | 65 | 399 | \$2,901,020 | 26.2% |
| 2 | Medical examination/evaluation | 10,833 | 18,245 | \$2,408,501 | 21.7% |
| 3 | Neoplasm-related encounters | 3,730 | 6,582 | \$1,997,596 | 18.0% |
| 4 | Exposure, enc, screen or contact w infectious dz | 5,471 | 7,924 | \$1,585,858 | 14.3% |
| 5 | Contraceptive & procreative management | 783 | 1,392 | \$576,531 | 5.2% |
| 6 | Implant, device or graft related encounter | 374 | 994 | \$257,471 | 2.3% |
| 7 | Other aftercare encounter | 507 | 944 | \$253,494 | 2.3% |
| 8 | Encount for obs & exam for conds ruled out | 2,101 | 2,909 | \$187,873 | 1.7% |
| 9 | Other specified status | 818 | 1,630 | \$141,996 | 1.3% |
| 10 | Organ transplant status | 26 | 258 | \$136,337 | 1.2% |
| 11 | Family history of disease | 168 | 224 | \$127,606 | 1.2% |
| 12 | Encounter for administrative purposes | 54 | 94 | \$92,323 | 0.8% |
| 13 | Personal history of malignant neoplasm | 99 | 144 | \$72,875 | 0.7% |
| 14 | Enc for prophylactic measures (ex immuniz) | 157 | 208 | \$69,177 | 0.6% |
| 15 | Encounter for prophylactic or oth procedures | 77 | 92 | \$66,824 | 0.6% |
| 16 | Personal history of other disease | 306 | 416 | \$65,843 | 0.6% |
| 17 | Other specified encounters & counseling | 330 | 770 | \$60,305 | 0.5% |
| 18 | Acquired absence of limb or organ | 54 | 94 | \$27,443 | 0.2% |
| 19 | Encounter for mental health conditions | 1,457 | 1,786 | \$12,692 | 0.1% |
| 20 | Lifestyle/life management factors | 69 | 110 | \$10,480 | 0.1% |
| ... | All Others | 345 | 447 | \$28,815 | 0.3% |
| = | Total | 15,228 | 45,485 | \$11,081,063 | 100.0% |

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range

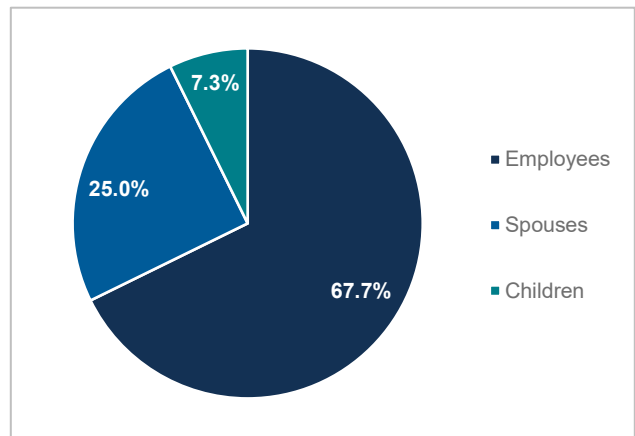


Musculoskeletal System

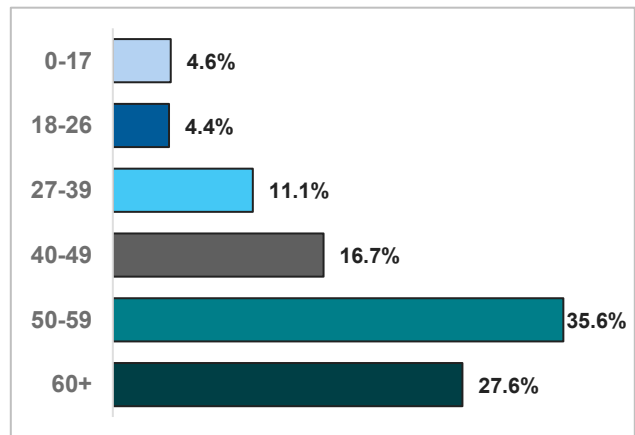
Breakout by Diagnostic Grouping & Demographics

| # | Musculoskeletal Dx Grouping | Patients | Claims | Total Paid | % Paid |
|----|--|--------------|---------------|--------------------|---------------|
| 1 | Spondylopathies & arthropathy | 1,795 | 7,593 | \$2,914,224 | 30.2% |
| 2 | Osteoarthritis & osteoporosis | 838 | 2,245 | \$1,733,019 | 17.9% |
| 3 | Other musculoskeletal pain | 3,525 | 11,846 | \$1,304,930 | 13.5% |
| 4 | Tendon, tissue, muscle disorders | 1,396 | 3,753 | \$1,179,894 | 12.2% |
| 5 | Scoliosis & oth deformities | 534 | 1,138 | \$790,966 | 8.2% |
| 6 | Joint disorders & fractures | 537 | 1,256 | \$537,574 | 5.6% |
| 7 | Other MSK | 107 | 425 | \$406,656 | 4.2% |
| 8 | Low back pain | 856 | 2,652 | \$339,318 | 3.5% |
| 9 | Rheumatoid arthritis & related disease | 166 | 662 | \$292,343 | 3.0% |
| 10 | Lupus | 138 | 472 | \$108,142 | 1.1% |
| 11 | Gout & crystal arthropathies | 103 | 167 | \$30,213 | 0.3% |
| 12 | Biomechanical lesions | 445 | 1,971 | \$26,164 | 0.3% |
| = | Total | 6,249 | 35,810 | \$9,663,444 | 100.0% |

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range

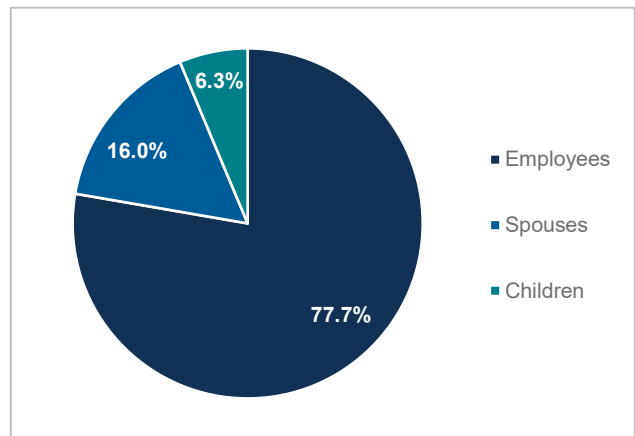


Neoplasms (Cancer)

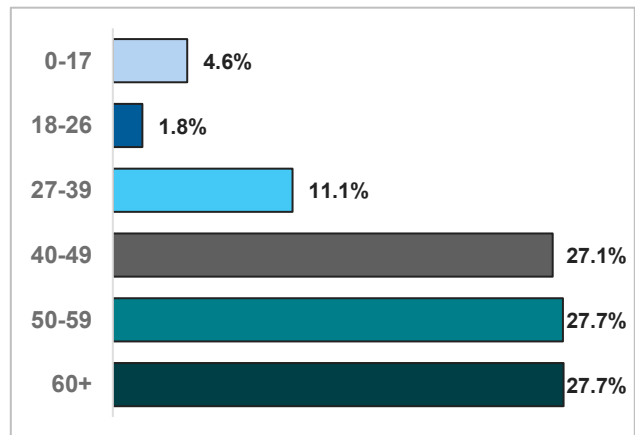
Breakout by Diagnostic Grouping & Demographics

| # | Neoplasms (Cancer) Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--------------------------------|--------------|---------------|--------------------|---------------|
| 1 | Breast cancer | 159 | 1,745 | \$2,004,782 | 22.5% |
| 2 | Benign neoplasms | 1,729 | 2,778 | \$1,311,425 | 14.7% |
| 3 | Other cancer | 55 | 280 | \$928,475 | 10.4% |
| 4 | Neoplasms of unspec nature | 965 | 1,431 | \$752,944 | 8.5% |
| 5 | Leukemia | 30 | 317 | \$544,666 | 6.1% |
| 6 | Secondary malignancies | 37 | 187 | \$499,087 | 5.6% |
| 7 | Other gastrointestinal cancers | 21 | 313 | \$422,535 | 4.8% |
| 8 | Multiple myeloma | 6 | 128 | \$419,166 | 4.7% |
| 9 | Lymphoma | 36 | 374 | \$363,546 | 4.1% |
| 10 | Colorectal cancer | 34 | 467 | \$362,669 | 4.1% |
| 11 | Skin cancer | 175 | 483 | \$304,022 | 3.4% |
| 12 | Prostate cancer | 57 | 428 | \$302,655 | 3.4% |
| 13 | Pancreatic cancer | 8 | 170 | \$192,876 | 2.2% |
| 14 | Head & neck cancers | 19 | 124 | \$129,997 | 1.5% |
| 15 | Thyroid cancer | 62 | 243 | \$91,411 | 1.0% |
| 16 | Respiratory cancers | 10 | 199 | \$69,819 | 0.8% |
| 17 | Kidney Cancer | 14 | 42 | \$59,308 | 0.7% |
| 18 | Ovarian cancer | 12 | 124 | \$41,625 | 0.5% |
| 19 | Brain cancer | 9 | 47 | \$27,451 | 0.3% |
| 20 | Oral cancer | 5 | 28 | \$22,686 | 0.3% |
| ... | All Others | 38 | 138 | \$42,813 | 0.5% |
| = | Total | 2,609 | 10,871 | \$8,893,961 | 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 \$4,898,616 – see Health Status for more details

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

| Mental & Behavioral
Diagnostic Grouping | 2024 (Full Year) | | 2025 (Full Year) | | 2026-3Q | | 2026-3Q Paid by Claim Type | | | |
|--|------------------|--------------------|------------------|--------------------|--------------|--------------------|----------------------------|------------------|--------------------|----------------|
| | Patients | Total Paid | Patients | Total Paid | Patients | Total Paid | Inpatient | Outpatient | Physician | Ancillary |
| Neurodevelopmental disorders | 839 | \$967,358 | 1,117 | \$2,005,009 | 1,202 | \$1,981,263 | \$11,747 | \$18,626 | \$1,948,252 | \$2,638 |
| Depressive disorders | 1,312 | \$1,765,217 | 1,657 | \$2,195,970 | 1,646 | \$1,821,736 | \$206,566 | \$29,514 | \$1,584,912 | \$744 |
| Anxiety & related Disorders | 1,659 | \$914,955 | 2,234 | \$1,366,176 | 2,267 | \$1,360,428 | \$58,129 | \$68,828 | \$1,233,471 | \$0 |
| Trauma & stressor disorders | 1,151 | \$777,003 | 1,462 | \$1,169,043 | 1,546 | \$1,065,016 | \$9,506 | \$10,034 | \$1,045,476 | \$0 |
| Other mental health | 359 | \$444,148 | 475 | \$484,670 | 460 | \$802,293 | \$196,182 | \$52,273 | \$553,838 | \$0 |
| Alcohol-related disorders | 100 | \$479,637 | 129 | \$614,122 | 116 | \$448,933 | \$251,629 | \$81,821 | \$114,057 | \$1,426 |
| Bipolar & related Disorders | 220 | \$270,639 | 285 | \$252,131 | 266 | \$320,539 | \$120,039 | \$4,118 | \$196,382 | \$0 |
| Eating disorders | 53 | \$266,949 | 67 | \$215,695 | 60 | \$178,051 | \$20,549 | \$0 | \$157,502 | \$0 |
| Suicidal ideation, attempt or self-harm | 61 | \$408,763 | 59 | \$212,799 | 48 | \$171,192 | \$46,138 | \$89,873 | \$35,180 | \$0 |
| Schizophrenia spectrum disorders | 29 | \$162,208 | 40 | \$204,689 | 35 | \$170,800 | \$115,485 | \$16,003 | \$39,312 | \$0 |
| Obsessive compulsive disorders | 82 | \$67,055 | 113 | \$292,390 | 129 | \$158,623 | \$16,682 | \$0 | \$141,941 | \$0 |
| Other substance use | 96 | \$10,587 | 94 | \$16,449 | 101 | \$46,188 | \$27,141 | \$2,337 | \$16,709 | \$0 |
| Cannabis-related disorders | 19 | \$5,535 | 26 | \$42,633 | 25 | \$27,276 | \$0 | \$18,865 | \$8,411 | \$0 |
| Stimulant disorders | 11 | \$15,213 | 10 | \$7,200 | 12 | \$17,289 | \$8,484 | \$0 | \$8,805 | \$0 |
| Opiod disorders | 23 | \$40,867 | 30 | \$70,004 | 33 | \$7,082 | -\$5,138 | \$558 | \$11,662 | \$0 |
| Total | 4,161 | \$6,596,135 | 5,403 | \$9,148,979 | 5,637 | \$8,576,708 | \$1,083,139 | \$392,851 | \$7,095,911 | \$4,808 |

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 | 76 | 3.1 | 20.6% | 45 | 1.8 | 18.4% | \$10,656 | 236.8 | 289.5 |
| Asthma | 846 | 34.3 | 12.1% | 333 | 13.5 | 5.0% | \$6,409 | 72.1 | 248.2 |
| Atrial Fibrillation | 183 | 7.4 | 24.5% | 119 | 4.8 | 12.3% | \$30,407 | 251.4 | 546.4 |
| Blood Disorders | 1,136 | 46.0 | 30.7% | 485 | 19.6 | 26.0% | \$16,555 | 134.7 | 264.1 |
| CAD | 299 | 12.1 | 30.6% | 147 | 6.0 | 31.3% | \$21,689 | 187.3 | 361.2 |
| COPD | 63 | 2.6 | 12.5% | 33 | 1.3 | 17.9% | \$33,625 | 285.7 | 428.6 |
| Cancer | 1,624 | 65.8 | 15.3% | 775 | 31.4 | 21.3% | \$17,453 | 91.1 | 177.3 |
| Chronic Pain | 162 | 6.6 | 19.1% | 69 | 2.8 | 25.5% | \$28,563 | 364.2 | 555.6 |
| CHF | 60 | 2.4 | 13.2% | 33 | 1.3 | 3.1% | \$24,396 | 450.0 | 433.3 |
| Demyelinating Diseases | 77 | 3.1 | 26.2% | 49 | 2.0 | 4.3% | \$31,974 | 77.9 | 480.5 |
| Depression | 1,756 | 71.1 | 16.5% | 1,308 | 53.0 | 17.8% | \$8,685 | 104.2 | 284.7 |
| Diabetes | 1,628 | 65.9 | 18.6% | 1,178 | 47.7 | 25.2% | \$8,237 | 64.5 | 246.9 |
| ESRD | 73 | 3.0 | 21.7% | 48 | 1.9 | 17.1% | \$46,250 | 726.0 | 1,630.1 |
| Eating Disorders | 65 | 2.6 | 14.0% | 39 | 1.6 | -2.5% | \$12,259 | 46.2 | 384.6 |
| HIV/AIDS | 43 | 1.7 | 22.9% | 39 | 1.6 | 69.6% | \$3,837 | 46.5 | 139.5 |
| Hyperlipidemia | 985 | 39.9 | 34.6% | 297 | 12.0 | 16.9% | \$2,838 | 11.2 | 58.9 |
| Hypertension | 2,123 | 86.0 | 16.4% | 1,048 | 42.5 | 20.6% | \$7,572 | 75.4 | 238.8 |
| Immune Disorders | 83 | 3.4 | 22.1% | 41 | 1.7 | 57.7% | \$58,228 | 216.9 | 241.0 |
| IBD | 126 | 5.1 | 40.0% | 30 | 1.2 | 7.1% | \$3,373 | 15.9 | 95.2 |
| Liver Disease | 2 | 0.1 | -60.0% | 2 | 0.1 | -50.0% | \$88,676 | 1,500.0 | 3,000.0 |
| Morbid Obesity | 418 | 16.9 | 21.9% | 206 | 8.3 | 19.1% | \$8,492 | 93.3 | 220.1 |
| Osteoarthritis | 796 | 32.2 | 24.0% | 339 | 13.7 | 21.9% | \$7,806 | 31.4 | 135.7 |
| Peripheral Vascular Disease | 91 | 3.7 | 7.1% | 24 | 1.0 | 14.3% | \$6,456 | 65.9 | 197.8 |
| Rheumatoid Arthritis | 159 | 6.4 | 16.1% | 119 | 4.8 | 22.7% | \$11,195 | 62.9 | 358.5 |

- *Most prevalent chronic condition is Hypertension, with 2,123 members*
- *Depression is the condition with the most moderate/high risk members (1,308)*
- *Members with mod/high risk Cancer have the highest combined cost: 775 members totaling \$13.5M*

Date Range: Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

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:** \$6,146
- **Admits per 1000:** 44.4
- **ER Visits per 1000:** 214.9

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

| Preventive Service | Population | 2024 | | | 2025 | | | Rate Change | UMR Norm | |
|----------------------|--|----------|--------|---------|----------|--------|---------|-------------|----------|----------|
| | | Eligible | Actual | Rate | Eligible | Actual | Rate | | Rate | 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 | 271.4 | 1,504 | 5,542.6 | 321.8 | 1,833 | 5,696.7 | 2.8% | 5,373.2 | 6.0% |
| Well Child Visit | 3 - 6 years | 1,064.4 | 880 | 826.8 | 1,226.6 | 1,004 | 818.5 | -1.0% | 806.3 | 1.5% |
| Adults w/ Well Visit | Adults 18+ | 16,205 | 7,168 | 44.2% | 18,703 | 8,389 | 44.9% | 0.6 pts | 44.9% | 0.0 pts |
| Screenings | Rate for all screenings is the percentage of eligible population who had the screening during the period. | | | | | | | | | |
| Mammogram | Females 40 - 69 | 4,944 | 2,389 | 48.3% | 5,716 | 2,804 | 49.1% | 0.7 pts | 51.6% | -2.6 pts |
| Cervical Cancer | Females 21 - 64 | 8,550 | 2,570 | 30.1% | 9,864 | 2,693 | 27.3% | -2.8 pts | 24.8% | 2.5 pts |
| Prostate Cancer | Males 50 - 70 | 2,205 | 1,015 | 46.0% | 2,528 | 1,229 | 48.6% | 2.6 pts | 46.7% | 1.9 pts |
| Colorectal Cancer | Members 45 - 75 | 6,865 | 1,283 | 18.7% | 7,933 | 1,473 | 18.6% | -0.1 pts | 17.7% | 0.8 pts |
| Cholesterol | Female 45+ Male 35+ | 8,457 | 5,019 | 59.3% | 9,770 | 5,787 | 59.2% | -0.1 pts | 51.2% | 8.0 pts |
| Condition-specific | Screening | | | | | | | | | |
| Asthma | Office Visit for Asthma | 755 | 620 | 82.1% | 846 | 657 | 77.7% | -4.5 pts | | |
| COPD | Spirometry Test | 56 | 11 | 19.6% | 63 | 11 | 17.5% | -2.2 pts | | |
| Type 2 Diabetes | A1c Test | 1,256 | 1,164 | 92.7% | 1,502 | 1,381 | 91.9% | -0.7 pts | 84.5% | 7.5 pts |
| | Eye Exam | - | - | - | 0 | 0 | 0 | - | 0 | 0 |
| | Lipid Panel | 1,256 | 1,048 | 83.4% | 1,502 | 1,213 | 80.8% | -2.7 pts | 72.9% | 7.9 pts |
| | Urine Protein Test | 1,256 | 878 | 69.9% | 1,502 | 1,024 | 68.2% | -1.7 pts | 66.2% | 1.9 pts |
| | Any Diabetes Screen | 1,256 | 1,196 | 95.2% | 1,502 | 1,412 | 94.0% | -1.2 pts | 88.4% | 5.6 pts |
| Hyperlipidemia | Lipid Profile | 732 | 373 | 51.0% | 985 | 476 | 48.3% | -2.6 pts | | |
| Hypertension | Creatinine Test | 1,824 | 348 | 19.1% | 2,123 | 413 | 19.5% | 0.4 pts | | |
| | Lipid Profile | 1,824 | 466 | 25.5% | 2,123 | 528 | 24.9% | -0.7 pts | | |

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.



14.9

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

14.7 Q3 CDHP Performance Report

14.8 Q3 LD PPO Performance Report

14.9 Q3 EPO Performance Report



Public Employees' Benefits Program

Quarterly Plan Performance Review

EPO Plan • 2026-3Q



A UnitedHealthcare Company

Report Criteria & Contents

Experience Periods*

➤ 2026 Plan Year (Current)

2026-3Q. 1st three Quarters: Claims Paid 7/1/2025 - 3/31/2026

➤ 2025 Plan Year

2025-3Q. 1st three Quarters: Claims Paid 7/1/2024 - 3/31/2025

2025 Full Year: Claims paid 7/1/2024 - 6/30/2025

➤ 2024 Plan Year

2024-3Q. 1st three Quarters: Claims Paid 7/1/2023 - 3/31/2024

2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

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 InfoPortSM
- Composition: 5,293 groups with approximately 8.8 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 3/31/2026

* Additional date ranges for specific figures are defined on the page if applicable

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Executive Summary



Cost Drivers

- Overall Cost Trend based on Medical Paid PEPY: -16.5%
- High-Cost Claimants Paid PMPM trend: -38.3%; Non HCCs trend: -1.6%
- Top Paid Diagnostic Chapters: Musculoskeletal (-1.7% Paid PMPM), Injury & Poisoning (+21.2%), Health Status & Services (+4.2%)



Membership & Demographics

- Total membership is 13.8% lower than prior period
- Employees decreased 12.4%, while Dependents were down 15.5%
- 70.4% of members had < \$2,500 medical paid, with 11.1% having no claims paid at all during the reporting period



Utilization Key Indicators

- Paid per IP Admit was \$61,704, which is 59.4% higher than 2025-3Q
- Paid per ER Visit was \$3,360, which is 4.7% higher than 2025-3Q



Network Utilization & Savings

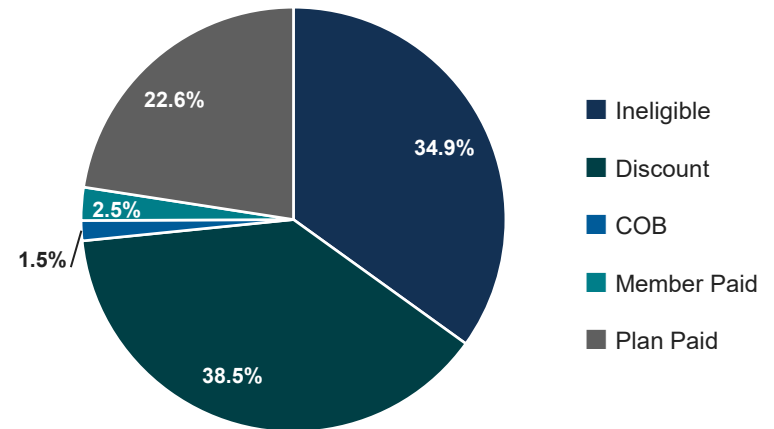
- 95.8% of all Medical spend dollars were to In Network providers
- The average In Network discount was 60.8%, which is 5.2 pts above the 2025 average discount of 55.7%

Medical Total Savings Summary

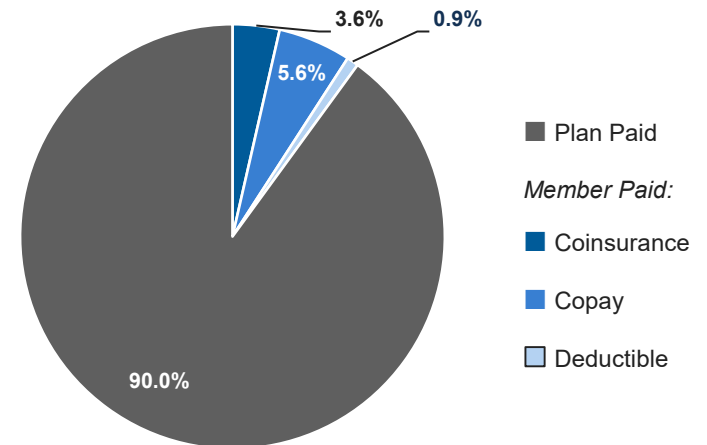
Dollar Chain: Billed to Paid Dollars

| Dollar Amount | 2026-3Q
Total Dollars | 2026-3Q
PMPM* | 2025
PMPM* | Trend |
|-------------------|--------------------------|------------------|---------------|--------|
| Medical Billed | \$112,006,666 | \$2,776 | \$2,435 | 14.0% |
| (-) Ineligible | \$39,093,908 | \$969 | \$628 | 54.2% |
| Medical Covered | \$72,912,758 | \$1,807 | \$1,807 | 0.0% |
| (-) Discount | \$43,054,455 | \$1,067 | \$981 | 8.8% |
| Medical Allowed | \$29,858,303 | \$740 | \$826 | -10.4% |
| (-) COB | \$1,714,773 | \$43 | \$32 | 31.8% |
| (-) Coinsurance | \$1,003,965 | \$25 | \$23 | 9.9% |
| (-) Copay | \$1,557,912 | \$39 | \$36 | 7.2% |
| (-) Deductible | \$250,969 | \$6 | \$5 | 21.6% |
| Total Member Paid | \$2,812,846 | \$70 | \$64 | 9.3% |
| Total Plan Paid | \$25,244,632 | \$626 | \$728 | -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 | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | | 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 | \$3,428,909 | \$11,731 | \$1,400 | \$5 | \$3,430,309 | \$11,735 | \$1,161,332 | \$4,438 | \$677 | \$3 | \$1,162,009 | \$4,440 | -66.1% | -62.2% |
| 1 | \$237,262 | \$681 | \$2,868 | \$8 | \$240,131 | \$689 | \$53,151 | \$210 | \$145 | \$1 | \$53,296 | \$211 | -77.8% | -69.4% |
| 2 - 4 | \$145,553 | \$115 | \$8,093 | \$6 | \$153,646 | \$121 | \$220,711 | \$204 | \$13,619 | \$13 | \$234,330 | \$216 | 52.5% | 78.5% |
| 5 - 9 | \$485,995 | \$172 | \$43,595 | \$15 | \$529,590 | \$188 | \$574,007 | \$254 | \$40,133 | \$18 | \$614,140 | \$272 | 16.0% | 44.8% |
| 10 - 14 | \$685,552 | \$203 | \$131,262 | \$39 | \$816,815 | \$241 | \$758,943 | \$270 | \$72,222 | \$26 | \$831,165 | \$296 | 1.8% | 22.5% |
| 15 - 19 | \$1,390,650 | \$353 | \$505,497 | \$128 | \$1,896,147 | \$481 | \$1,139,048 | \$332 | \$183,088 | \$53 | \$1,322,136 | \$385 | -30.3% | -19.9% |
| 20 - 24 | \$1,055,255 | \$266 | \$396,403 | \$100 | \$1,451,658 | \$366 | \$963,966 | \$286 | \$547,709 | \$162 | \$1,511,675 | \$448 | 4.1% | 22.6% |
| 25 - 29 | \$436,507 | \$322 | \$222,633 | \$164 | \$659,140 | \$486 | \$357,323 | \$302 | \$153,094 | \$129 | \$510,417 | \$431 | -22.6% | -11.4% |
| 30 - 34 | \$927,652 | \$508 | \$500,091 | \$274 | \$1,427,743 | \$781 | \$1,073,294 | \$668 | \$447,116 | \$278 | \$1,520,410 | \$946 | 6.5% | 21.1% |
| 35 - 39 | \$1,393,214 | \$519 | \$361,384 | \$135 | \$1,754,598 | \$653 | \$995,818 | \$473 | \$255,115 | \$121 | \$1,250,934 | \$594 | -28.7% | -9.1% |
| 40 - 44 | \$1,633,240 | \$502 | \$1,536,549 | \$473 | \$3,169,789 | \$975 | \$1,375,112 | \$517 | \$1,183,003 | \$445 | \$2,558,115 | \$961 | -19.3% | -1.4% |
| 45 - 49 | \$4,218,503 | \$1,268 | \$1,045,342 | \$314 | \$5,263,845 | \$1,583 | \$1,765,779 | \$592 | \$1,137,194 | \$382 | \$2,902,973 | \$974 | -44.9% | -38.4% |
| 50 - 54 | \$2,964,371 | \$661 | \$1,339,368 | \$299 | \$4,303,739 | \$960 | \$1,931,560 | \$530 | \$1,270,627 | \$349 | \$3,202,187 | \$879 | -25.6% | -8.5% |
| 55 - 59 | \$4,647,035 | \$898 | \$2,388,320 | \$461 | \$7,035,355 | \$1,359 | \$4,204,533 | \$879 | \$2,419,855 | \$506 | \$6,624,389 | \$1,385 | -5.8% | 1.9% |
| 60 - 64 | \$6,080,839 | \$1,114 | \$2,742,837 | \$503 | \$8,823,676 | \$1,617 | \$5,677,045 | \$1,228 | \$2,398,146 | \$519 | \$8,075,190 | \$1,747 | -8.5% | 8.0% |
| 65+ | \$4,784,684 | \$1,479 | \$1,882,123 | \$582 | \$6,666,808 | \$2,061 | \$2,993,009 | \$909 | \$2,324,329 | \$706 | \$5,317,339 | \$1,615 | -20.2% | -21.7% |
| Total | \$34,515,222 | \$737 | \$13,107,766 | \$280 | \$47,622,989 | \$1,017 | \$25,244,632 | \$626 | \$12,446,074 | \$308 | \$37,690,706 | \$934 | -20.9% | -8.2% |

Financial Summary – YTD Trend

Total Plan & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|--------------|--------------|--------------|---------------|--------------|-----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 1,713 | 64.7% | 2,821 | -12.4% | 2,471 | | |
| Spouses | 336 | 61.9% | 543 | -15.0% | 462 | | |
| Children | 1,131 | 62.4% | 1,837 | -15.7% | 1,550 | | |
| Tot. Members | 3,179 | 63.6% | 5,202 | -13.8% | 4,482 | | |
| Avg. Family Size | 1.9 | -0.7% | 1.8 | -1.6% | 1.8 | 1.9 | -5.5% |
| Financial Summary | | | | | | | |
| Allowed | \$20,748,298 | 89.6% | \$39,335,984 | -24.1% | \$29,858,303 | | |
| Plan Paid | \$18,051,842 | 91.2% | \$34,515,222 | -26.9% | \$25,244,632 | | |
| Member Paid (OOP) | \$1,722,564 | 78.6% | \$3,076,700 | -8.6% | \$2,812,846 | | |
| Paid PEPY | \$14,054 | 16.1% | \$16,313 | -16.5% | \$13,620 | \$10,453 | 30.3% |
| Paid PMPY | \$7,570 | 16.9% | \$8,847 | -15.1% | \$7,509 | \$5,447 | 37.9% |
| Paid PEPM | \$1,171 | 16.1% | \$1,359 | -16.5% | \$1,135 | \$871 | 30.3% |
| Paid PMPM | \$631 | 16.9% | \$737 | -15.1% | \$626 | \$454 | 37.9% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 44 | -2.3% | 43 | -23.3% | 33 | | |
| HCCs per 1000 | 13.8 | -40.3% | 8.3 | -10.9% | 7.4 | 4.9 | 51.3% |
| Paid per HCC | \$214,618 | 37.5% | \$295,158 | -30.7% | \$204,405 | \$219,275 | -6.8% |
| HCC Paid % of Tot | 52.3% | -15.5 pts | 36.8% | -10.1 pts | 26.7% | 27.8% | -1.0 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$1,820 | 62.6% | \$2,958 | -48.6% | \$1,521 | \$1,303 | 16.7% |
| Outpatient | \$2,380 | 6.5% | \$2,535 | -4.5% | \$2,422 | \$1,587 | 52.6% |
| Physician | \$3,285 | -0.8% | \$3,258 | 6.4% | \$3,466 | \$2,457 | 41.1% |
| Ancillary | \$85 | 12.5% | \$96 | 4.6% | \$100 | \$100 | 0.7% |

- With \$19.9M paid, the State Active population is 79.0% of total 2026-3Q med spend
- On a Paid PMPM basis, State Actives are down 19.7% compared to prior year
- Total EPO Plan Paid PMPM trend is -15.1%

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 | | | | |
|--|--------------|--------------|--------------|---------------|--------------|------------------|--------------|------------|-------------|------------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 1,414 | 63.0% | 2,305 | -13.9% | 1,984 | 1 | 60.0% | 2 | 0.0% | 2 |
| Spouses | 286 | 61.2% | 461 | -17.0% | 383 | 0 | - | 0 | - | 0 |
| Children | 1,053 | 62.0% | 1,705 | -16.3% | 1,427 | 0 | - | 0 | - | 0 |
| Tot. Members | 2,753 | 62.4% | 4,472 | -15.2% | 3,794 | 1 | 60.0% | 2 | 0.0% | 2 |
| Avg. Family Size | 1.9 | -0.3% | 1.9 | -1.4% | 1.9 | 1.0 | 0.0% | 1.0 | 0.0% | 1.0 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$16,927,415 | 90.5% | \$32,239,924 | -30.6% | \$22,362,958 | \$3,074 | 77.9% | \$5,468 | -46.3% | \$2,936 |
| Plan Paid | \$15,379,347 | 90.4% | \$29,286,836 | -31.9% | \$19,949,149 | \$2,412 | 75.1% | \$4,224 | -41.0% | \$2,490 |
| Member Paid (OOP) | \$1,410,070 | 77.8% | \$2,507,012 | -11.8% | \$2,210,999 | \$663 | 87.7% | \$1,244 | -64.2% | \$446 |
| Paid PEPY | \$14,500 | 16.8% | \$16,939 | -20.9% | \$13,406 | \$2,894 | 9.5% | \$3,168 | -41.0% | \$1,868 |
| Paid PMPY | \$7,449 | 17.2% | \$8,733 | -19.7% | \$7,011 | \$2,894 | 9.5% | \$3,168 | -41.0% | \$1,868 |
| Paid PEPM | \$1,208 | 16.8% | \$1,412 | -20.9% | \$1,117 | \$241 | 9.5% | \$264 | -41.0% | \$156 |
| Paid PMPM | \$621 | 17.2% | \$728 | -19.7% | \$584 | \$241 | 9.5% | \$264 | -41.0% | \$156 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 38 | -10.5% | 34 | -26.5% | 25 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 13.8 | -44.9% | 7.6 | -13.3% | 6.6 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$218,375 | 47.3% | \$321,651 | -41.6% | \$187,804 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 54.0% | -16.6 pts | 37.3% | -13.8 pts | 23.5% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,936 | 60.1% | \$3,101 | -57.4% | \$1,321 | \$0 | - | \$0 | - | \$0 |
| Outpatient | \$2,216 | 7.1% | \$2,373 | -0.5% | \$2,362 | \$0 | - | \$0 | - | \$0 |
| Physician | \$3,220 | -1.6% | \$3,169 | 2.1% | \$3,236 | \$2,894 | -5.6% | \$2,732 | -47.6% | \$1,431 |
| Ancillary | \$77 | 18.0% | \$90 | 1.8% | \$92 | \$0 | - | \$436 | 0.2% | \$436 |

Financial Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|-------------|--------------|-------------|--------------------|--------------|-----------|--------------|-------------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 271 | 73.6% | 470 | -5.8% | 442 | 27 | 65.1% | 44 | -2.8% | 43 |
| Spouses | 45 | 67.0% | 74 | -3.2% | 72 | 5 | 54.3% | 8 | -11.3% | 7 |
| Children | 72 | 70.9% | 124 | -7.5% | 114 | 6 | 33.3% | 8 | -5.3% | 8 |
| Tot. Members | 387 | 72.3% | 668 | -5.8% | 629 | 38 | 58.4% | 61 | -4.2% | 58 |
| Avg. Family Size | 1.4 | -0.7% | 1.4 | 0.0% | 1.4 | 1.4 | -4.1% | 1.4 | -1.5% | 1.3 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$3,579,996 | 88.3% | \$6,741,799 | -8.6% | \$6,159,429 | \$237,812 | 46.7% | \$348,793 | 282.2% | \$1,332,979 |
| Plan Paid | \$2,562,946 | 96.5% | \$5,036,904 | -9.5% | \$4,557,143 | \$107,137 | 74.8% | \$187,259 | 293.0% | \$735,850 |
| Member Paid (OOP) | \$279,440 | 88.1% | \$525,504 | 1.8% | \$535,112 | \$32,391 | 32.6% | \$42,940 | 54.4% | \$66,289 |
| Paid PEPY | \$12,631 | 13.2% | \$14,299 | -4.0% | \$13,733 | \$5,335 | 5.8% | \$5,646 | 304.1% | \$22,817 |
| Paid PMPY | \$8,821 | 14.0% | \$10,059 | -3.9% | \$9,664 | \$3,737 | 10.3% | \$4,123 | 310.3% | \$16,916 |
| Paid PEPM | \$1,053 | 13.2% | \$1,192 | -4.0% | \$1,144 | \$445 | 5.8% | \$470 | 304.1% | \$1,901 |
| Paid PMPM | \$735 | 14.0% | \$838 | -3.9% | \$805 | \$311 | 10.3% | \$344 | 310.3% | \$1,410 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 6 | 50.0% | 9 | -22.2% | 7 | 0 | - | 0 | - | 1 |
| HCCs per 1000 | 15.5 | -13.0% | 13.5 | -17.4% | 11.1 | 0.0 | - | 0.0 | - | 17.2 |
| Paid per HCC | \$181,053 | 5.3% | \$190,600 | 11.0% | \$211,623 | \$0 | - | \$0 | - | \$558,806 |
| HCC Paid % of Tot | 42.4% | -8.3 pts | 34.1% | -1.6 pts | 32.5% | 0.0% | - | 0.0% | - | 75.9% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$1,071 | 106.8% | \$2,216 | -18.3% | \$1,811 | \$1,070 | -30.5% | \$744 | 1447.7% | \$11,510 |
| Outpatient | \$3,667 | 0.6% | \$3,688 | -24.9% | \$2,769 | \$1,220 | 50.7% | \$1,838 | 43.7% | \$2,641 |
| Physician | \$3,951 | 1.5% | \$4,011 | 22.9% | \$4,931 | \$1,196 | 31.4% | \$1,572 | 70.7% | \$2,683 |
| Ancillary | \$131 | 10.1% | \$145 | 5.2% | \$152 | \$252 | -112.0% | -\$30 | -371.4% | \$82 |

Financial Summary – Full Year Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|--|--------------|--------------|--------------|---------------|--------------|------------|--------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Average Enrollment | | | | | | | |
| Employees | 2,041 | 37.4% | 2,804 | -11.9% | 2,471 | | |
| Spouses | 400 | 34.8% | 539 | -14.4% | 462 | | |
| Children | 1,347 | 35.6% | 1,827 | -15.2% | 1,550 | | |
| Tot. Members | 3,788 | 36.5% | 5,170 | -13.3% | 4,482 | | |
| Avg. Family Size | 1.9 | -0.7% | 1.8 | -1.6% | 1.8 | 1.9 | -5.5% |
| Financial Summary | | | | | | | |
| Allowed | \$35,356,369 | 44.9% | \$51,230,661 | -41.7% | \$29,858,303 | | |
| Plan Paid | \$31,068,720 | 45.3% | \$45,156,705 | -44.1% | \$25,244,632 | | |
| Member Paid (OOP) | \$2,685,152 | 47.3% | \$3,956,451 | -28.9% | \$2,812,846 | | |
| Paid PEPY | \$15,224 | 5.8% | \$16,103 | -15.4% | \$13,620 | \$10,453 | 30.3% |
| Paid PMPY | \$8,201 | 6.5% | \$8,734 | -14.0% | \$7,509 | \$5,447 | 37.9% |
| Paid PEPM | \$1,269 | 5.8% | \$1,342 | -15.4% | \$1,135 | \$871 | 30.3% |
| Paid PMPM | \$683 | 6.5% | \$728 | -14.0% | \$626 | \$454 | 37.9% |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | |
| # of HCCs | 62 | -4.8% | 59 | -44.1% | 33 | | |
| HCCs per 1000 | 16.4 | -30.3% | 11.4 | -35.5% | 7.4 | 4.9 | 51.3% |
| Paid per HCC | \$268,731 | 7.9% | \$289,942 | -29.5% | \$204,405 | \$219,275 | -6.8% |
| HCC Paid % of Tot | 53.6% | -15.7 pts | 37.9% | -11.2 pts | 26.7% | 27.8% | -1.0 pts |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | |
| Inpatient | \$2,536 | 10.0% | \$2,789 | -45.5% | \$1,521 | \$1,303 | 16.7% |
| Outpatient | \$2,270 | 8.1% | \$2,455 | -1.3% | \$2,422 | \$1,587 | 52.6% |
| Physician | \$3,307 | 2.7% | \$3,396 | 2.1% | \$3,466 | \$2,457 | 41.1% |
| Ancillary | \$89 | 6.3% | \$94 | 6.7% | \$100 | \$100 | 0.7% |

- Total plan paid amount for the first three quarters of 2024 was 76.4% of the full year
- Annualizing 2025 paid dollars using the same ratio would result in a total paid of \$33.0 M

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 for the 2024 Plan Year.

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 – Full Year Trend

Active Members

| Measure | State Active | | | | | Non-State Active | | | | |
|--|--------------|--------------|--------------|---------------|--------------|------------------|--------------|------------|--------------|------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 1,685 | 35.9% | 2,291 | -13.4% | 1,984 | 1 | 12.5% | 2 | 18.5% | 2 |
| Spouses | 341 | 34.3% | 457 | -16.3% | 383 | 0 | - | 0 | - | 0 |
| Children | 1,253 | 35.2% | 1,694 | -15.7% | 1,427 | 0 | - | 0 | - | 0 |
| Tot. Members | 3,279 | 35.5% | 4,442 | -14.6% | 3,794 | 1 | 12.5% | 2 | 18.5% | 2 |
| Avg. Family Size | 1.9 | -0.3% | 1.9 | -1.4% | 1.9 | 1.0 | 0.0% | 1.0 | 0.0% | 1.0 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$29,401,900 | 42.9% | \$42,008,318 | -46.8% | \$22,362,958 | \$4,294 | 30.8% | \$5,618 | -47.7% | \$2,936 |
| Plan Paid | \$26,976,131 | 42.0% | \$38,309,548 | -47.9% | \$19,949,149 | \$3,368 | 29.3% | \$4,354 | -42.8% | \$2,490 |
| Member Paid (OOP) | \$2,208,831 | 45.1% | \$3,203,983 | -31.0% | \$2,210,999 | \$926 | 36.5% | \$1,264 | -64.7% | \$446 |
| Paid PEPY | \$16,009 | 4.5% | \$16,724 | -19.8% | \$13,406 | \$2,526 | 14.9% | \$2,903 | -35.7% | \$1,868 |
| Paid PMPY | \$8,228 | 4.8% | \$8,625 | -18.7% | \$7,011 | \$2,526 | 14.9% | \$2,903 | -35.7% | \$1,868 |
| Paid PEPM | \$1,334 | 4.5% | \$1,394 | -19.8% | \$1,117 | \$210 | 14.9% | \$242 | -35.7% | \$156 |
| Paid PMPM | \$686 | 4.8% | \$719 | -18.7% | \$584 | \$210 | 14.9% | \$242 | -35.7% | \$156 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 54 | -11.1% | 48 | -47.9% | 25 | 0 | - | 0 | - | 0 |
| HCCs per 1000 | 16.5 | -34.4% | 10.8 | -39.0% | 6.6 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per HCC | \$278,222 | 10.8% | \$308,200 | -39.1% | \$187,804 | \$0 | - | \$0 | - | \$0 |
| HCC Paid % of Tot | 55.7% | -17.1 pts | 38.6% | -15.1 pts | 23.5% | 0.0% | - | 0.0% | - | 0.0% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$2,791 | 3.9% | \$2,899 | -54.4% | \$1,321 | \$0 | - | \$0 | - | \$0 |
| Outpatient | \$2,118 | 9.4% | \$2,317 | 1.9% | \$2,362 | \$0 | - | \$0 | - | \$0 |
| Physician | \$3,237 | 2.5% | \$3,318 | -2.5% | \$3,236 | \$2,345 | 7.3% | \$2,516 | -43.1% | \$1,431 |
| Ancillary | \$81 | 10.7% | \$90 | 2.0% | \$92 | \$181 | 114.3% | \$387 | 12.7% | \$436 |

Financial Summary – Full Year Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|--|----------------|--------------|-------------|--------------|-------------|--------------------|--------------|-----------|--------------|-------------|
| | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q | 2024 | ⇒ | 2025 | ⇒ | 2026-3Q |
| Average Enrollment | | | | | | | | | | |
| Employees | 323 | 45.0% | 468 | -5.5% | 442 | 32 | 39.1% | 44 | -2.1% | 43 |
| Spouses | 53 | 39.1% | 74 | -3.0% | 72 | 6 | 26.0% | 8 | -8.7% | 7 |
| Children | 87 | 43.0% | 124 | -8.1% | 114 | 8 | 11.1% | 8 | -4.0% | 8 |
| Tot. Members | 463 | 43.9% | 667 | -5.7% | 629 | 45 | 32.7% | 60 | -3.2% | 58 |
| Avg. Family Size | 1.4 | -0.7% | 1.4 | -0.2% | 1.4 | 1.4 | -4.6% | 1.4 | -1.1% | 1.3 |
| Financial Summary | | | | | | | | | | |
| Allowed | \$5,453,744 | 59.6% | \$8,705,026 | -29.2% | \$6,159,429 | \$496,431 | 3.1% | \$511,699 | 160.5% | \$1,332,979 |
| Plan Paid | \$3,824,979 | 72.2% | \$6,587,906 | -30.8% | \$4,557,143 | \$264,242 | -3.5% | \$254,897 | 188.7% | \$735,850 |
| Member Paid (OOP) | \$423,702 | 62.8% | \$689,806 | -22.4% | \$535,112 | \$51,693 | 18.8% | \$61,398 | 8.0% | \$66,289 |
| Paid PEPY | \$11,847 | 18.8% | \$14,073 | -2.4% | \$13,733 | \$8,367 | -30.6% | \$5,804 | 293.1% | \$22,817 |
| Paid PMPY | \$8,258 | 19.7% | \$9,882 | -2.2% | \$9,664 | \$5,850 | -27.3% | \$4,254 | 297.6% | \$16,916 |
| Paid PEPM | \$987 | 18.8% | \$1,173 | -2.4% | \$1,144 | \$697 | -30.6% | \$484 | 293.1% | \$1,901 |
| Paid PMPM | \$688 | 19.7% | \$823 | -2.2% | \$805 | \$488 | -27.3% | \$355 | 297.6% | \$1,410 |
| High-Cost Claimants (Med Paid \$100,000+) | | | | | | | | | | |
| # of HCCs | 7 | 57.1% | 11 | -36.4% | 7 | 1 | -100.0% | 0 | - | 1 |
| HCCs per 1000 | 15.1 | 9.2% | 16.5 | -32.5% | 11.1 | 22.1 | -100.0% | 0.0 | - | 17.2 |
| Paid per HCC | \$201,561 | 2.5% | \$206,510 | 2.5% | \$211,623 | \$132,680 | -100.0% | \$0 | - | \$558,806 |
| HCC Paid % of Tot | 36.9% | -2.4 pts | 34.5% | -2.0 pts | 32.5% | 50.2% | -50.2 pts | 0.0% | - | 75.9% |
| Cost Distribution by Claim Type (Paid PMPY) | | | | | | | | | | |
| Inpatient | \$834 | 165.5% | \$2,216 | -18.3% | \$1,811 | \$1,548 | -28.1% | \$1,113 | 934.4% | \$11,510 |
| Outpatient | \$3,299 | 4.9% | \$3,459 | -19.9% | \$2,769 | \$2,807 | -44.6% | \$1,556 | 69.7% | \$2,641 |
| Physician | \$4,002 | 1.9% | \$4,077 | 20.9% | \$4,931 | \$1,238 | 29.5% | \$1,603 | 67.4% | \$2,683 |
| Ancillary | \$123 | 6.3% | \$130 | 16.8% | \$152 | \$258 | -106.8% | -\$17 | -573.2% | \$82 |

Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

| Claim Type | 2025-3Q (7/1/2024 - 3/31/2025) | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | Trend |
|--------------------------|--------------------------------|-----------------------|-------------------|---------------------|--------------------------------|-----------------------|-------------------|---------------------|---------------|
| | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Total |
| State Members | | | | | | | | | |
| Inpatient | \$10,398,426 | \$850,944 | \$258,401 | \$11,507,771 | \$3,759,542 | \$612,227 | \$241,757 | \$4,613,526 | -59.9% |
| Outpatient | \$7,958,109 | \$1,719,024 | \$127,660 | \$9,804,793 | \$6,720,535 | \$1,151,895 | \$154,107 | \$8,026,538 | -18.1% |
| Physician | \$10,627,542 | \$1,805,622 | \$202,854 | \$12,636,018 | \$9,207,456 | \$1,977,807 | \$347,625 | \$11,532,887 | -8.7% |
| Ancillary | \$302,760 | \$55,661 | \$16,737 | \$375,159 | \$261,615 | \$64,076 | \$7,649 | \$333,341 | -11.1% |
| Total | \$29,286,836 | \$4,431,252 | \$605,652 | \$34,323,740 | \$19,949,149 | \$3,806,005 | \$751,139 | \$24,506,292 | -28.6% |
| PMPM | \$727.73 | \$886.81 | \$598.59 | \$742.09 | \$584.25 | \$829.37 | \$702.12 | \$615.68 | -17.0% |
| Non-State Members | | | | | | | | | |
| Inpatient | \$0 | \$27,438 | \$6,337 | \$33,775 | \$0 | \$443,749 | \$56,934 | \$500,682 | 1382.4% |
| Outpatient | \$0 | \$0 | \$83,467 | \$83,467 | \$0 | \$64,788 | \$50,098 | \$114,887 | 37.6% |
| Physician | \$3,643 | \$11,110 | \$60,286 | \$75,038 | \$1,908 | \$63,634 | \$53,064 | \$118,606 | 58.1% |
| Ancillary | \$581 | \$0 | -\$1,378 | -\$797 | \$582 | \$100 | \$3,483 | \$4,165 | -622.3% |
| Total | \$4,224 | \$38,547 | \$148,711 | \$191,482 | \$2,490 | \$572,271 | \$163,579 | \$738,340 | 285.6% |
| PMPM | \$263.99 | \$856.60 | \$297.42 | \$341.32 | \$155.64 | \$12,717.13 | \$342.93 | \$1,372.38 | 302.1% |
| All Members | | | | | | | | | |
| Inpatient | \$10,398,426 | \$878,381 | \$264,738 | \$11,541,545 | \$3,759,542 | \$1,055,975 | \$298,691 | \$5,114,208 | -55.7% |
| Outpatient | \$7,958,109 | \$1,719,024 | \$211,127 | \$9,888,260 | \$6,720,535 | \$1,216,684 | \$204,205 | \$8,141,424 | -17.7% |
| Physician | \$10,631,185 | \$1,816,732 | \$263,140 | \$12,711,056 | \$9,209,364 | \$2,041,440 | \$400,689 | \$11,651,493 | -8.3% |
| Ancillary | \$303,341 | \$55,661 | \$15,359 | \$374,361 | \$262,197 | \$64,176 | \$11,133 | \$337,506 | -9.8% |
| Total | \$29,291,060 | \$4,469,799 | \$754,363 | \$34,515,222 | \$19,951,639 | \$4,378,275 | \$914,718 | \$25,244,632 | -26.9% |
| PMPM | \$727.54 | \$886.54 | \$498.99 | \$737.28 | \$584.05 | \$944.81 | \$591.35 | \$625.77 | -15.1% |

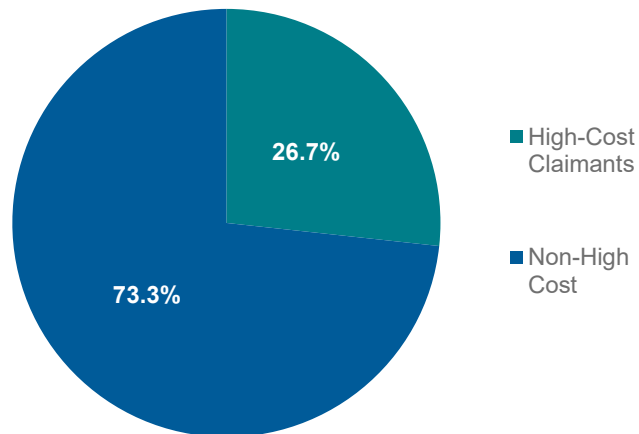
Medical Cost Distribution

Distribution by Member Cost

| Member Total Paid Range | 2025-3Q (7/1/2024 - 3/31/2025) | | | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | | |
|----------------------------------|--------------------------------|------------------|---------------------|-------------------|-------------------------|---------------|--------------------------------|------------------|---------------------|-------------------|-------------------------|---------------|
| | *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 | 668 | 11.5% | \$0 | 0.0% | \$0 | 0.0% | 568 | 11.1% | \$0 | 0.0% | \$0 | 0.0% |
| < \$0 - \$0 | 186 | 3.2% | -\$98,350 | -0.3% | \$3,207 | 0.1% | 226 | 4.4% | -\$228,884 | -0.9% | \$3,007 | 0.1% |
| > \$0 - \$2,500 | 3,323 | 57.1% | \$2,588,717 | 7.5% | \$734,115 | 23.9% | 2,824 | 55.0% | \$2,269,470 | 9.0% | \$628,182 | 22.3% |
| > \$2,500 - \$5,000 | 647 | 11.1% | \$2,284,584 | 6.6% | \$522,043 | 17.0% | 631 | 12.3% | \$2,284,818 | 9.1% | \$518,414 | 18.4% |
| > \$5,000 - \$10,000 | 441 | 7.6% | \$3,043,545 | 8.8% | \$564,339 | 18.3% | 409 | 8.0% | \$2,808,357 | 11.1% | \$526,632 | 18.7% |
| > \$10,000 - \$25,000 | 310 | 5.3% | \$4,937,433 | 14.3% | \$590,874 | 19.2% | 303 | 5.9% | \$4,800,271 | 19.0% | \$617,046 | 21.9% |
| > \$25,000 - \$50,000 | 142 | 2.4% | \$4,915,249 | 14.2% | \$341,387 | 11.1% | 104 | 2.0% | \$3,592,715 | 14.2% | \$267,069 | 9.5% |
| > \$50,000 - \$100,000 | 61 | 1.0% | \$4,152,252 | 12.0% | \$175,936 | 5.7% | 41 | 0.8% | \$2,972,511 | 11.8% | \$126,518 | 4.5% |
| > \$100,000 | 43 | 0.7% | \$12,691,792 | 36.8% | \$144,800 | 4.7% | 33 | 0.6% | \$6,745,374 | 26.7% | \$125,978 | 4.5% |
| Total | 5,821 | 100.0% | \$34,515,222 | 100.0% | \$3,076,700 | 100.0% | 5,139 | 100.0% | \$25,244,632 | 100.0% | \$2,812,846 | 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 | Injury, Poisoning & External Causes | 17 | \$1,372,313 | 20.3% |
| 2 | Neoplasms | 13 | \$1,070,616 | 15.9% |
| 3 | Health Status & Health Services | 27 | \$767,083 | 11.4% |
| 4 | Perinatal Originating Conditions | 4 | \$496,407 | 7.4% |
| 5 | Circulatory System | 20 | \$477,243 | 7.1% |
| 6 | Musculoskeletal System | 17 | \$466,391 | 6.9% |
| 7 | Respiratory System | 11 | \$367,179 | 5.4% |
| 8 | Digestive System | 14 | \$328,742 | 4.9% |
| 9 | Endocrine, Nutritional & Metabolic | 15 | \$312,323 | 4.6% |
| 10 | Pregnancy, Childbirth & the Puerperium | 1 | \$205,670 | 3.0% |
| ... | All Others | | \$881,405 | 13.1% |
| = | Total | 33 | \$6,745,374 | 100.0% |

Utilization Summary – YTD Trend

Plan Totals & Norm

| Measure | Total Plan | | | | | UMR Norm | |
|------------------------------|------------|---------|----------|----------|----------|----------|----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2026-3Q | Variance |
| Inpatient Admissions | | | | | | | |
| # of Admits | 263 | -9.1% | 239 | -37.7% | 149 | | |
| # of Admit Days | 1,379 | 14.6% | 1,581 | -46.6% | 845 | | |
| Paid per Admit | \$35,762 | 8.2% | \$38,704 | 59.4% | \$61,704 | \$28,343 | 117.7% |
| Paid per Admit Day | \$6,820 | -14.2% | \$5,851 | 86.0% | \$10,880 | \$5,770 | 88.6% |
| Admits per 1000 | 110.3 | -44.5% | 61.3 | -27.7% | 44.3 | 45.7 | -3.1% |
| Average LOS | 5.2 | 26.2% | 6.6 | -14.3% | 5.7 | 4.9 | 15.5% |
| Emergency Room Visits | | | | | | | |
| # of ER Visits | 999 | -5.6% | 943 | -9.7% | 852 | | |
| ~ % resulting in Admit | 15.0% | 0.0 pts | 15.1% | -4.1 pts | 10.9% | 10.5% | 0.5 pts |
| ER Visits per Patient | 1.5 | -5.9% | 1.4 | 1.9% | 1.4 | | |
| ER Visits per 1000 | 418.9 | -42.3% | 241.7 | 4.8% | 253.4 | 220.4 | 15.0% |
| Paid per ER Visit | \$3,069 | 4.6% | \$3,210 | 4.7% | \$3,360 | \$2,447 | 37.3% |
| Urgent Care Visits | | | | | | | |
| # of UC Visits | 2,073 | -4.2% | 1,986 | -26.0% | 1,470 | | |
| UC Visits per Patient | 1.5 | -0.1% | 1.5 | -4.5% | 1.5 | | - |
| UC Visits per 1000 | 869.3 | -41.4% | 509.1 | -14.1% | 437.3 | 249.2 | 75.5% |
| Paid per UC Visit | \$126 | 6.1% | \$133 | 5.1% | \$140 | \$121 | 16.3% |
| Office Visits | | | | | | | |
| Off Visits per Patient | 4.7 | 3.6% | 4.8 | 0.5% | 4.9 | | |
| Paid per Office Visit | \$112 | 3.4% | \$116 | 6.9% | \$124 | \$98 | 27.5% |
| Office Visits Paid PMPY | \$1,084 | -41.4% | \$635 | 9.3% | \$694 | \$379 | 83.2% |
| Services | | | | | | | |
| Radiology Svcs per 1000 | 5,989.6 | -35.4% | 3,866.8 | -5.2% | 3,666.2 | 3,555.6 | 3.1% |
| Radiology Paid PMPY | \$975 | -36.7% | \$618 | -8.6% | \$565 | | |
| Lab Services per 1000 | 19,512.6 | -42.7% | 11,177.4 | 7.6% | 12,029.5 | 9,761.3 | 23.2% |
| Labs Paid PMPY | \$412 | -30.0% | \$288 | -10.2% | \$259 | | |

- Inpatient Admission rate per 1000 decreased significantly (-27.7%), but amount paid per Admission is significantly (+59.4%) higher than prior period
- ER utilization increased 4.8%, and amount paid per ER visit is 4.7% 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 | | | | |
|------------------------------|--------------|----------|----------|----------|----------|------------------|--------|----------|---------|---------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 224 | -17.0% | 186 | -39.2% | 113 | 0 | - | 0 | - | 0 |
| # of Admit Days | 1,177 | 4.4% | 1,229 | -48.2% | 637 | 0 | - | 0 | - | 0 |
| Paid per Admit | \$36,993 | 13.4% | \$41,961 | 64.7% | \$69,097 | \$0 | - | \$0 | - | \$0 |
| Paid per Admit Day | \$7,040 | -9.8% | \$6,350 | 93.0% | \$12,257 | \$0 | - | \$0 | - | \$0 |
| Admits per 1000 | 108.5 | -48.9% | 55.5 | -28.4% | 39.7 | 0.0 | - | 0.0 | - | 0.0 |
| Average LOS | 5.3 | 25.8% | 6.6 | -14.7% | 5.6 | 0.0 | - | 0.0 | - | 0.0 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 862 | -9.6% | 779 | -12.3% | 683 | 0 | - | 1 | -100.0% | 0 |
| ~ % resulting in Admit | 13.8% | -1.9 pts | 11.9% | -1.4 pts | 10.5% | 0.0% | - | 0.0% | 0.0 pts | 0.0% |
| ER Visits per Patient | 1.4 | -5.5% | 1.4 | 3.7% | 1.4 | 0.0 | - | 1.0 | -100.0% | 0.0 |
| ER Visits per 1000 | 417.5 | -44.4% | 232.3 | 3.3% | 240.0 | 0.0 | - | 750.0 | -100.0% | 0.0 |
| Paid per ER Visit | \$3,117 | 5.2% | \$3,278 | 8.0% | \$3,539 | \$0 | - | \$369 | -100.0% | \$0 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 1,859 | -6.1% | 1,745 | -25.3% | 1,304 | 0 | - | 0 | - | 0 |
| UC Visits per Patient | 1.6 | -0.3% | 1.6 | -3.7% | 1.5 | 0.0 | - | 0.0 | - | 0.0 |
| UC Visits per 1000 | 900.4 | -42.2% | 520.3 | -11.9% | 458.3 | 0.0 | - | 0.0 | - | 0.0 |
| Paid per UC Visit | \$128 | 5.7% | \$136 | 5.9% | \$144 | \$0 | - | \$0 | - | \$0 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 4.5 | 3.0% | 4.6 | 0.7% | 4.6 | 8.0 | -12.5% | 7.0 | -14.3% | 6.0 |
| Paid per Office Visit | \$116 | 4.3% | \$121 | 6.5% | \$129 | \$140 | 8.8% | \$152 | 19.9% | \$182 |
| Office Visits Paid PMPY | \$1,066 | -41.6% | \$623 | 9.6% | \$682 | \$1,341 | -40.5% | \$798 | 2.8% | \$820 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 5,682.1 | -37.0% | 3,581.1 | -4.8% | 3,410.0 | 4,800.0 | -37.5% | 3,000.0 | 0.0% | 3,000.0 |
| Radiology Paid PMPY | \$951 | -36.9% | \$601 | -9.7% | \$542 | \$386 | -26.9% | \$282 | 7.6% | \$304 |
| Lab Services per 1000 | 18,773.4 | -42.9% | 10,722.2 | 6.1% | 11,377.9 | 25,200.0 | -40.5% | 15,000.0 | -50.0% | 7,500.0 |
| Labs Paid PMPY | \$412 | -31.4% | \$283 | -9.6% | \$255 | \$588 | -19.5% | \$473 | -85.5% | \$69 |

Utilization Summary – YTD Trend

Retired Members

| Measure | State Retirees | | | | | Non-State Retirees | | | | |
|------------------------------|----------------|----------|----------|-----------|----------|--------------------|-----------|----------|----------|-----------|
| | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q | 2024-3Q | ⇒ | 2025-3Q | ⇒ | 2026-3Q |
| Inpatient Admissions | | | | | | | | | | |
| # of Admits | 34 | 47.1% | 50 | -34.0% | 33 | 5 | -40.0% | 3 | 0.0% | 3 |
| # of Admit Days | 188 | 81.9% | 342 | -45.3% | 187 | 14 | -28.6% | 10 | 110.0% | 21 |
| Paid per Admit | \$28,568 | -1.8% | \$28,059 | -3.2% | \$27,172 | \$29,509 | -51.9% | \$14,188 | 1049.4% | \$163,078 |
| Paid per Admit Day | \$5,167 | -20.6% | \$4,102 | 16.9% | \$4,795 | \$10,539 | -59.6% | \$4,256 | 447.3% | \$23,297 |
| Admits per 1000 | 117.0 | -14.7% | 99.9 | -29.9% | 70.0 | 174.4 | -62.1% | 66.1 | 4.4% | 69.0 |
| Average LOS | 5.5 | 23.7% | 6.8 | -17.2% | 5.7 | 2.8 | 19.0% | 3.3 | 110.0% | 7.0 |
| Emergency Room Visits | | | | | | | | | | |
| # of ER Visits | 129 | 14.7% | 148 | 2.0% | 151 | 8 | 87.5% | 15 | 20.0% | 18 |
| ~ % resulting in Admit | 20.9% | 10.8 pts | 31.8% | -18.5 pts | 13.2% | 50.0% | -36.7 pts | 13.3% | -7.8 pts | 5.6% |
| ER Visits per Patient | 1.7 | -11.7% | 1.5 | -8.1% | 1.4 | 1.1 | 19.3% | 1.4 | 10.0% | 1.5 |
| ER Visits per 1000 | 444.0 | -33.4% | 295.6 | 8.3% | 320.2 | 279.1 | 18.3% | 330.3 | 25.3% | 413.8 |
| Paid per ER Visit | \$2,760 | 13.0% | \$3,118 | -11.2% | \$2,769 | \$2,856 | -73.1% | \$768 | 95.0% | \$1,498 |
| Urgent Care Visits | | | | | | | | | | |
| # of UC Visits | 194 | 16.0% | 225 | -33.3% | 150 | 20 | -20.0% | 16 | 0.0% | 16 |
| UC Visits per Patient | 1.5 | -0.7% | 1.5 | -7.3% | 1.4 | 1.4 | 24.4% | 1.8 | -35.7% | 1.1 |
| UC Visits per 1000 | 667.7 | -32.7% | 449.4 | -29.2% | 318.1 | 697.7 | -49.5% | 352.3 | 4.4% | 367.8 |
| Paid per UC Visit | \$111 | 12.8% | \$125 | -0.6% | \$124 | \$50 | -30.8% | \$35 | -11.4% | \$31 |
| Office Visits | | | | | | | | | | |
| Off Visits per Patient | 5.7 | 6.3% | 6.1 | -6.1% | 5.7 | 5.7 | 0.6% | 5.8 | 17.8% | 6.8 |
| Paid per Office Visit | \$100 | -0.8% | \$99 | 11.2% | \$111 | \$48 | 9.1% | \$52 | 12.6% | \$59 |
| Office Visits Paid PMPY | \$1,262 | -40.9% | \$746 | 5.7% | \$788 | \$606 | -40.6% | \$359 | 33.4% | \$480 |
| Services | | | | | | | | | | |
| Radiology Svcs per 1000 | 8,091.6 | -27.8% | 5,839.6 | -16.2% | 4,892.2 | 6,872.1 | -52.9% | 3,236.7 | 120.9% | 7,149.4 |
| Radiology Paid PMPY | \$1,222 | -38.1% | \$756 | -5.4% | \$716 | \$235 | 56.2% | \$368 | 10.2% | \$405 |
| Lab Services per 1000 | 24,774.0 | -40.9% | 14,648.9 | 7.8% | 15,796.2 | 19,255.8 | -66.7% | 6,407.3 | 117.8% | 13,954.0 |
| Labs Paid PMPY | \$427 | -20.7% | \$339 | -12.8% | \$295 | \$236 | -37.3% | \$148 | -29.5% | \$104 |

On Demand Care Summary

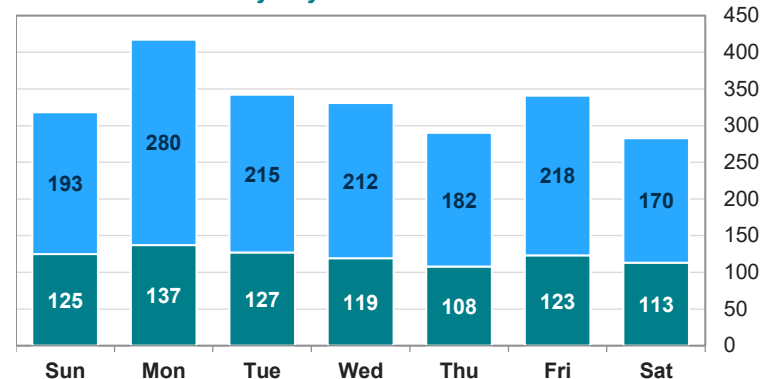
Emergency Room & Urgent Care

| Measure | 2025-3Q | 2026-3Q | Change | UMR Norm | Variance |
|--------------------------------|-------------|-------------|---------|----------|-----------|
| Emergency Room | | | | | |
| # of Visits | 943 | 852 | -9.7% | | |
| # of Patients | 687 | 609 | -11.4% | | |
| Total Plan Paid | \$3,027,209 | \$2,862,505 | -5.4% | | |
| Total Mem Paid | \$451,005 | \$426,965 | -5.3% | | |
| Visits per 1000 | 241.7 | 253.4 | 4.8% | 220.4 | 15.0% |
| Paid per Visit | \$3,210 | \$3,360 | 4.7% | \$2,447 | 37.3% |
| Paid PMPM | \$65 | \$71 | 9.7% | \$45 | 57.9% |
| % ER Patients w/ Office Visit* | 95.6% | 96.4% | 0.8 pts | | |
| % Potentially Avoidable** | 12.8% | 13.4% | 0.5 pts | 82.2% | -68.9 pts |
| Urgent Care | | | | | |
| # of Visits | 1,986 | 1,470 | -26.0% | | |
| # of Patients | 1,285 | 996 | -22.5% | | |
| Total Plan Paid | \$265,125 | \$206,249 | -22.2% | | |
| Total Mem Paid | \$90,053 | \$68,465 | -24.0% | | |
| Visits per 1000 | 509.1 | 437.3 | -14.1% | 249.2 | 75.5% |
| Paid per Visit | \$133 | \$140 | 5.1% | \$121 | 16.3% |
| Paid PMPM | \$6 | \$5 | -9.7% | \$3 | 104.1% |

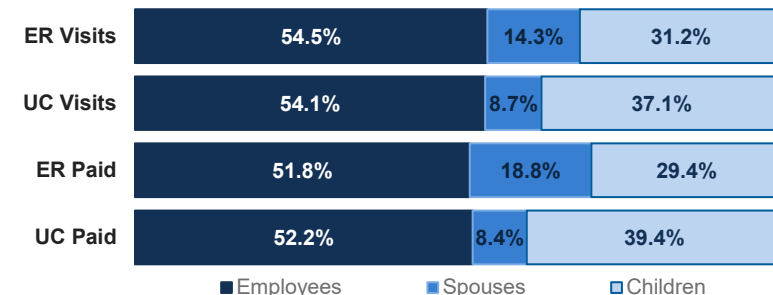
* Office Visit within prior 12 months..

** 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.

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



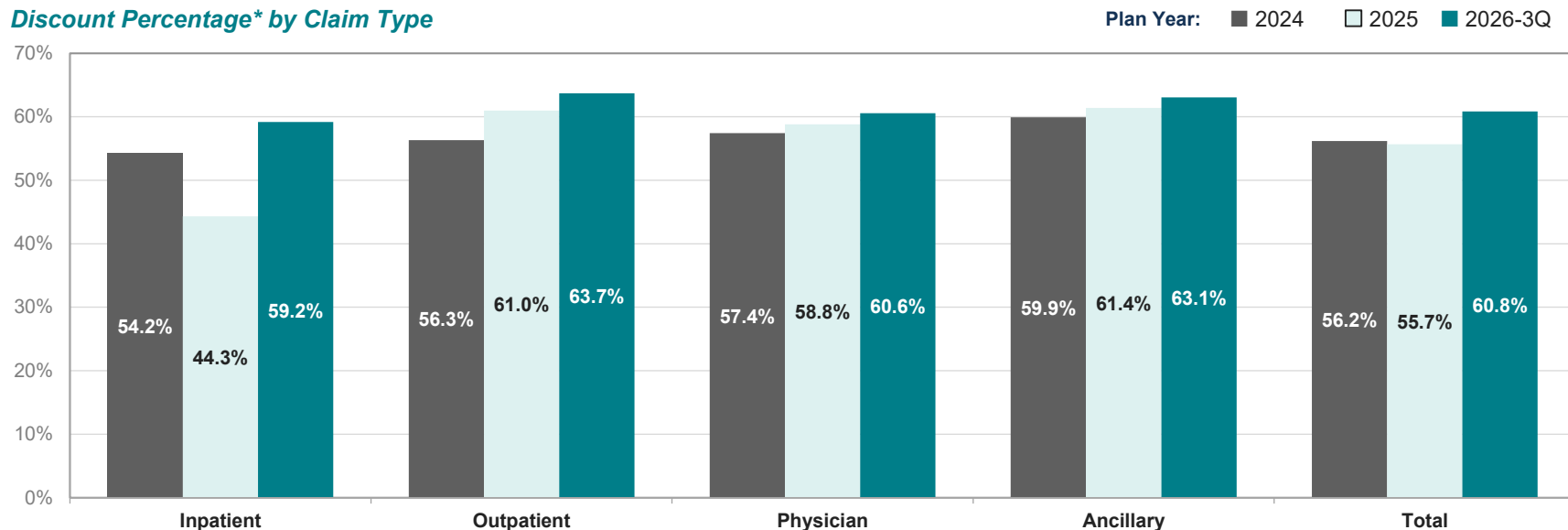
| | # of Visits | | | Total Paid | | |
|----------|-------------|-------|-------|-------------|-----------|-------------|
| | ER | UC | Total | ER | UC | Total |
| Employee | 464 | 796 | 1,260 | \$1,482,152 | \$107,659 | \$1,589,811 |
| Spouse | 122 | 128 | 250 | \$537,672 | \$17,266 | \$554,939 |
| Child | 266 | 546 | 812 | \$842,681 | \$81,323 | \$924,004 |
| Total | 852 | 1,470 | 2,322 | \$2,862,505 | \$206,249 | \$3,068,754 |



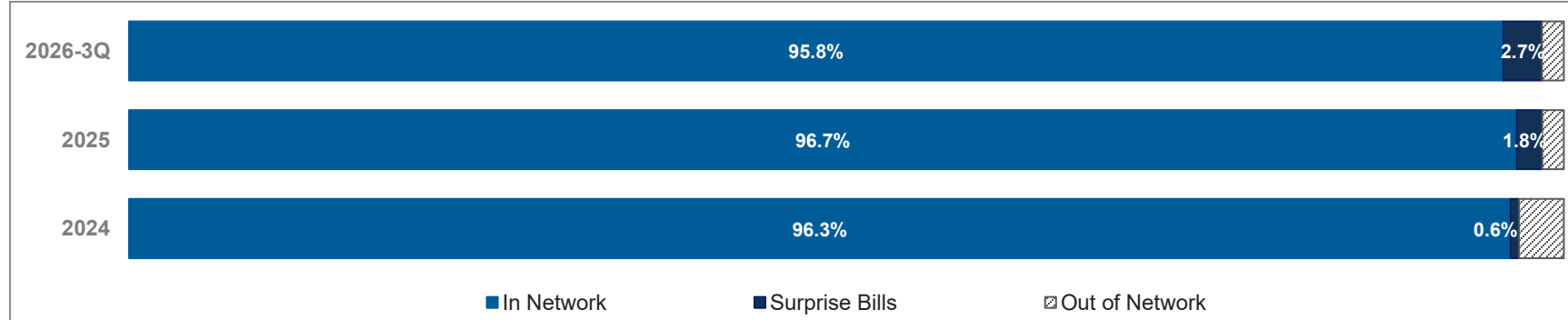
Network Summary

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

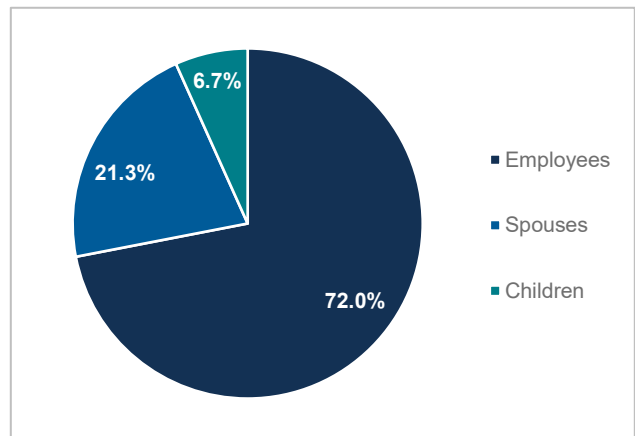
| Diagnostic Chapter | 2025 (Full Year) | | 2026-3Q | | CYTD Paid by Relationship | | | CYTD Paid by Sex | |
|--|------------------|---------------------|--------------|---------------------|---------------------------|--------------------|--------------------|---------------------|---------------------|
| | Patients | Total Paid | Patients | Total Paid | Employee | Spouse | Child | Male | Female |
| Musculoskeletal System | 1,916 | \$5,111,750 | 1,477 | \$3,268,683 | \$2,351,985 | \$697,053 | \$219,646 | \$1,492,443 | \$1,776,240 |
| Injury, Poisoning & External Causes | 954 | \$3,217,301 | 696 | \$2,534,726 | \$1,576,305 | \$281,966 | \$676,454 | \$1,584,640 | \$950,087 |
| Health Status & Health Services | 3,709 | \$3,578,036 | 2,822 | \$2,424,454 | \$1,515,619 | \$502,278 | \$406,557 | \$899,074 | \$1,525,379 |
| Neoplasms | 948 | \$5,069,259 | 650 | \$2,095,411 | \$1,434,656 | \$490,844 | \$169,911 | \$659,756 | \$1,435,655 |
| Circulatory System | 1,057 | \$4,561,417 | 763 | \$2,073,271 | \$1,591,006 | \$420,576 | \$61,690 | \$926,013 | \$1,147,258 |
| Mental, Behavioral & Neurodevelopmental | 1,305 | \$2,232,030 | 1,054 | \$1,668,043 | \$719,644 | \$140,228 | \$808,170 | \$630,386 | \$1,037,657 |
| Digestive System | 839 | \$3,833,453 | 597 | \$1,553,697 | \$1,191,012 | \$222,697 | \$139,988 | \$675,781 | \$877,916 |
| Symptoms, Signs & Findings, NEC | 2,460 | \$2,751,576 | 1,809 | \$1,463,582 | \$889,503 | \$226,870 | \$347,209 | \$544,416 | \$919,166 |
| Nervous System | 1,081 | \$1,684,188 | 880 | \$1,357,283 | \$776,908 | \$265,101 | \$315,274 | \$511,324 | \$845,959 |
| Respiratory System | 1,683 | \$1,989,295 | 1,115 | \$1,338,572 | \$633,690 | \$141,361 | \$563,520 | \$887,100 | \$451,471 |
| Genitourinary System | 1,125 | \$2,141,134 | 834 | \$1,255,280 | \$888,721 | \$246,455 | \$120,104 | \$459,243 | \$796,036 |
| Endocrine, Nutritional & Metabolic | 1,718 | \$1,519,332 | 1,352 | \$1,137,620 | \$873,704 | \$183,550 | \$80,366 | \$582,997 | \$554,622 |
| Pregnancy, Childbirth & the Puerperium | 100 | \$1,125,245 | 90 | \$788,585 | \$604,905 | \$67,316 | \$116,363 | \$7 | \$788,577 |
| Perinatal Originating Conditions | 60 | \$3,326,874 | 41 | \$623,199 | \$524 | \$0 | \$622,675 | \$432,739 | \$190,461 |
| Infectious & Parasitic Diseases | 496 | \$868,889 | 282 | \$453,954 | \$297,341 | \$126,400 | \$30,213 | \$125,598 | \$328,357 |
| Eye and Adnexa | 1,537 | \$443,366 | 1,079 | \$453,398 | \$297,141 | \$50,411 | \$105,845 | \$202,376 | \$251,022 |
| Skin & Subcutaneous Tissue | 1,389 | \$471,294 | 1,045 | \$314,839 | \$201,304 | \$39,463 | \$74,073 | \$179,832 | \$135,007 |
| Ear and Mastoid Process | 513 | \$468,197 | 340 | \$188,041 | \$91,974 | \$30,450 | \$65,617 | \$79,385 | \$108,656 |
| Congenital Malformations & Abnormalities | 97 | \$259,127 | 74 | \$132,327 | \$21,985 | \$186 | \$110,157 | \$116,982 | \$15,345 |
| Blood & Immune Disorders | 216 | \$504,817 | 167 | \$119,668 | \$104,164 | \$10,263 | \$5,240 | \$34,246 | \$85,422 |
| External Causes of Morbidity | 1 | \$124 | 0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Total | 5,279 | \$45,156,705 | 4,423 | \$25,244,632 | \$16,062,090 | \$4,143,469 | \$5,039,073 | \$11,024,340 | \$14,220,292 |

Musculoskeletal System

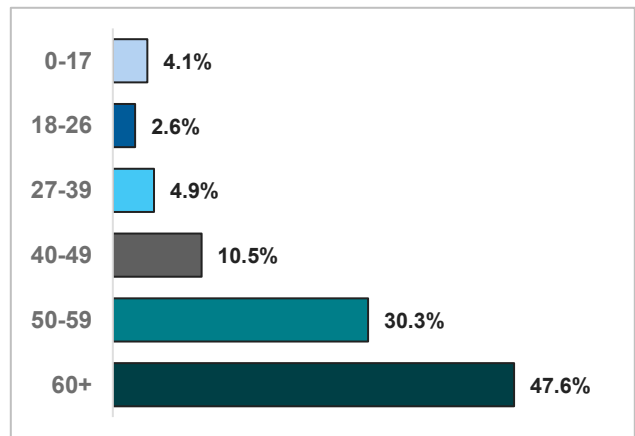
Breakout by Diagnostic Grouping & Demographics

| # | Musculoskeletal Dx Grouping | Patients | Claims | Total Paid | % Paid |
|----|--|--------------|--------------|--------------------|---------------|
| 1 | Spondylopathies & arthropathy | 463 | 2,188 | \$1,113,111 | 34.1% |
| 2 | Osteoarthritis & osteoporosis | 276 | 770 | \$628,434 | 19.2% |
| 3 | Tendon, tissue, muscle disorders | 357 | 906 | \$449,298 | 13.7% |
| 4 | Other musculoskeletal pain | 900 | 3,047 | \$444,826 | 13.6% |
| 5 | Joint disorders & fractures | 122 | 334 | \$183,249 | 5.6% |
| 6 | Scoliosis & oth deformities | 122 | 254 | \$180,709 | 5.5% |
| 7 | Low back pain | 192 | 648 | \$97,378 | 3.0% |
| 8 | Other MSK | 22 | 125 | \$79,299 | 2.4% |
| 9 | Lupus | 34 | 117 | \$45,876 | 1.4% |
| 10 | Rheumatoid arthritis & related disease | 45 | 189 | \$36,816 | 1.1% |
| 11 | Gout & crystal arthropathies | 34 | 52 | \$6,640 | 0.2% |
| 12 | Biomechanical lesions | 110 | 597 | \$3,049 | 0.1% |
| = | Total | 1,477 | 9,548 | \$3,268,683 | 100.0% |

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range

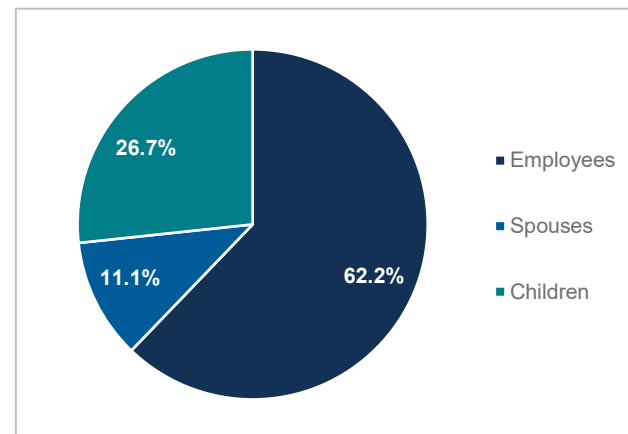


Injury, Poisoning & External Causes

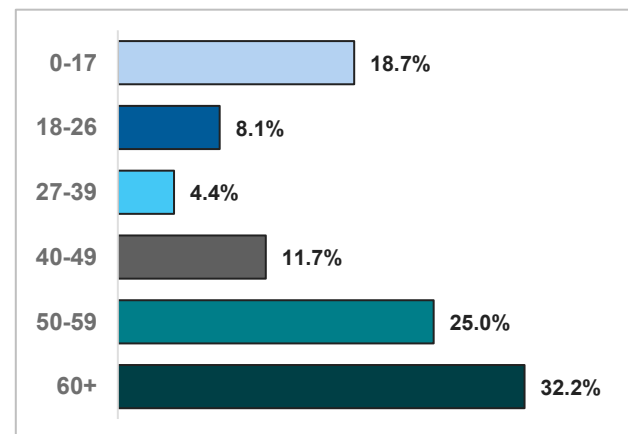
Breakout by Diagnostic Grouping & Demographics

| # | Injury & Poisoning Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--|------------|--------------|--------------------|---------------|
| 1 | Traumatic brain injury (TBI); concuss | 23 | 81 | \$891,193 | 35.2% |
| 2 | Sprains & strains | 242 | 602 | \$282,120 | 11.1% |
| 3 | Fracture of lower limb (except hip) | 43 | 161 | \$230,326 | 9.1% |
| 4 | Compl of surg or med care, injury | 24 | 75 | \$192,560 | 7.6% |
| 5 | Open wounds to limbs | 80 | 135 | \$181,188 | 7.1% |
| 6 | Fracture of neck of the femur (hip) | 6 | 30 | \$154,730 | 6.1% |
| 7 | Fracture of the upper limb | 52 | 193 | \$81,154 | 3.2% |
| 8 | Internal organ injury | 1 | 4 | \$72,242 | 2.9% |
| 9 | Compl of intern orthop device or implant | 12 | 37 | \$65,603 | 2.6% |
| 10 | Other unspecified injury | 121 | 181 | \$64,369 | 2.5% |
| 11 | Compl of transplanted organs or tissue | 3 | 15 | \$60,363 | 2.4% |
| 12 | Dislocations | 24 | 63 | \$53,333 | 2.1% |
| 13 | Superficial injury; contusion | 114 | 153 | \$51,226 | 2.0% |
| 14 | Open wounds of head & neck | 30 | 44 | \$26,164 | 1.0% |
| 15 | Effect of for body entering opening | 12 | 20 | \$22,656 | 0.9% |
| 16 | Fracture of torso | 8 | 21 | \$18,307 | 0.7% |
| 17 | Allergic reactions | 32 | 50 | \$16,556 | 0.7% |
| 18 | Burn & corrosion | 10 | 21 | \$15,439 | 0.6% |
| 19 | Open wounds of trunk | 3 | 4 | \$10,713 | 0.4% |
| 20 | Other complication | 9 | 14 | \$10,343 | 0.4% |
| ... | All Others | 72 | 109 | \$34,138 | 1.3% |
| = | Total | 696 | 2,254 | \$2,534,726 | 100.0% |

Injury & Poisoning Paid by Relationship



Injury & Poisoning Paid by Age Range

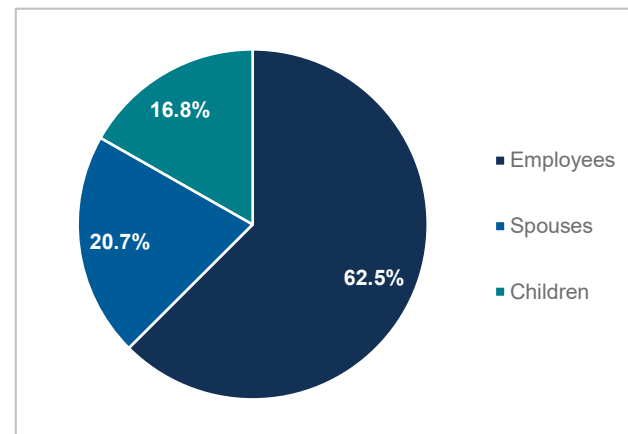


Health Status & Health Services

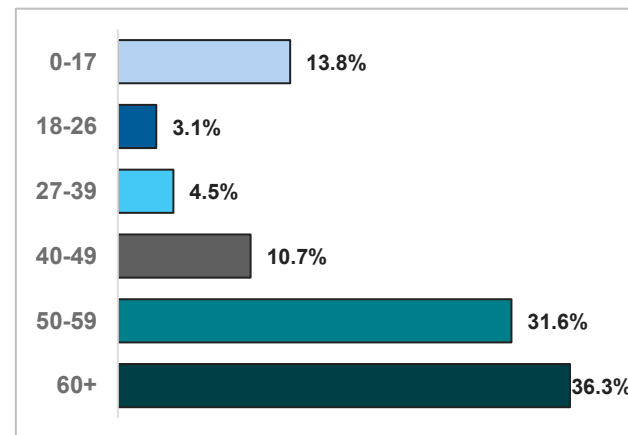
Breakout by Diagnostic Grouping & Demographics

| # | Health Status & Services Dx Grouping | Patients | Claims | Total Paid | % Paid |
|-----|--|--------------|--------------|--------------------|---------------|
| 1 | Encounter for antineoplastic therapies | 14 | 51 | \$727,331 | 30.0% |
| 2 | Neoplasm-related encounters | 782 | 1,626 | \$507,749 | 20.9% |
| 3 | Medical examination/evaluation | 1,924 | 3,035 | \$451,617 | 18.6% |
| 4 | Exposure, enc, screen or contact w infectious dz | 1,148 | 1,513 | \$293,631 | 12.1% |
| 5 | Implant, device or graft related encounter | 126 | 421 | \$109,190 | 4.5% |
| 6 | Contraceptive & procreative management | 101 | 170 | \$94,262 | 3.9% |
| 7 | Other aftercare encounter | 110 | 196 | \$89,386 | 3.7% |
| 8 | Encount for obs & exam for conds ruled out | 271 | 382 | \$45,149 | 1.9% |
| 9 | Other specified status | 219 | 475 | \$25,245 | 1.0% |
| 10 | Encounter for administrative purposes | 10 | 20 | \$16,198 | 0.7% |
| 11 | Personal history of other disease | 51 | 65 | \$13,981 | 0.6% |
| 12 | Enc for prophylactic measures (ex immuniz) | 23 | 42 | \$10,976 | 0.5% |
| 13 | Family history of disease | 36 | 41 | \$8,860 | 0.4% |
| 14 | Other specified encounters & counseling | 40 | 82 | \$6,124 | 0.3% |
| 15 | Encounter for prophylactic or oth procedures | 8 | 8 | \$5,293 | 0.2% |
| 16 | Genetic susceptibility to disease | 6 | 8 | \$5,203 | 0.2% |
| 17 | Personal history of malignant neoplasm | 26 | 38 | \$4,956 | 0.2% |
| 18 | Personal history of nicotine dependence | 11 | 12 | \$2,672 | 0.1% |
| 19 | Organ transplant status | 9 | 49 | \$2,117 | 0.1% |
| 20 | Acquired absence of limb or organ | 11 | 15 | \$1,726 | 0.1% |
| ... | All Others | 129 | 154 | \$2,788 | 0.1% |
| = | Total | 2,822 | 8,585 | \$2,424,454 | 100.0% |

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

| Mental & Behavioral
Diagnostic Grouping | 2024 (Full Year) | | 2025 (Full Year) | | 2026-3Q | | 2026-3Q Paid by Claim Type | | | |
|--|------------------|--------------------|------------------|--------------------|--------------|--------------------|----------------------------|------------------|--------------------|----------------|
| | Patients | Total Paid | Patients | Total Paid | Patients | Total Paid | Inpatient | Outpatient | Physician | Ancillary |
| Depressive disorders | 424 | \$531,931 | 410 | \$621,974 | 315 | \$439,263 | \$96,833 | \$6,633 | \$335,797 | \$0 |
| Neurodevelopmental disorders | 253 | \$292,459 | 260 | \$259,148 | 217 | \$334,818 | \$0 | \$1,335 | \$330,288 | \$3,196 |
| Anxiety & related Disorders | 512 | \$337,685 | 490 | \$381,768 | 403 | \$301,107 | \$0 | \$8,172 | \$292,935 | \$0 |
| Trauma & stressor disorders | 338 | \$370,626 | 332 | \$297,354 | 274 | \$244,364 | \$0 | \$4,525 | \$239,839 | \$0 |
| Other mental health | 141 | \$117,944 | 133 | \$99,065 | 92 | \$112,097 | \$6,022 | \$69,165 | \$36,910 | \$0 |
| Bipolar & related Disorders | 79 | \$92,390 | 66 | \$83,919 | 49 | \$64,871 | \$28,395 | \$0 | \$36,476 | \$0 |
| Suicidal ideation, attempt or self-harm | 23 | \$42,788 | 24 | \$141,882 | 14 | \$57,769 | \$0 | \$53,636 | \$4,133 | \$0 |
| Alcohol-related disorders | 45 | \$307,936 | 30 | \$150,432 | 26 | \$42,473 | \$3,952 | \$28,194 | \$10,327 | \$0 |
| Cannabis-related disorders | 5 | \$3,870 | 10 | \$2,953 | 6 | \$23,680 | \$15,984 | \$7,199 | \$497 | \$0 |
| Obsessive compulsive disorders | 22 | \$60,775 | 20 | \$9,774 | 27 | \$18,041 | \$0 | \$0 | \$18,041 | \$0 |
| Eating disorders | 15 | \$51,171 | 13 | \$88,845 | 8 | \$12,435 | \$0 | \$0 | \$12,435 | \$0 |
| Schizophrenia spectrum disorders | 16 | \$33,159 | 13 | \$68,703 | 9 | \$8,785 | \$420 | -\$591 | \$8,957 | \$0 |
| Opiod disorders | 13 | \$38,318 | 8 | \$13,737 | 5 | \$4,277 | \$592 | \$3,198 | \$486 | \$0 |
| Other substance use | 40 | \$10,408 | 37 | \$7,180 | 23 | \$2,707 | \$0 | \$199 | \$2,509 | \$0 |
| Stimulant disorders | 6 | \$31,146 | 1 | \$5,296 | 3 | \$1,355 | \$0 | \$0 | \$1,355 | \$0 |
| Total | 1,352 | \$2,322,608 | 1,305 | \$2,232,030 | 1,054 | \$1,668,043 | \$152,198 | \$181,664 | \$1,330,984 | \$3,196 |

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 | 10 | 2.1 | 11.1% | 4 | 0.8 | -20.0% | \$8,250 | 400.0 | 200.0 |
| Asthma | 218 | 45.3 | -7.2% | 83 | 17.2 | -27.2% | \$4,473 | 64.2 | 165.1 |
| Atrial Fibrillation | 68 | 14.1 | -2.9% | 52 | 10.8 | 4.0% | \$33,680 | 352.9 | 602.9 |
| Blood Disorders | 209 | 43.4 | 0.0% | 102 | 21.2 | 5.2% | \$24,489 | 157.9 | 430.6 |
| CAD | 92 | 19.1 | 10.8% | 51 | 10.6 | 15.9% | \$14,068 | 130.4 | 434.8 |
| COPD | 33 | 6.9 | -10.8% | 24 | 5.0 | 9.1% | \$26,763 | 333.3 | 727.3 |
| Cancer | 467 | 97.0 | -18.5% | 238 | 49.4 | -13.8% | \$18,146 | 83.5 | 235.5 |
| Chronic Pain | 36 | 7.5 | -18.2% | 24 | 5.0 | 14.3% | \$74,683 | 750.0 | 1,083.3 |
| CHF | 23 | 4.8 | -20.7% | 6 | 1.2 | -68.4% | \$16,381 | 217.4 | 217.4 |
| Demyelinating Diseases | 21 | 4.4 | 16.7% | 17 | 3.5 | 41.7% | \$16,659 | 0.0 | 476.2 |
| Depression | 361 | 75.0 | -13.6% | 270 | 56.1 | -9.4% | \$14,241 | 119.1 | 376.7 |
| Diabetes | 484 | 100.5 | -3.4% | 366 | 76.0 | -1.3% | \$11,177 | 62.0 | 258.3 |
| ESRD | 19 | 3.9 | 18.8% | 13 | 2.7 | 18.2% | \$84,079 | 684.2 | 1,473.7 |
| Eating Disorders | 11 | 2.3 | -21.4% | 8 | 1.7 | -20.0% | \$20,352 | 363.6 | 636.4 |
| HIV/AIDS | 6 | 1.2 | 0.0% | 4 | 0.8 | -20.0% | \$2,987 | 0.0 | 0.0 |
| Hyperlipidemia | 210 | 43.6 | 4.5% | 73 | 15.2 | 10.6% | \$4,140 | 19.0 | 100.0 |
| Hypertension | 540 | 112.1 | -5.8% | 250 | 51.9 | 8.2% | \$11,993 | 114.8 | 272.2 |
| Immune Disorders | 26 | 5.4 | 8.3% | 13 | 2.7 | 18.2% | \$27,467 | 76.9 | 423.1 |
| IBD | 29 | 6.0 | 16.0% | 9 | 1.9 | 0.0% | \$3,637 | 0.0 | 103.4 |
| Liver Disease | 0 | 0.0 | -100.0% | 0 | 0.0 | -100.0% | \$0 | 0.0 | 0.0 |
| Morbid Obesity | 93 | 19.3 | -8.8% | 45 | 9.3 | -25.0% | \$7,056 | 53.8 | 182.8 |
| Osteoarthritis | 279 | 57.9 | -1.4% | 124 | 25.7 | 0.0% | \$13,234 | 60.9 | 179.2 |
| Peripheral Vascular Disease | 18 | 3.7 | -41.9% | 5 | 1.0 | -50.0% | \$10,371 | 166.7 | 333.3 |
| Rheumatoid Arthritis | 56 | 11.6 | -8.2% | 44 | 9.1 | -6.4% | \$11,516 | 89.3 | 303.6 |

- *Most prevalent chronic condition is Hypertension, with 540 members*
- *Diabetes is the condition with the most moderate/high risk members (366)*
- *Members with mod/high risk Cancer have the highest combined cost: 238 members totaling \$4.32M*

Date Range: Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

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:** \$8,694
- **Admits per 1000:** 52.1
- **ER Visits per 1000:** 235.1

Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

| Preventive Service | Population | 2024 | | | 2025 | | | Rate Change | UMR Norm | |
|----------------------|--|----------|--------|---------|----------|--------|---------|-------------|----------|----------|
| | | Eligible | Actual | Rate | Eligible | Actual | Rate | | Rate | 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 | 46.6 | 263 | 5,649.6 | 36.6 | 214 | 5,841.3 | 3.4% | 5,373.2 | 8.7% |
| Well Child Visit | 3 - 6 years | 227.5 | 191 | 839.6 | 196.5 | 170 | 865.2 | 3.1% | 806.3 | 7.3% |
| Adults w/ Well Visit | Adults 18+ | 4,227 | 1,827 | 43.2% | 3,771 | 1,686 | 44.7% | 1.5 pts | 44.9% | -0.2 pts |
| Screenings | Rate for all screenings is the percentage of eligible population who had the screening during the period. | | | | | | | | | |
| Mammogram | Females 40 - 69 | 1,525 | 789 | 51.7% | 1,353 | 687 | 50.8% | -1.0 pts | 51.6% | -0.8 pts |
| Cervical Cancer | Females 21 - 64 | 2,028 | 496 | 24.5% | 1,757 | 438 | 24.9% | 0.5 pts | 24.8% | 0.1 pts |
| Prostate Cancer | Males 50 - 70 | 890 | 448 | 50.3% | 834 | 399 | 47.8% | -2.5 pts | 46.7% | 1.1 pts |
| Colorectal Cancer | Members 45 - 75 | 2,455 | 446 | 18.2% | 2,231 | 382 | 17.1% | -1.0 pts | 17.7% | -0.6 pts |
| Cholesterol | Female 45+ Male 35+ | 2,770 | 1,602 | 57.8% | 2,512 | 1,450 | 57.7% | -0.1 pts | 51.2% | 6.5 pts |
| Condition-specific | Screening | | | | | | | | | |
| Asthma | Office Visit for Asthma | 235 | 194 | 82.6% | 218 | 187 | 85.8% | 3.2 pts | | |
| COPD | Spirometry Test | 37 | 4 | 10.8% | 33 | 7 | 21.2% | 10.4 pts | | |
| Type 2 Diabetes | A1c Test | 459 | 415 | 90.4% | 445 | 402 | 90.3% | -0.1 pts | 84.5% | 5.8 pts |
| | Eye Exam | - | - | - | 0 | 0 | 0 | - | 0 | 0 |
| | Lipid Panel | 459 | 344 | 74.9% | 445 | 325 | 73.0% | -1.9 pts | 72.9% | 0.1 pts |
| | Urine Protein Test | 459 | 296 | 64.5% | 445 | 293 | 65.8% | 1.4 pts | 66.2% | -0.4 pts |
| | Any Diabetes Screen | 459 | 428 | 93.2% | 445 | 411 | 92.4% | -0.9 pts | 88.4% | 3.9 pts |
| Hyperlipidemia | Lipid Profile | 201 | 92 | 45.8% | 210 | 109 | 51.9% | 6.1 pts | | |
| Hypertension | Creatinine Test | 573 | 128 | 22.3% | 540 | 140 | 25.9% | 3.6 pts | | |
| | Lipid Profile | 573 | 160 | 27.9% | 540 | 148 | 27.4% | -0.5 pts | | |

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 1/1/2025 - 12/31/2025, Paid through 3/31/2026

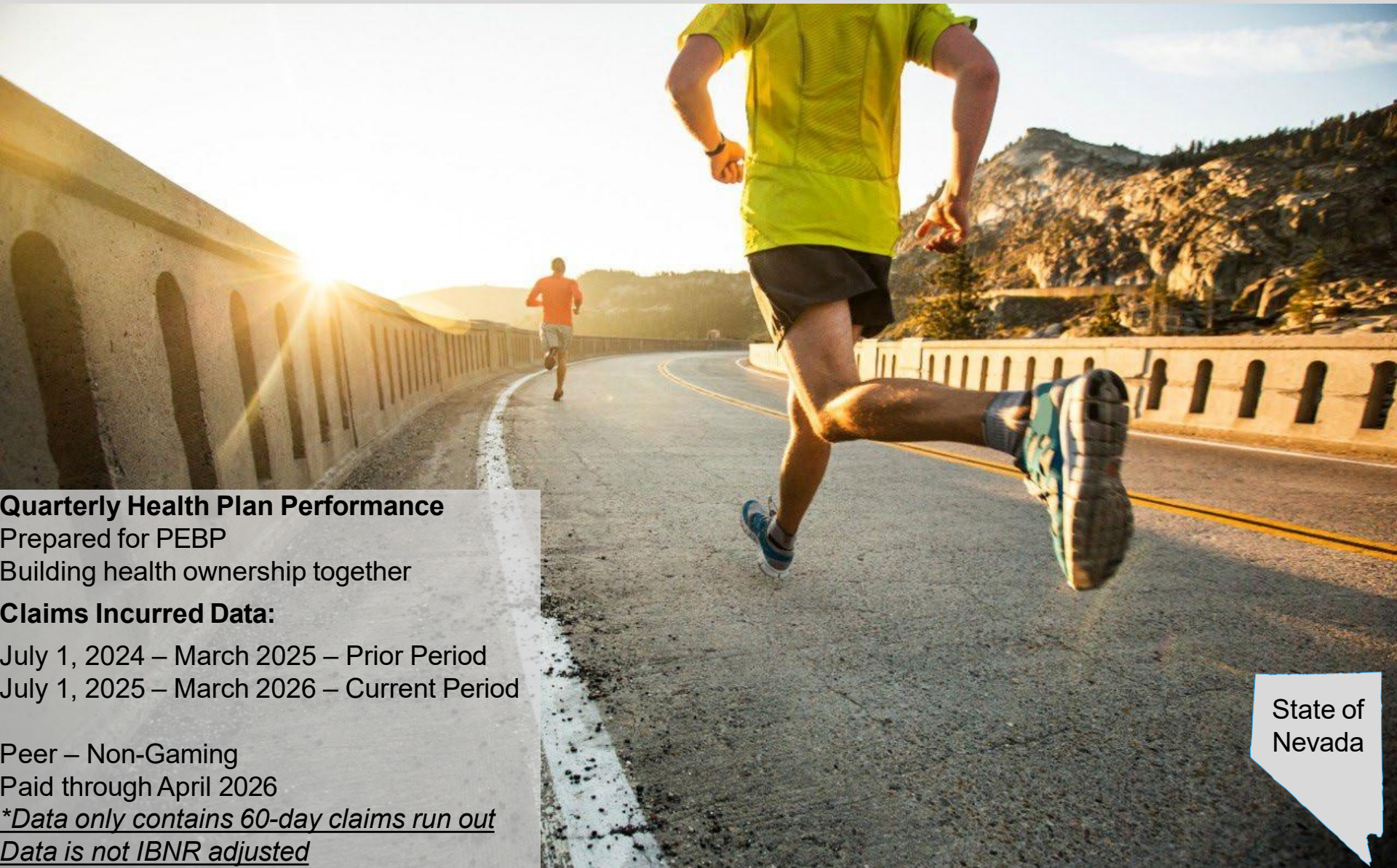
Note: Preventive Services do not include those performed at onsite clinics or ones for which no claim was submitted to UMR.



14.10

- 14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)
 - 14.1 Q3 UMR – Obesity & Diabetes Care Management
 - 14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
 - 14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management
 - 14.4 Q3 UnitedHealthcare – Basic Life Insurance
 - 14.5 Q3 Express Scripts – Utilization Report
 - 14.6 Q3 Express Scripts – Summary Report
 - 14.7 Q3 CDHP Performance Report
 - 14.8 Q3 LD PPO Performance Report
 - 14.9 Q3 EPO Performance Report
 - 14.10 Q3 HPN Performance Report**

Power Of Partnership.



Quarterly Health Plan Performance

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2024 – March 2025 – Prior Period

July 1, 2025 – March 2026 – Current Period

Peer – Non-Gaming

Paid through April 2026

**Data only contains 60-day claims run out*

Data is not IBNR adjusted

State of
Nevada

Executive Summary
Spend and Utilization

Executive Summary Utilization & Spend



Population

- -8.4% decrease for employees from prior period
- -8.6% decrease for members from prior period

Medical Paid PMPM

- 10.0% increase in medical paid PMPM from prior period
- Non-Catastrophic spend decreased -9.4% from prior period
- 25.4% increase in Catastrophic spend

High-Cost Claimants

- 64 HCC in Q3 2026, up 23.1%
- 34.9% of medical spend comes from HCC

Emergency Room

- ER Visits Per 1,000 members decreased -24.4%
- Avg. paid per ER Visit increased 13.2%
 - High Acuity level of ER visits

Urgent Care

- Urgent Care visits per 1,000 members decreased by -10.7%
- Avg. paid per Urgent care visit increased 12.0%
 - High Acuity Level of UC Visits

Rx Drivers

- Rx Net Paid PMPM increased 17.9%
- Specialty Spend increased 7.2%
- Specialty Rx driving 35.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 12.8% on PMPM basis

Executive Summary Utilization & Spend



| Claims Paid by Age Group | | | | | | | | | | | | | | |
|--------------------------|------------------|--------------|--------------|---------|-----------------|-------------|----------------------|--------------|--------------|---------|-----------------|-------------|-----------------|-----------------|
| July - March Q3 2025 | | | | | | | July - March Q3 2026 | | | | | | 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 | \$699,304 | \$1,998 | \$4,327 | \$12 | \$703,631 | \$2,010 | \$291,610 | \$791 | \$5,466 | \$15 | \$297,076 | \$806 | -57.8% | 19.9% |
| 01 | \$74,941 | \$256 | \$388 | \$1 | \$75,329 | \$257 | \$106,030 | \$343 | \$13,786 | \$45 | \$119,816 | \$387 | 34.0% | 3262.6% |
| 02-04 | \$594,010 | \$402 | \$4,679 | \$3 | \$598,690 | \$405 | \$486,304 | \$446 | \$3,167 | \$3 | \$489,470 | \$449 | 11.0% | -8.2% |
| 05-09 | \$574,997 | \$207 | \$25,700 | \$9 | \$600,696 | \$217 | \$670,377 | \$259 | \$23,759 | \$9 | \$694,136 | \$268 | 24.9% | -1.0% |
| 10-14 | \$635,903 | \$163 | \$66,264 | \$17 | \$702,167 | \$180 | \$575,221 | \$165 | \$46,620 | \$13 | \$621,841 | \$179 | 1.6% | -21.0% |
| 15-19 | \$873,687 | \$191 | \$150,603 | \$33 | \$1,024,290 | \$224 | \$761,217 | \$187 | \$168,830 | \$42 | \$930,046 | \$229 | -1.8% | 26.4% |
| 20-24 | \$864,544 | \$197 | \$204,061 | \$47 | \$1,068,606 | \$244 | \$894,831 | \$216 | \$121,202 | \$29 | \$1,016,034 | \$246 | 9.6% | -37.1% |
| 25-29 | \$741,532 | \$291 | \$261,479 | \$103 | \$1,003,011 | \$393 | \$735,158 | \$357 | \$227,075 | \$110 | \$962,233 | \$467 | 22.8% | 7.6% |
| 30-34 | \$1,119,817 | \$420 | \$394,712 | \$148 | \$1,514,528 | \$568 | \$841,505 | \$359 | \$388,554 | \$166 | \$1,230,059 | \$525 | -14.5% | 12.0% |
| 35-39 | \$1,467,910 | \$449 | \$710,348 | \$217 | \$2,178,258 | \$666 | \$1,529,472 | \$521 | \$888,826 | \$303 | \$2,418,298 | \$824 | 16.1% | 39.4% |
| 40-44 | \$1,279,434 | \$335 | \$678,216 | \$178 | \$1,957,650 | \$513 | \$1,382,328 | \$374 | \$954,376 | \$258 | \$2,336,704 | \$632 | 11.5% | 45.2% |
| 45-49 | \$2,294,044 | \$504 | \$1,423,233 | \$313 | \$3,717,277 | \$817 | \$1,806,312 | \$448 | \$1,033,090 | \$256 | \$2,839,402 | \$704 | -11.2% | -18.2% |
| 50-54 | \$2,327,232 | \$414 | \$2,051,141 | \$365 | \$4,378,373 | \$778 | \$3,324,226 | \$650 | \$2,600,614 | \$508 | \$5,924,840 | \$1,158 | 57.1% | 39.5% |
| 55-59 | \$2,052,680 | \$377 | \$2,140,596 | \$393 | \$4,193,276 | \$770 | \$2,290,061 | \$432 | \$2,511,997 | \$474 | \$4,802,058 | \$907 | 14.7% | 20.7% |
| 60-64 | \$2,127,485 | \$413 | \$1,832,405 | \$356 | \$3,959,890 | \$769 | \$3,036,800 | \$630 | \$1,934,240 | \$401 | \$4,971,040 | \$1,032 | 52.6% | 12.9% |
| 65+ | \$3,001,196 | \$764 | \$1,662,940 | \$424 | \$4,664,136 | \$1,188 | \$2,110,384 | \$567 | \$1,585,906 | \$426 | \$3,696,290 | \$993 | -25.8% | 0.6% |
| Total | \$20,728,717 | \$378 | \$11,611,091 | \$212 | \$32,339,808 | \$590 | \$20,841,836 | \$416 | \$12,507,509 | \$250 | \$33,349,345 | \$666 | 3.1% | 12.8% |

Financial Summary



| Financial and Demographic (July 2025 thru March 2026 Q2) | | | | | | | | | | | | |
|--|--------------|--------------|--------------|--------|--------------|--------------|--------------|--------|---------------------------|-------------|-------------|--------|
| | Total | | | | State Active | | | | Retiree (State/Non-State) | | | |
| Summary | Thru 3Q24 | Thru 3Q25 | Thru 3Q26 | ▲ | Thru 3Q24 | Thru 3Q25 | Thru 3Q26 | ▲ | Thru 3Q24 | Thru 3Q25 | Thru 3Q26 | ▲ |
| Avg. # Employees | 3,537 | 3,503 | 3,210 | -8.4% | 3,097 | 3,101 | 2,831 | -8.7% | 440 | 402 | 379 | -5.8% |
| Avg. # Members | 6,180 | 6,086 | 5,563 | -8.6% | 5,578 | 5,535 | 5,043 | -8.9% | 601 | 551 | 519 | -5.8% |
| Ratio | 1.7 | 1.7 | 1.7 | -0.2% | 1.8 | 1.8 | 1.8 | -0.2% | 1.4 | 1.4 | 1.4 | 0.0% |
| Financial | | | | | | | | | | | | |
| Medical Paid | \$19,207,298 | \$20,728,717 | \$20,841,836 | 0.5% | \$16,235,958 | \$18,272,310 | \$18,467,902 | 1.1% | \$2,971,340 | \$2,456,408 | \$2,373,934 | -3.4% |
| Member Paid | \$1,717,696 | \$2,012,487 | \$1,632,984 | -18.9% | \$1,222,896 | \$1,273,048 | \$1,127,728 | -11.4% | \$494,800 | \$739,438 | \$505,256 | -31.7% |
| Net Paid PEPY | \$7,241 | \$7,889 | \$8,658 | 9.7% | \$6,990 | \$7,857 | \$8,698 | 10.7% | \$9,009 | \$8,142 | \$8,361 | 2.7% |
| Net Paid PMPY | \$4,144 | \$4,541 | \$4,996 | 10.0% | \$3,881 | \$4,402 | \$4,882 | 10.9% | \$6,585 | \$5,939 | \$6,098 | 2.7% |
| Net Paid PEPM | \$603 | \$657 | \$721 | 9.7% | \$582 | \$655 | \$725 | 10.7% | \$751 | \$678 | \$697 | 2.7% |
| Net Paid PMPM | \$345 | \$378 | \$416 | 10.0% | \$323 | \$367 | \$407 | 10.9% | \$549 | \$495 | \$508 | 2.7% |
| High Cost Claimants | | | | | | | | | | | | |
| # of HCC's > \$50k | 51 | 52 | 64 | 23.1% | 37 | 43 | 53 | 23.3% | 14 | 9 | 11 | 22.2% |
| Avg. paid per claimant | \$101,840 | \$113,499 | \$115,399 | 1.7% | \$102,152 | \$115,111 | \$118,995 | 3.4% | \$101,015 | \$105,800 | \$98,074 | -7.3% |
| HCC % of Spend | 26.9% | 28.0% | 34.9% | 24.8% | 23.2% | 27.0% | 33.8% | 25.0% | 47.1% | 34.4% | 43.5% | 26.5% |
| Spend by Location (PMPY) | | | | | | | | | | | | |
| Inpatient | \$1,142 | \$1,350 | \$1,323 | -2.0% | \$994 | \$1,448 | \$1,402 | -3.2% | \$2,520 | \$2,230 | \$1,903 | -14.6% |
| Outpatient | \$1,073 | \$1,240 | \$1,273 | 2.6% | \$1,014 | \$1,194 | \$1,198 | 0.3% | \$1,583 | \$1,385 | \$1,328 | -4.1% |
| Professional | \$1,933 | \$1,952 | \$2,423 | 24.1% | \$1,873 | \$1,349 | \$1,807 | 34.0% | \$2,486 | \$2,327 | \$2,863 | 23.1% |
| Total | \$4,148 | \$4,543 | \$5,019 | 10.5% | \$3,881 | \$4,402 | \$4,882 | 10.9% | \$6,588 | \$5,942 | \$6,095 | 2.6% |

Paid Claims by Claim Type



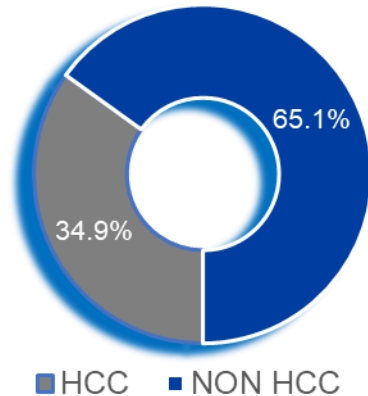
| Net Paid Claims - Total | | | | | | | | | |
|-------------------------|----------------------|--------------|-------------|--------------|----------------------|--------------|-------------|--------------|--------|
| Total Participants | | | | | | | | | |
| | July - March 2025 Q3 | | | | July - March 2026 Q3 | | | | ▲ |
| | Actives | Pre-Medicare | Medicare | Total | Actives | Pre-Medicare | Medicare | Total | |
| Medical | | | | | | | | | |
| InPatient | \$4,527,839 | \$178,808 | \$1,456,928 | \$6,163,576 | \$4,491,776 | \$0 | \$1,029,540 | \$5,521,317 | -10.4% |
| OutPatient | \$12,758,780 | \$267,952 | \$1,538,410 | \$14,565,141 | \$14,001,229 | \$221,869 | \$1,097,421 | \$15,320,519 | 5.2% |
| Total - Medical | \$17,286,619 | \$446,760 | \$2,995,338 | \$20,728,717 | \$18,493,006 | \$221,869 | \$2,126,961 | \$20,841,836 | 0.5% |
| | | | | | | | | | |
| Net Paid Claims - Total | | | | | | | | | |
| Total Participants | | | | | | | | | |
| | July - March 2025 Q3 | | | | July - March 2026 Q3 | | | | ▲ |
| | Actives | Pre-Medicare | Medicare | Total | Actives | Pre-Medicare | Medicare | Total | |
| Medical PMPM | \$347 | \$421 | \$2,823 | \$378 | \$406 | \$266 | \$572 | \$416 | 10.0% |

Cost Distribution – Medical Claims > \$50K



| July - March 3Q26 | | | | | | | July - March 3Q26 | | | | | |
|-------------------|-----------------|-------------|-----------|-----------------|-----------------------|---------------|-------------------|-----------------|-------------|-----------|-----------------|-----------------------|
| # 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 |
| 5 | 0.1% | \$1,567,888 | 7.6% | \$1,337,098 | 85.3% | > \$100k | 8 | 0.1% | \$1,749,554 | 8.4% | \$636,376 | 36.4% |
| 18 | 0.3% | \$1,438,799 | 6.9% | \$689,907 | 48.0% | \$50k- \$100k | 23 | 0.4% | \$1,671,744 | 8.0% | \$1,227,269 | 73.4% |
| 62 | 1.0% | \$2,247,270 | 10.8% | \$1,446,734 | 64.4% | \$25k - \$50k | 50 | 0.9% | \$1,999,299 | 9.6% | \$1,563,658 | 78.2% |
| 168 | 2.8% | \$3,639,400 | 17.6% | \$2,253,537 | 61.9% | \$10k - \$25k | 165 | 3.0% | \$3,858,333 | 18.5% | \$2,637,919 | 68.4% |
| 329 | 5.4% | \$2,860,183 | 13.8% | \$1,809,471 | 63.3% | \$5k - \$10k | 332 | 6.0% | \$2,859,159 | 13.7% | \$1,754,808 | 61.4% |

% Paid Attributed to Catastrophic Cases



HCC > \$50k - CCSR Chapter Conditions - Thru 3Q26

| Top 5 AHRQ Category conditions | # of Patients | Total Paid | % of Med Paid |
|---|---------------|-------------|---------------|
| Diseases of the circulatory system | 11 | \$1,805,016 | 21.9% |
| Neoplasms | 9 | \$1,679,548 | 20.4% |
| Endocrine, nutritional and metabolic diseases | 5 | \$647,983 | 7.9% |
| Certain infectious and parasitic diseases | 6 | \$632,799 | 7.7% |
| Injury, poisoning and certain other external causes | 5 | \$626,388 | 7.6% |

Utilization Summary



| Utilization Summary | | | | | | | | | |
|--------------------------------|----------------------|----------------------|--------|----------------------|----------------------|--------|-------------------------|----------------------|--------|
| | Total | | | State Active | | | Retiree State/Non-State | | |
| | July - March
3Q25 | July - March
3Q26 | ▲ | July - March
3Q25 | July - March
3Q26 | ▲ | July - March
3Q25 | July - March
3Q26 | ▲ |
| Inpatient | | | | | | | | | |
| # of Admits | 288 | 202 | -29.9% | 246 | 172 | -30.1% | 42 | 30 | -28.6% |
| # of Bedays | 1,831 | 1,132 | -38.2% | 1,449 | 841 | -42.0% | 382 | 291 | -23.8% |
| Avg. Paid per Admit | \$20,568 | \$21,025 | 2.2% | \$20,414 | \$20,899 | 2.4% | \$21,470 | \$21,750 | 1.3% |
| Avg. Paid per Day | \$3,235 | \$3,752 | 16.0% | \$3,466 | \$4,274 | 23.3% | \$2,361 | \$2,242 | -5.0% |
| Admits Per K | 63.1 | 48.4 | -23.3% | 59.3 | 45.5 | -23.3% | 101.6 | 77.0 | -24.2% |
| Days Per K | 401.1 | 271.3 | -32.4% | 349.1 | 222.3 | -36.3% | 924.0 | 747.1 | -19.1% |
| ALOS | 6.4 | 5.6 | -11.9% | 5.9 | 4.9 | -17.0% | 5.5 | 5.9 | 7.3% |
| Admits from ER | 140 | 116 | -17.1% | 117 | 98 | -16.2% | 23 | 18 | -21.7% |
| Physician Office Visits | | | | | | | | | |
| Per Member Per Year | 0.8 | 0.8 | -0.1% | 0.7 | 0.8 | 1.4% | 0.9 | 0.7 | -13.3% |
| Paid Per Visit | \$162 | \$179 | 10.9% | \$167 | \$187 | 12.0% | \$117 | \$106 | -10.1% |
| Net Paid PMPM | \$10.13 | \$11.22 | 10.7% | \$10.31 | \$11.70 | 13.5% | \$8.38 | \$6.53 | -22.1% |
| Emergency Room | | | | | | | | | |
| # of Visits | 631 | 436 | -30.9% | 574 | 385 | -32.9% | 57 | 51 | -10.5% |
| Visits Per K | 138.2 | 104.5 | -24.4% | 138.3 | 101.8 | -26.4% | 137.9 | 130.9 | -5.0% |
| Avg Paid Per Visit | \$2,961 | \$3,352 | 13.2% | \$2,979 | \$3,433 | 15.2% | \$2,778 | \$2,741 | -1.3% |
| Urgent Care | | | | | | | | | |
| # of Visits | 3,055 | 2,494 | -18.4% | 2,748 | 2,256 | -17.9% | 306 | 236 | -22.9% |
| Visits Per K | 669.3 | 597.8 | -10.7% | 662.0 | 596.4 | -9.9% | 740.2 | 605.9 | -18.1% |
| Avg Paid Per Visit | \$126 | \$141 | 12.0% | \$91 | \$96 | 5.2% | \$78 | \$79 | 2.0% |

*Not Representative of all utilization

Data based on medical spend

Diagnosis Grouper Summary – Top 25



| Top 25 CCSR Category | Total Paid | % Paid | Insured | Spouse | Dependent | Male | Female | Unassigned |
|--|------------|--------|-----------|-----------|-----------|-----------|-----------|------------|
| Respiratory failure; insufficiency; arrest | \$905,420 | 5.3% | \$170,181 | \$733,025 | \$2,214 | \$736,709 | \$168,711 | \$0 |
| Spondylopathies/spondyloarthropathy | \$853,927 | 5.0% | \$614,362 | \$238,379 | \$1,186 | \$370,496 | \$483,432 | \$0 |
| Neurodevelopmental disorders | \$831,634 | 4.9% | \$27,496 | \$2,719 | \$801,420 | \$541,402 | \$290,232 | \$0 |
| Encounter for antineoplastic therapies | \$490,238 | 2.9% | \$490,238 | | | \$25,129 | \$465,109 | \$0 |
| Diabetes mellitus with complication | \$456,255 | 2.7% | \$317,905 | \$109,925 | \$28,425 | \$334,734 | \$121,521 | \$0 |
| Sleep wake disorders | \$364,380 | 2.1% | \$308,401 | \$40,626 | \$15,353 | \$179,018 | \$185,361 | \$0 |
| Other specified and unspecified liver disease | \$327,990 | 1.9% | \$3,692 | \$323,904 | \$393 | \$325,604 | \$2,385 | \$0 |
| Septicemia | \$320,660 | 1.9% | \$269,581 | \$50,556 | \$522 | \$154,296 | \$166,364 | \$0 |
| Complication of other surgical or medical care | \$315,192 | 1.9% | \$151,487 | \$61,917 | \$101,789 | \$228,438 | \$86,754 | \$0 |
| Leukemia - acute myeloid leukemia (AML) | \$305,927 | 1.8% | \$305,927 | | | | \$305,927 | \$0 |
| Headache; including migraine | \$287,226 | 1.7% | \$140,004 | \$130,916 | \$16,306 | \$10,514 | \$276,712 | \$0 |
| Chronic kidney disease | \$272,926 | 1.6% | \$272,241 | \$685 | | \$272,926 | \$0 | \$0 |
| Breast cancer - all other types | \$272,213 | 1.6% | \$116,687 | \$155,526 | | \$1,165 | \$271,047 | \$0 |
| Cardiac dysrhythmias | \$227,402 | 1.3% | \$221,778 | \$5,625 | \$0 | \$99,450 | \$127,953 | \$0 |
| Neoplasm-related encounters | \$226,631 | 1.3% | \$192,021 | \$32,600 | \$2,009 | \$62,828 | \$163,804 | \$0 |
| Abdominal pain and other digestive/abdomen | \$223,284 | 1.3% | \$146,598 | \$55,158 | \$21,528 | \$46,669 | \$176,615 | \$0 |
| Depressive disorders | \$217,836 | 1.3% | \$129,667 | \$22,782 | \$65,386 | \$76,619 | \$141,217 | \$0 |
| Sprains and strains, initial encounter | \$197,951 | 1.2% | \$136,772 | \$34,796 | \$26,384 | \$71,840 | \$126,111 | \$0 |
| Medical examination/evaluation | \$195,596 | 1.1% | \$53,404 | \$9,532 | \$132,661 | \$80,997 | \$114,599 | \$0 |
| Other specified and unspecified upper respiratory diseases | \$195,528 | 1.1% | \$107,222 | \$70,933 | \$17,373 | \$91,694 | \$103,834 | \$0 |
| Nonspecific chest pain | \$194,938 | 1.1% | \$131,460 | \$18,869 | \$44,609 | \$75,056 | \$119,882 | \$0 |
| Other unspecified nutritional and metabolic disorders | \$192,573 | 1.1% | \$105,728 | \$86,625 | \$221 | \$105,181 | \$87,393 | \$0 |
| Respiratory cancers | \$172,893 | 1.0% | \$168,771 | \$4,121 | | \$11,703 | \$161,189 | \$0 |
| Hearing loss | \$167,216 | 1.0% | \$122,663 | \$33,581 | \$10,972 | \$92,352 | \$74,864 | \$0 |
| Other unspecified diseases of kidney and ureters | \$166,849 | 1.0% | \$141,126 | \$775 | \$24,947 | \$87,008 | \$79,841 | \$0 |

*Not Representative of all utilization

Data based on medical spend only

Mental Health Drilldown



| Top 10 Mental Health | | | | |
|---|-------------------|------------|-------------------|------------|
| CCSR Category Description | July - March 3Q25 | | July - March 3Q26 | |
| | Patients | Total Paid | Patients | Total Paid |
| Neurodevelopmental disorders | 205 | \$510,364 | 188 | \$831,634 |
| Depressive disorders | 320 | \$295,639 | 336 | \$217,836 |
| Anxiety and fear-related disorders | 409 | \$168,405 | 360 | \$139,432 |
| Trauma- and stressor-related disorders | 233 | \$115,487 | 203 | \$125,724 |
| Bipolar and related disorders | 74 | \$59,680 | 63 | \$46,272 |
| Suicidal ideation/attempt/intentional self-harm | 9 | \$26,835 | 12 | \$67,489 |
| Alcohol-related disorders | 23 | \$56,572 | 9 | \$32,883 |
| Schizophrenia spectrum other psychotic disorders | 9 | \$5,769 | 13 | \$15,085 |
| Other specified and unspecified mood disorders | 15 | \$8,156 | 17 | \$11,385 |
| Disruptive, impulse-control and conduct disorders | 7 | \$4,293 | 11 | \$11,093 |

**Not Representative of all utilization*

Data based on medical spend only

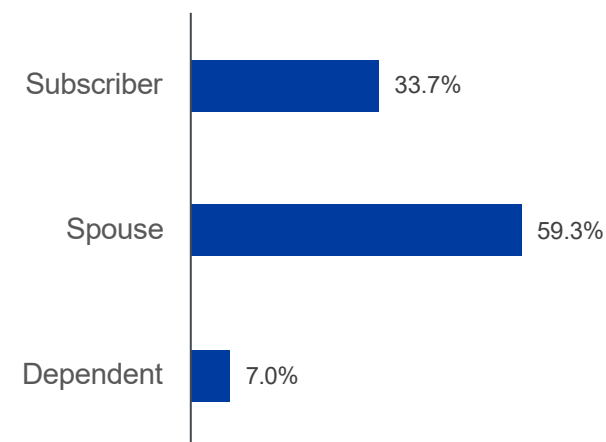
Respiratory Disorders

| Top 10 Respiratory Disorders | | | | |
|--|----------|--------|------------|--------|
| CCSR Category Description | Patients | Claims | Total Paid | % Paid |
| Respiratory failure; insufficiency; arrest | 19 | 125 | \$905,420 | 57.5% |
| Unspecified upper respiratory disease | 248 | 840 | \$195,528 | 12.4% |
| Sinusitis | 213 | 318 | \$110,694 | 7.0% |
| Pneumonia | 25 | 65 | \$98,144 | 6.2% |
| Pleural effusion and pulmonary collapse | 18 | 68 | \$63,444 | 4.0% |
| Asthma | 145 | 276 | \$62,291 | 4.0% |
| Other specified upper respiratory infections | 471 | 612 | \$40,663 | 2.6% |
| Acute and chronic tonsillitis | 45 | 72 | \$30,186 | 1.9% |
| Influenza | 74 | 84 | \$28,289 | 1.8% |
| Acute bronchitis | 165 | 198 | \$21,473 | 1.4% |

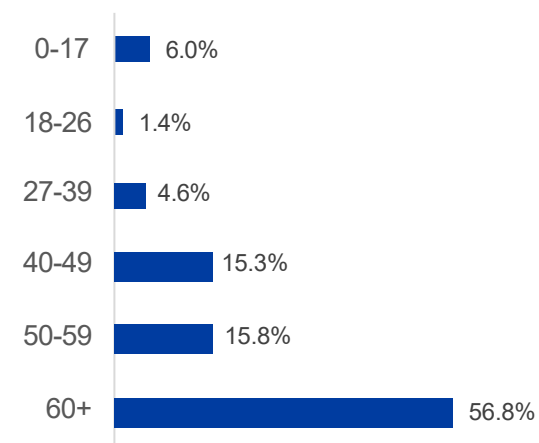
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range

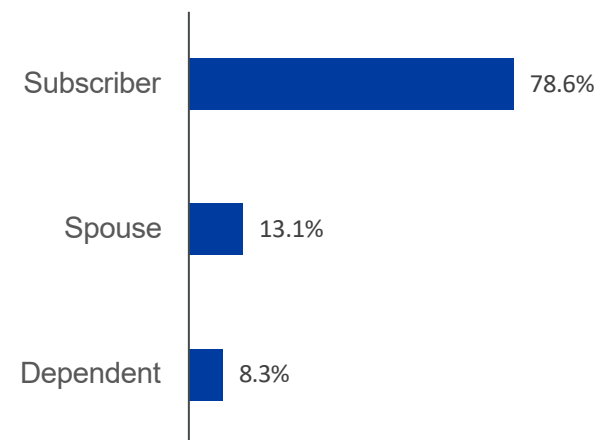


| Top 10 Infectious and Parasitic Diseases | | | | |
|---|----------|--------|------------|--------|
| CCSR Description | Patients | Claims | Total Paid | % Paid |
| Septicemia | 20 | 57 | \$320,660 | 78.4% |
| Viral infection | 100 | 146 | \$47,406 | 11.6% |
| COVID-19 | 53 | 100 | \$18,953 | 4.6% |
| Foodborne intoxications | 3 | 3 | \$12,310 | 3.0% |
| HIV infection | 27 | 161 | \$3,573 | 0.9% |
| STD (excluding HIV and hepatitis) | 18 | 24 | \$2,804 | 0.7% |
| Hepatitis | 7 | 25 | \$1,348 | 0.3% |
| Fungal infections | 70 | 94 | \$1,177 | 0.3% |
| Bacterial infections | 11 | 12 | \$691 | 0.2% |
| Parasitic, other specified and unspecified infections | 3 | 4 | \$0 | 0.0% |

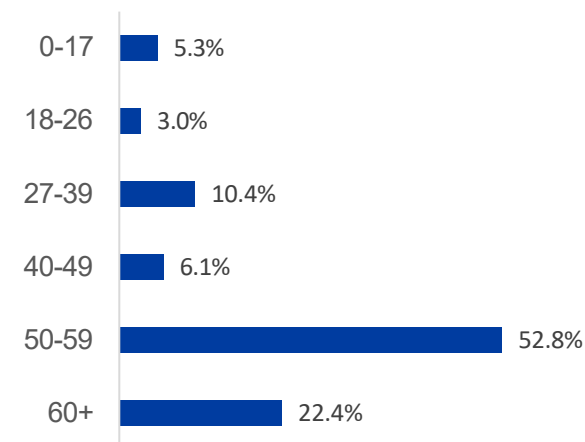
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range



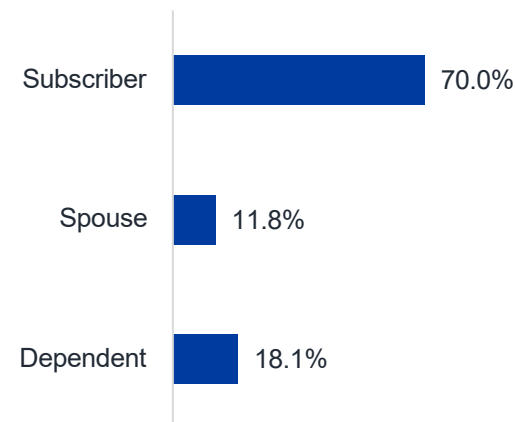
Pregnancy Related Disorders

| Top 10 Complications of Pregnancy | | | | |
|---|----------|--------|------------|--------|
| CCSR Description | Patients | Claims | Total Paid | % Paid |
| Other specified complications in pregnancy | 29 | 116 | \$72,667 | 13.5% |
| Early or threatened labor | 9 | 15 | \$63,243 | 11.8% |
| Malposition, disproportion or other labor complications | 12 | 18 | \$57,912 | 10.8% |
| Complications specified during childbirth | 14 | 18 | \$56,880 | 10.6% |
| Uncomplicated pregnancy, delivery or puerperium | 47 | 166 | \$53,740 | 10.0% |
| Diabetes or abnormal glucose tolerance complicating | 10 | 82 | \$36,365 | 6.8% |
| Early, first or unspecified trimester hemorrhage | 12 | 30 | \$35,765 | 6.7% |
| Hypertension and hypertensive-related conditions | 8 | 61 | \$35,508 | 6.6% |
| Previous C-section | 4 | 8 | \$33,798 | 6.3% |
| OB-related trauma to perineum and vulva | 5 | 6 | \$18,028 | 3.4% |

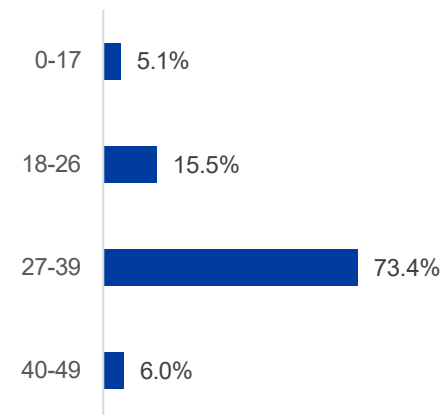
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range



Emergency Room and Urgent Care



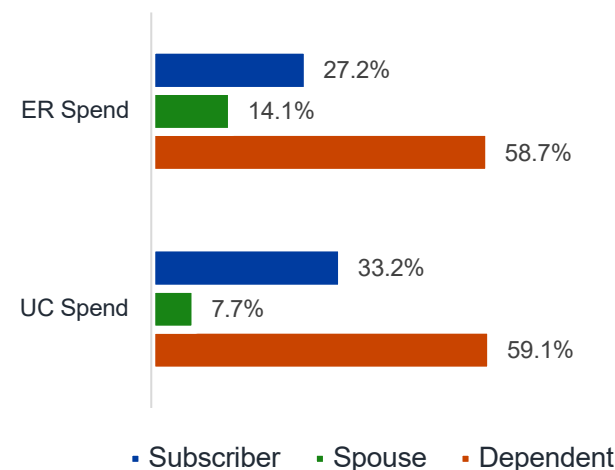
| | July - March 3Q25 | | July - March 3Q26 | | Peer | |
|---------------------|-------------------|-------------|-------------------|-------------|---------|-------------|
| Metric | ER | Urgent Care | ER | Urgent Care | ER | Urgent Care |
| # of Visits | 631 | 3,055 | 436 | 2,494 | | |
| Visits Per Member | 0.10 | 0.48 | 0.08 | 0.54 | 0.07 | 0.13 |
| Visits Per K | 138.2 | 669.3 | 104.5 | 597.8 | 104.3 | 586.2 |
| Avg. Paid Per Visit | \$2,961 | \$112 | \$3,352.20 | \$121 | \$2,891 | \$121 |

**Not Representative of all utilization*

Data based on medical spend only

| Emergency Room and Urgent Care Visits by Relationships - 3Q26 | | | | |
|---|-----------|----------|-----------|----------|
| Relationship | ER Visits | ER Per K | UC Visits | UC Per K |
| Member | 122 | 29.2 | 671 | 160.8 |
| Spouse | 46 | 11.0 | 205 | 49.1 |
| Dependent | 268 | 64.2 | 1,618 | 387.8 |
| Total | 436 | 104.5 | 2,494 | 597.8 |

ER / UC Spend by Relationship



Clinical Conditions by Medical Spend

(CCSR Chapters Conditions) *Updated as of 2026-05



| Top 15 Chapter Conditions | Members Per K | PMPM |
|---|---------------|---------|
| Diseases of the respiratory system | 210.7 | \$31.45 |
| Neoplasms | 97.3 | \$31.26 |
| Mental, behavioral and neurodevelopmental disorders | 169.3 | \$30.35 |
| Diseases of the circulatory system | 181.9 | \$28.51 |
| Diseases of the musculoskeletal system and connective tissue | 254.2 | \$28.29 |
| Factors influencing health status and contact with health services | 571.8 | \$27.10 |
| Injury, poisoning and certain other consequences of external causes | 119.2 | \$25.42 |
| Diseases of the digestive system | 122.1 | \$24.86 |
| Diseases of the nervous system | 157.8 | \$21.72 |
| Diseases of the genitourinary system | 186.2 | \$21.47 |
| Endocrine, nutritional and metabolic diseases | 293.9 | \$17.76 |
| Symptoms, signs and abnormal clinical and laboratory findings | 364.8 | \$15.98 |
| Pregnancy, childbirth and the puerperium | 12.0 | \$10.72 |
| Certain infectious and parasitic diseases | 53.0 | \$8.17 |
| Diseases of the ear and mastoid process | 57.0 | \$4.35 |

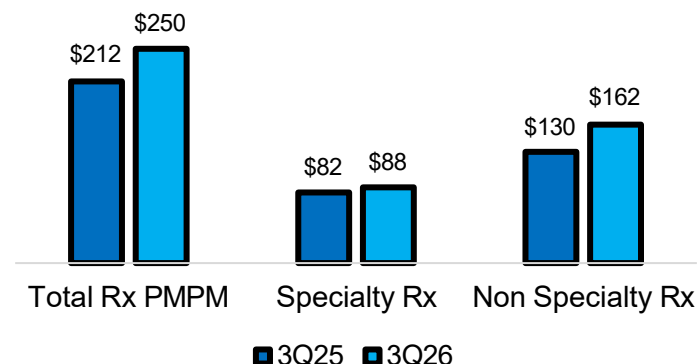
**Not Representative of all utilization*

Data based on medical spend only

Pharmacy Drivers

| | July - March
3Q25 | July - March
3Q26 | Δ |
|-------------------------------|----------------------|----------------------|-------|
| Enrolled Members | 18,258 | 16,688 | -8.6% |
| Average Prescriptions PMPY | 17.5 | 18.4 | 4.9% |
| Formulary Rate | 88.7% | 89.3% | 0.6% |
| Generic Use Rate | 85.1% | 84.6% | -0.6% |
| Generic Substitution Rate | 98.9% | 98.8% | -0.1% |
| Avg Net Paid per Prescription | \$145 | \$163 | 12.4% |
| Net Paid PMPM | \$212 | \$250 | 17.9% |

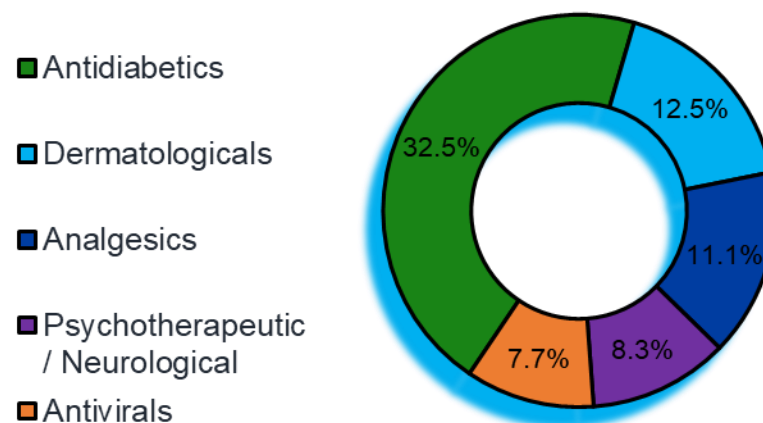
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of 17.9%, (**\$37 PMPM**) from prior period
- Avg. paid per Script increased 12.4% (**\$18 PMPM**) year over year
- Specialty Rx spend driving **35.3%** of Rx Spend
- Specialty Rx spend decreased **-9.03%** from the prior period
- Specialty Rx Drivers:
 - Mounjaro** (Antidiabetic) Spend up **60.01%**
 - Ozempic** (Antidiabetic) Spend down **-6.1%** in the current period

Top 5 Therapeutic Classes by Spend



14.11

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management

14.4 Q3 UnitedHealthcare – Basic Life Insurance

14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

14.7 Q3 CDHP Performance Report

14.8 Q3 LD PPO Performance Report

14.9 Q3 EPO Performance Report

14.10 Q3 HPN Performance Report

14.11 Q3 Dental Performance Review



Public Employees' Benefits Program

Quarterly Plan Performance Review

Dental • 2026-3Q

Claims Paid 7/1/2025 - 3/31/2026



A UnitedHealthcare Company





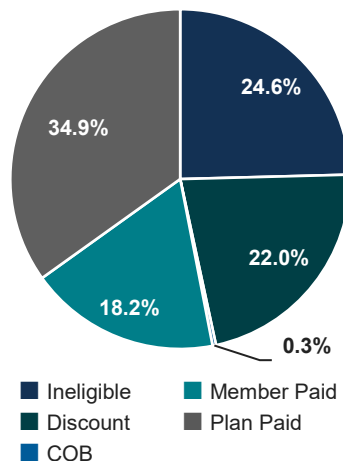
Dental Total Savings Summary

Breakouts & Network Performance

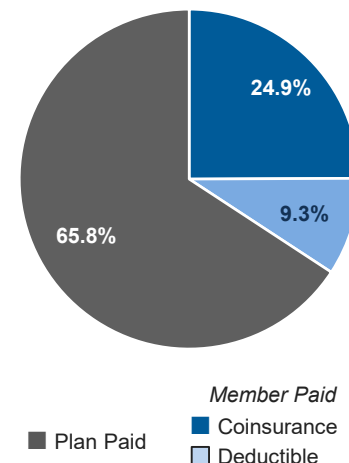
Dental Dollar Chain: Billed to Paid Dollars

| Dollar Amount | Total Dollars | PMPM |
|-------------------|---------------|----------|
| Dental Billed | \$63,522,733 | \$103.19 |
| (-) Ineligible | \$15,993,753 | \$25.98 |
| Dental Covered | \$47,528,980 | \$77.21 |
| (-) Discount | \$14,332,838 | \$23.28 |
| Dental Allowed | \$33,196,143 | \$53.92 |
| (-) COB | \$212,124 | \$0.34 |
| (-) Coinsurance | \$8,606,390 | \$13.98 |
| (-) Deductible | \$3,210,632 | \$5.22 |
| Total Member Paid | \$11,817,022 | \$19.20 |
| Total Plan Paid | \$22,702,172 | \$36.88 |

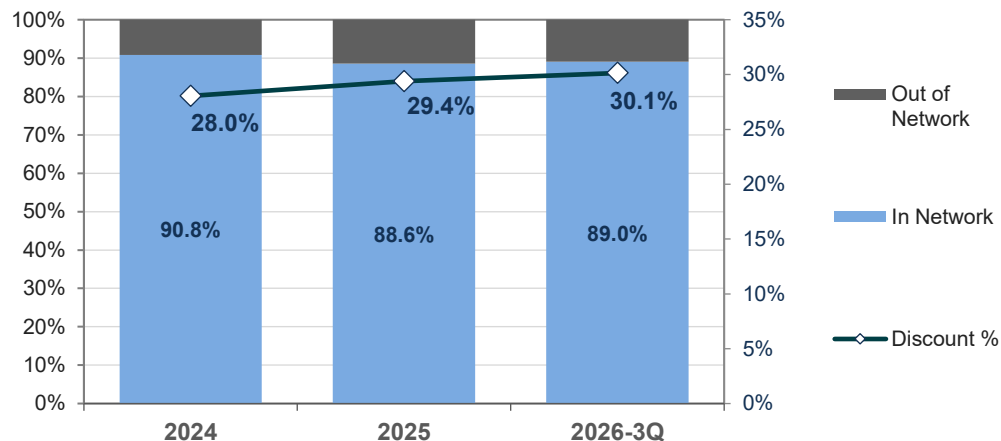
Breakout of Billed Dollars



Breakout of Paid Dollars



Dental Network Performance





Dental Claims Breakouts

Age Range, Member Cost, and Dental Category

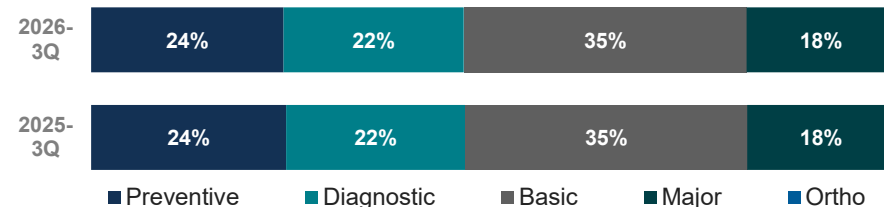
Dental Paid Claims by Age Range

| Age | 2025-3Q | | 2026-3Q | | Change | |
|---------|--------------|-----------|--------------|-----------|--------|-------|
| | Total Paid | Paid PMPM | Total Paid | Paid PMPM | Total | PMPM |
| < 01 | \$5,976 | \$1.65 | \$7,771 | \$2.07 | 30.0% | 25.0% |
| 01 | \$39,831 | \$10.40 | \$45,481 | \$10.99 | 14.2% | 5.6% |
| 02 - 04 | \$348,599 | \$24.00 | \$335,719 | \$24.13 | -3.7% | 0.5% |
| 05 - 09 | \$981,018 | \$33.81 | \$1,034,490 | \$35.73 | 5.5% | 5.7% |
| 10 - 14 | \$1,078,007 | \$31.65 | \$1,138,882 | \$32.89 | 5.6% | 3.9% |
| 15 - 19 | \$1,404,531 | \$35.34 | \$1,587,923 | \$39.87 | 13.1% | 12.8% |
| 20 - 24 | \$909,632 | \$21.50 | \$985,128 | \$23.03 | 8.3% | 7.1% |
| 25 - 29 | \$749,479 | \$24.78 | \$821,099 | \$26.22 | 9.6% | 5.8% |
| 30 - 34 | \$951,473 | \$27.13 | \$996,011 | \$28.83 | 4.7% | 6.2% |
| 35 - 39 | \$1,224,978 | \$31.05 | \$1,220,285 | \$29.76 | -0.4% | -4.2% |
| 40 - 44 | \$1,266,353 | \$30.26 | \$1,377,878 | \$31.90 | 8.8% | 5.4% |
| 45 - 49 | \$1,303,187 | \$33.27 | \$1,442,712 | \$35.22 | 10.7% | 5.9% |
| 50 - 54 | \$1,576,652 | \$35.34 | \$1,586,535 | \$36.87 | 0.6% | 4.3% |
| 55 - 59 | \$1,687,874 | \$37.46 | \$1,783,697 | \$38.93 | 5.7% | 3.9% |
| 60 - 64 | \$1,972,648 | \$42.25 | \$2,039,916 | \$44.86 | 3.4% | 6.2% |
| 65+ | \$5,999,459 | \$49.27 | \$6,298,644 | \$51.52 | 5.0% | 4.6% |
| Total | \$21,499,699 | \$35.19 | \$22,702,172 | \$36.88 | 5.6% | 4.8% |

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 | 28,613 | 38.9% | \$0 | 0.0% | \$0 | 0.0% |
| < \$0 - \$0 | 1,197 | 1.6% | -\$23,187 | -0.1% | \$121,806 | 1.0% |
| > \$0 - \$250 | 17,915 | 24.4% | \$2,812,824 | 12.4% | \$1,031,312 | 8.7% |
| > \$250 - \$500 | 12,913 | 17.6% | \$4,581,608 | 20.2% | \$1,354,794 | 11.5% |
| > \$500 - \$750 | 4,143 | 5.6% | \$2,524,453 | 11.1% | \$1,195,062 | 10.1% |
| > \$750 - \$1000 | 2,447 | 3.3% | \$2,116,153 | 9.3% | \$1,277,477 | 10.8% |
| > \$1000 | 6,257 | 8.5% | \$10,690,320 | 47.1% | \$6,836,572 | 57.9% |
| Total | 73,485 | 100.0% | \$22,702,172 | 100.0% | \$11,817,022 | 100.0% |

Paid Breakout by Dental Category



| Dental Category | 2025-3Q | | 2026-3Q | | Change |
|-----------------|----------|--------------|----------|--------------|------------|
| | Patients | Total Paid | Patients | Total Paid | Total Paid |
| Preventive | 34,354 | \$5,218,364 | 34,780 | \$5,436,342 | 4.2% |
| Diagnostic | 38,126 | \$4,784,973 | 38,961 | \$5,088,197 | 6.3% |
| Basic | 18,449 | \$7,550,480 | 18,764 | \$7,993,495 | 5.9% |
| Major | 5,742 | \$3,945,882 | 5,928 | \$4,184,137 | 6.0% |
| Orthodontia | 2 | \$0 | 4 | \$0 | - |
| Total Dental | 43,956 | \$21,499,699 | 44,418 | \$22,702,172 | 5.6% |



Dental Paid by Member Status

Breakout of State vs. Non-State by Member Status

| Program | 2025-3Q (7/1/2024 - 3/31/2025) | | | | 2026-3Q (7/1/2025 - 3/31/2026) | | | | Trend |
|--------------------------|--------------------------------|-----------------------|-------------------|--------------|--------------------------------|-----------------------|-------------------|--------------|-------|
| | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Active | Pre-Medicare Retirees | Medicare Retirees | Total | Total |
| State Members | | | | | | | | | |
| Dental | \$14,485,137 | \$1,709,570 | \$452,448 | \$16,647,155 | \$15,385,863 | \$1,708,536 | \$490,362 | \$17,584,760 | 5.6% |
| Dental Exchange | | | \$3,173,728 | \$3,173,728 | | | \$3,450,284 | \$3,450,284 | 8.7% |
| Total | \$14,485,137 | \$1,709,570 | \$3,626,176 | \$19,820,883 | \$15,385,863 | \$1,708,536 | \$3,940,646 | \$21,035,045 | 6.1% |
| PMPM | \$31.49 | \$40.26 | \$50.21 | \$34.49 | \$33.02 | \$41.64 | \$53.35 | \$36.21 | 5.0% |
| Non-State Members | | | | | | | | | |
| Dental | \$3,635 | \$47,057 | \$171,384 | \$222,076 | \$4,719 | \$36,413 | \$168,993 | \$210,125 | -5.4% |
| Dental Exchange | | | \$1,456,739 | \$1,456,739 | | | \$1,457,002 | \$1,457,002 | 0.0% |
| Total | \$3,635 | \$47,057 | \$1,628,123 | \$1,678,815 | \$4,719 | \$36,413 | \$1,625,994 | \$1,667,127 | -0.7% |
| PMPM | \$32.23 | \$46.33 | \$46.35 | \$46.30 | \$31.74 | \$53.05 | \$47.98 | \$48.01 | 3.7% |
| All Members | | | | | | | | | |
| Dental | \$14,488,772 | \$1,756,627 | \$623,833 | \$16,869,232 | \$15,390,582 | \$1,744,949 | \$659,355 | \$17,794,885 | 5.5% |
| Dental Exchange | | | \$4,630,467 | \$4,630,467 | | | \$4,907,286 | \$4,907,286 | 6.0% |
| Total | \$14,488,772 | \$1,756,627 | \$5,254,300 | \$21,499,699 | \$15,390,582 | \$1,744,949 | \$5,566,641 | \$22,702,172 | 5.6% |
| PMPM | \$31.49 | \$40.41 | \$48.94 | \$35.19 | \$33.02 | \$41.83 | \$51.66 | \$36.88 | 4.8% |

14.12

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)

14.1 Q3 UMR – Obesity & Diabetes Care Management

14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network

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14.5 Q3 Express Scripts – Utilization Report

14.6 Q3 Express Scripts – Summary Report

14.7 Q3 CDHP Performance Report

14.8 Q3 LD PPO Performance Report

14.9 Q3 EPO Performance Report

14.10 Q3 HPN Performance Report

14.11 Q3 Dental Performance Review

14.12 Q3 Doctor on Demand Engagement Report



Virtual Care Engagement Monthly Report

UMR-State of Nevada
January 2026

Member Engagement



62

Registrations This Month

376

Unique Visitors This Month

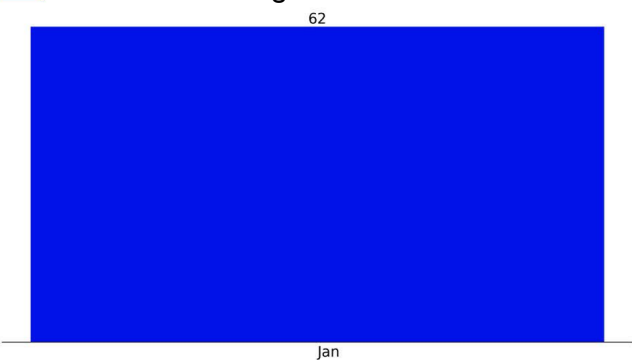
464

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)

New Member Registrations



48,935

Total Covered Lives

14,075

Registrations Lifetime to date

28.8%

Registration Rate Lifetime to date

-

Employee Covered Lives

62

Registrations Year to Date

0.1%

Registration Rate Year to Date

Visits Last 12 Months



28,158
Visits
Lifetime to Date

8,391
Unique Visitors
Lifetime to Date

3.4
Avg Visits Per Visitor
Lifetime to Date

17.1%
Engagement Rate
(Visitors/Lives)
Lifetime to Date

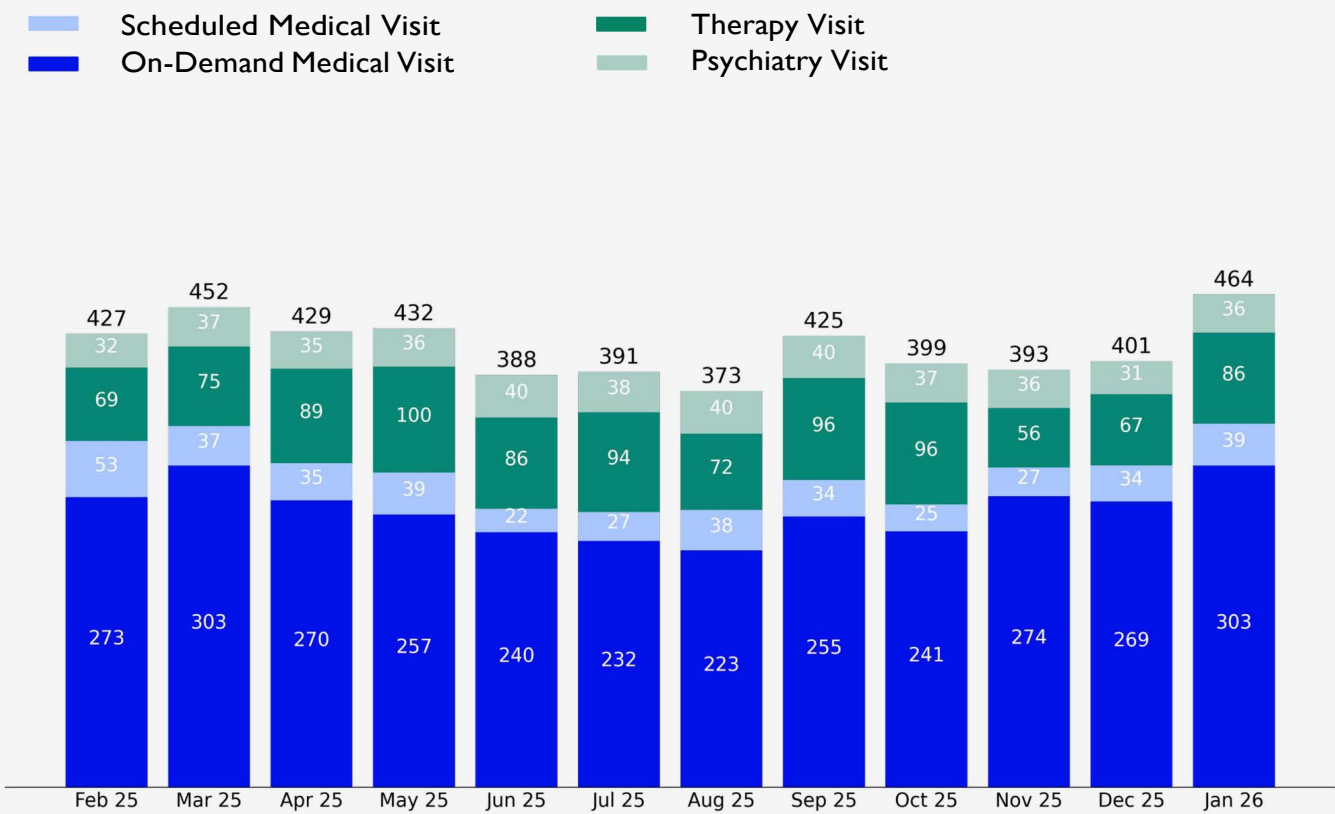
464
Visits
Year to Date

376
Unique Visitors
Year to Date

1.2
Avg Visits Per Visitor
Year to Date

0.8%
Engagement Rate
(Visitors/Lives)
Year to Date

Medical & Behavioral Health Visits (Rolling) - 4,974 Visits

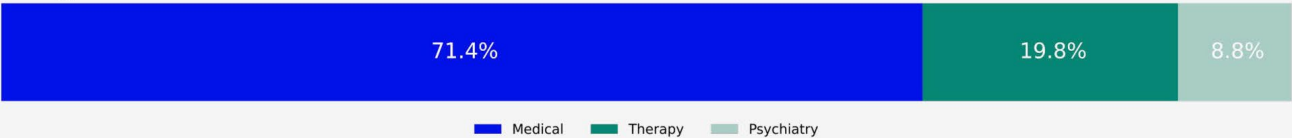


Member Demand by Visit Type Year to Date

Was the urgent care visit scheduled?



Visit Type:



Most Popular Day for Visits
Year to Date

Tuesday

Most Popular Time for Visits
Year to Date

Noon - 2PM

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

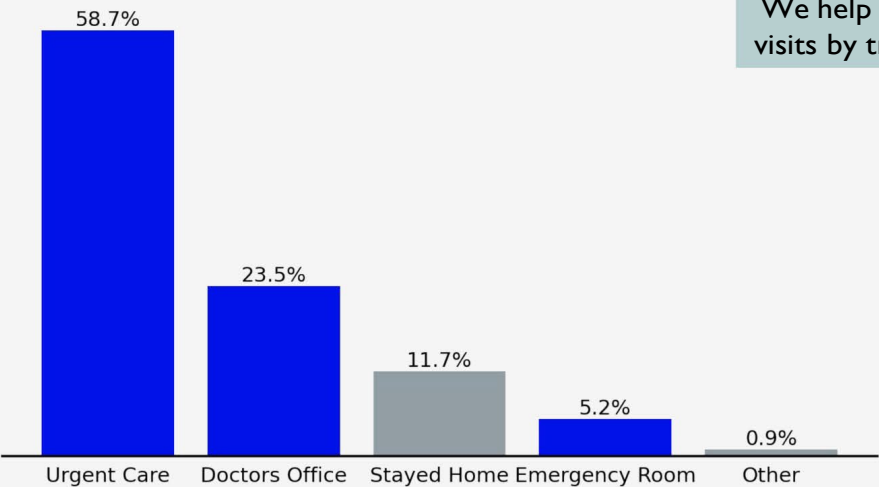
Supporting your population



Member access, demographics, and experience

Without Included Health, where would you have gone?

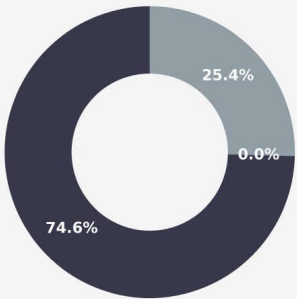
Percent Response Year to Date



We help members avoid unnecessary in-person visits by treating their needs virtually.

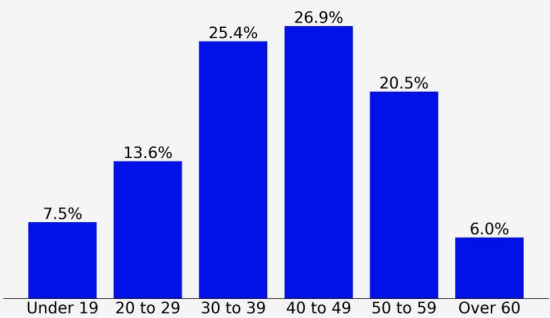
Visits by Reported Gender Year to Date

Female Male Other



Visits by Age Year to Date

Percent Distribution



| Member Experience Metrics | January | Year to Date |
|---|-------------------|-------------------|
| Average Member Rating | 4.9 / 5 (N = 262) | 4.9 / 5 (N = 262) |
| Median Wait Time for On-Demand Medical Appointments | 3.9 min | 3.9 min |

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 | 51 |
| Cough | 42 |
| Sore throat | 29 |
| Urinary tract infection (UTI) | 27 |
| Nasal congestion | 25 |
| Influenza | 24 |
| Anxiety | 22 |
| Eye issue | 12 |
| Other injury | 12 |
| Rash | 11 |

Member Conditions

Top 10 Diagnoses

| ICD-10 Diagnoses | Visits
Year to Date |
|----------------------------------|------------------------|
| Other upper respiratory infect.. | 126 |
| Anxiety disorders | 77 |
| Mood disorders | 44 |
| Bacterial infection; unspecifi.. | 39 |
| Adjustment disorders | 33 |
| Urinary tract infections | 29 |
| Influenza | 21 |
| Administrative/social admission | 16 |
| Viral infection | 16 |
| Inflammation; infection of eye.. | 15 |

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

| | | | |
|---|---|---------------------------------------|---|
| 564
Prescriptions
This Month | 84.7%
of Medical and
Psychiatry visits resulted
in a prescription order
Year to Date | 15
Lab Orders
This Month | 2.9%
of Medical visits
resulted in a lab order
Year to Date |
|---|---|---------------------------------------|---|

Top Prescriptions and Testing Orders

| Top Prescriptions | Count (YTD) |
|--------------------------------|-------------|
| benzonatate 200 mg capsule | 48 |
| amoxicillin 875 mg-potassium c | 28 |
| albuterol sulfate hfa 90 mcg/a | 26 |
| prednisone 20 mg tablet | 24 |
| nitrofurantoin monohydrate/mac | 22 |
| azelastine 137 mcg (0.1 %) nas | 2 |
| fluticasone propionate 50 mcg/ | 2 |
| doxycycline hyclate 100 mg cap | 1 |
| ipratropium bromide 42 mcg (0. | 1 |
| tamiflu 75 mg capsule | 14 |

| Top Labs | Count (YTD) |
|--------------------------------------|-------------|
| urinalysis complete, reflex culture | 5 |
| tsh + free t4, serum | 1 |
| culture, stool | 1 |
| urinalysis, complete | 1 |
| cmp, serum or plasma | 1 |
| rapid strep group a, throat | 1 |
| cbc w/ auto diff | 1 |
| uric acid, serum or plasma | 1 |
| c diff toxin a+b, qualitative, stool | 1 |
| o&p (ova & parasites), stool | 1 |

For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.



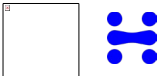
| Metric | Definition |
|-----------------------------|--|
| Behavioral Health Visit | Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first 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. |
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| 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. |
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Virtual Care Engagement Monthly Report

UMR-State of Nevada
February 2026

Member Engagement



44

Registrations This Month

319

Unique Visitors This Month

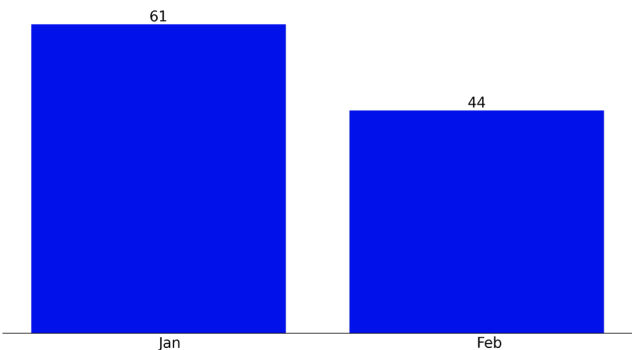
411

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)

New Member Registrations



48,935

Total Covered Lives

14,127

Registrations Lifetime to date

28.9%

Registration Rate Lifetime to date

-

Employee Covered Lives

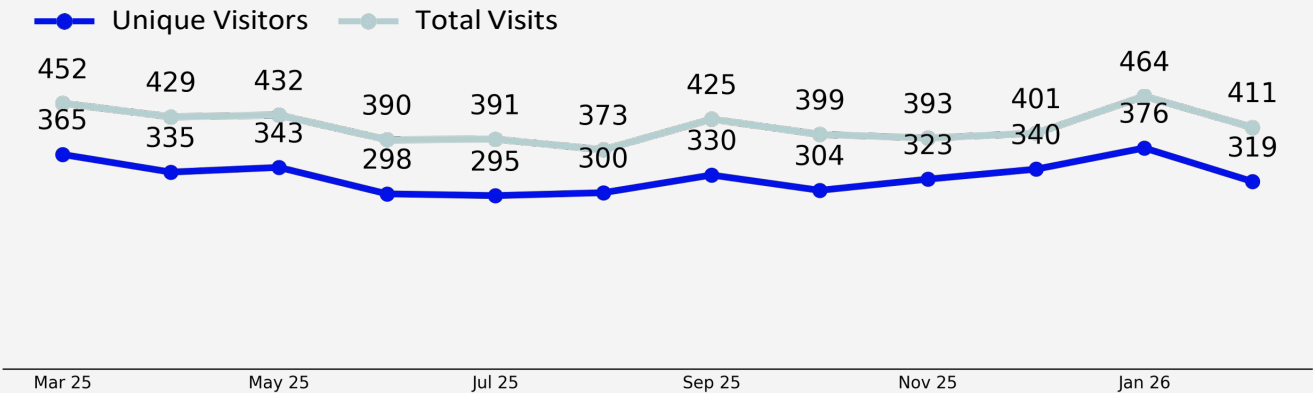
105

Registrations Year to Date

0.2%

Registration Rate Year to Date

Visits Last 12 Months



28,571

Visits Lifetime to Date

8,440

Unique Visitors Lifetime to Date

3.4

Avg Visits Per Visitor Lifetime to Date

17.2%

Engagement Rate (Visitors/Lives) Lifetime to Date

875

Visits Year to Date

607

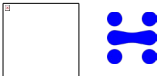
Unique Visitors Year to Date

1.4

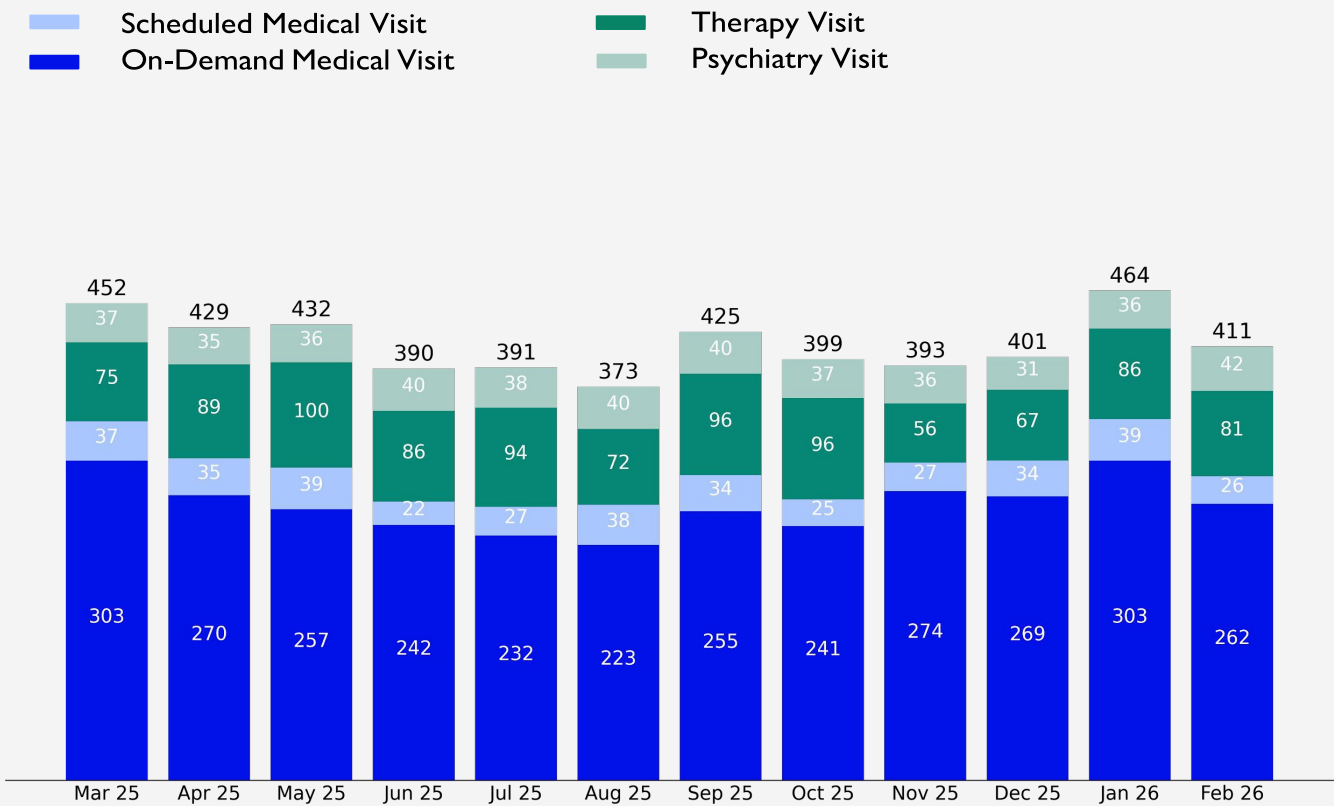
Avg Visits Per Visitor Year to Date

1.2%

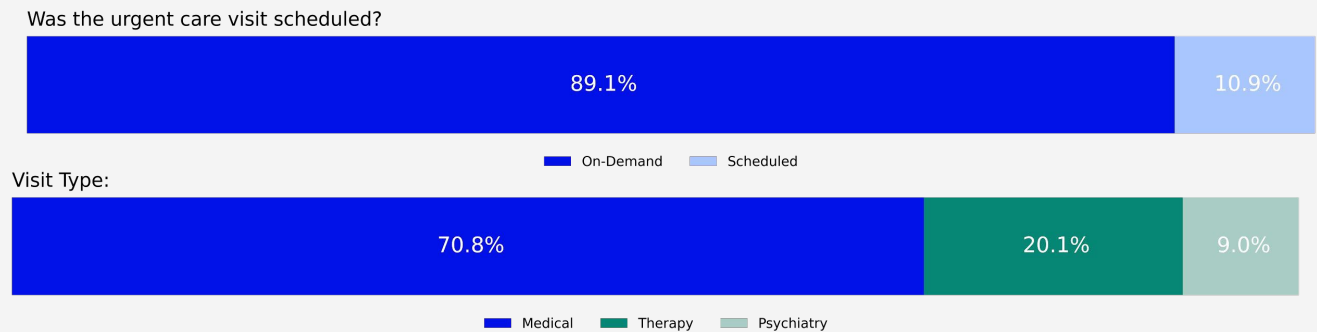
Engagement Rate (Visitors/Lives) Year to Date



Medical & Behavioral Health Visits (Rolling) - 4,960 Visits



Member Demand by Visit Type Year to Date



Most Popular Day for Visits
Year to Date

Monday

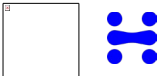
Most Popular Time for Visits
Year to Date

Noon - 2PM

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

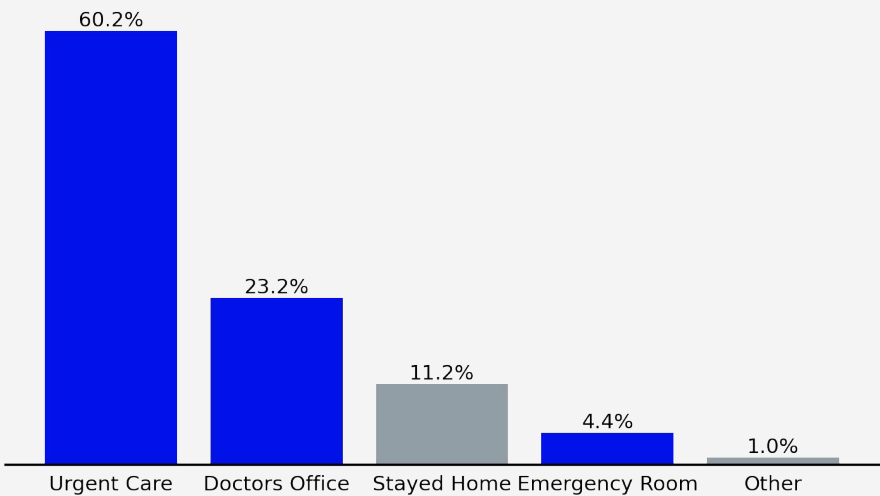
Supporting your population

Member access, demographics, and experience



Without Included Health, where would you have gone?

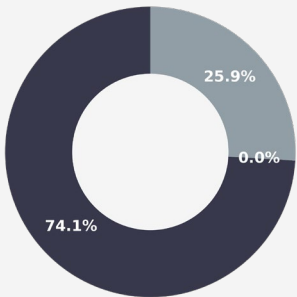
Percent Response Year to Date



We help members avoid unnecessary in-person visits by treating their needs virtually.

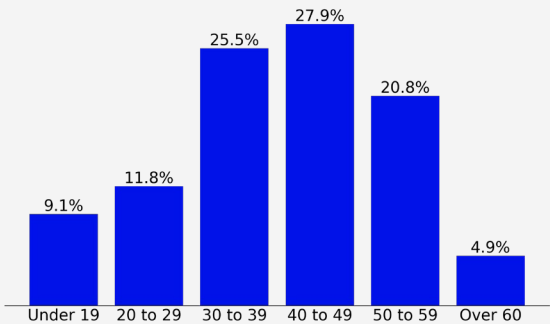
Visits by Reported Gender Year to Date

Female Male Other



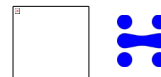
Visits by Age Year to Date

Percent Distribution



| Member Experience Metrics | February | Year to Date |
|---|-------------------|-------------------|
| Average Member Rating | 4.9 / 5 (N = 228) | 4.9 / 5 (N = 490) |
| Median Wait Time for On-Demand Medical Appointments | 17.3 min | 6.7 min |
| Median Days to Scheduled Appointment (BH) | 7.0 days | 12.0 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 | 82 |
| Cough | 73 |
| Urinary tract infection (UTI) | 60 |
| Sore throat | 50 |
| Nasal congestion | 48 |
| Anxiety | 44 |
| Influenza | 37 |
| Rash | 24 |
| Eye issue | 24 |
| Other injury | 23 |

Member Conditions

Top 10 Diagnoses

| ICD-10 Diagnoses | Visits
Year to Date |
|----------------------------------|------------------------|
| Other upper respiratory infect.. | 228 |
| Anxiety disorders | 168 |
| Mood disorders | 94 |
| Bacterial infection; unspecifi.. | 68 |
| Urinary tract infections | 59 |
| Adjustment disorders | 55 |
| Influenza | 36 |
| Residual codes; unclassified | 32 |
| Administrative/social admission | 29 |
| Viral infection | 27 |

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

| | | | |
|---|---|---------------------------------------|---|
| 477
Prescriptions
This Month | 83.5%
of Medical and
Psychiatry visits resulted
in a prescription order
Year to Date | 26
Lab Orders
This Month | 2.5%
of Medical visits
resulted in a lab order
Year to Date |
|---|---|---------------------------------------|---|

Top Prescriptions and Testing Orders

| Top Prescriptions | Count (YTD) |
|--------------------------------|-------------|
| benzonatate 200 mg capsule | 85 |
| amoxicillin 875 mg-potassium c | 61 |
| albuterol sulfate hfa 90 mcg/a | 47 |
| nitrofurantoin monohydrate/mac | 46 |
| prednisone 20 mg tablet | 41 |
| fluticasone propionate 50 mcg/ | 39 |
| azelastine 137 mcg (0.1 %) nas | 35 |
| doxycycline hyclate 100 mg cap | 28 |
| ipratropium bromide 42 mcg (0. | 26 |
| fluconazole 150 mg tablet | 23 |

| Top Labs | Count (YTD) |
|---|-------------|
| urinalysis complete, reflex culture | 8 |
| salmonella sp + shigella sp, culture, stool | 2 |
| o&p (ova & parasites), stool | 2 |
| cmp, serum or plasma | 2 |
| cbc w/ auto diff | 2 |
| c diff toxin a+b, qualitative, stool | 2 |
| h pylori ag, stool | 1 |
| tsh, ultra-sensitive, serum | 1 |
| testosterone, free + total, serum | 1 |
| lipid panel, serum | 1 |



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| 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 | <p>Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians.</p> <p>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</p> <p>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.</p> |
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Virtual Care Engagement Monthly Report



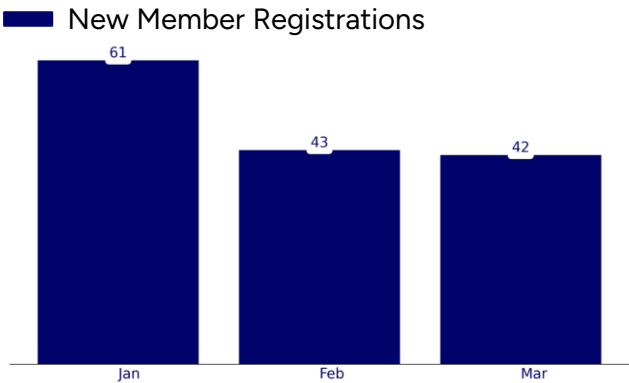
UMR-State of Nevada
March 2026

Member Engagement

| | | |
|--------------------------|----------------------------|-------------------------|
| 42 | 322 | 413 |
| Registrations This Month | Unique Visitors This Month | Total Visits This month |

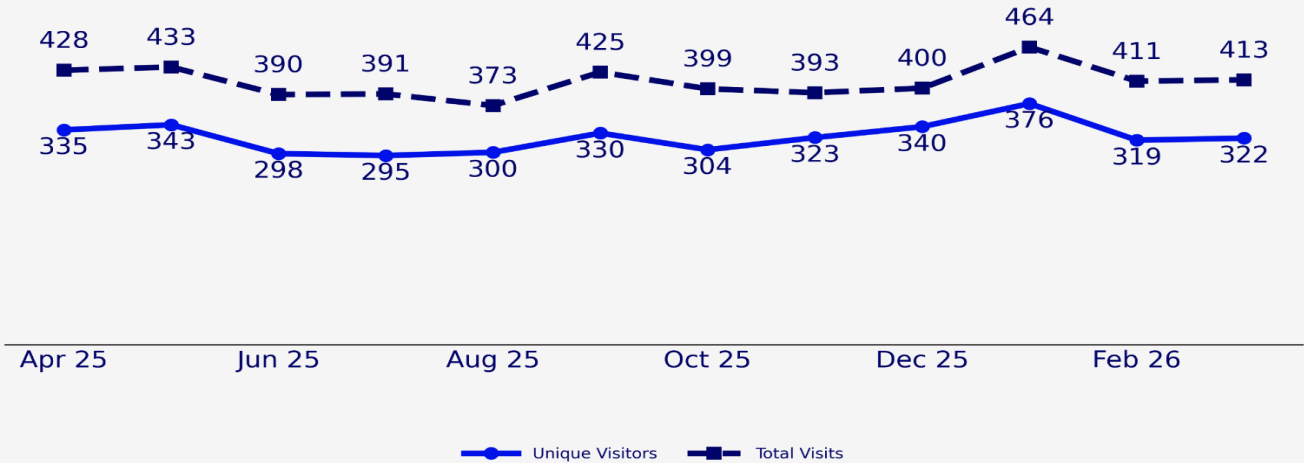
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New Registrations (Year to Date)



| | | |
|------------------------|--------------------------------|------------------------------------|
| 48,935 | 14,171 | 29% |
| Total Covered Lives | Registrations Lifetime to date | Registration Rate Lifetime to date |
| - | 146 | 0.3% |
| Employee Covered Lives | Registrations Year to Date | Registration Rate Year to Date |

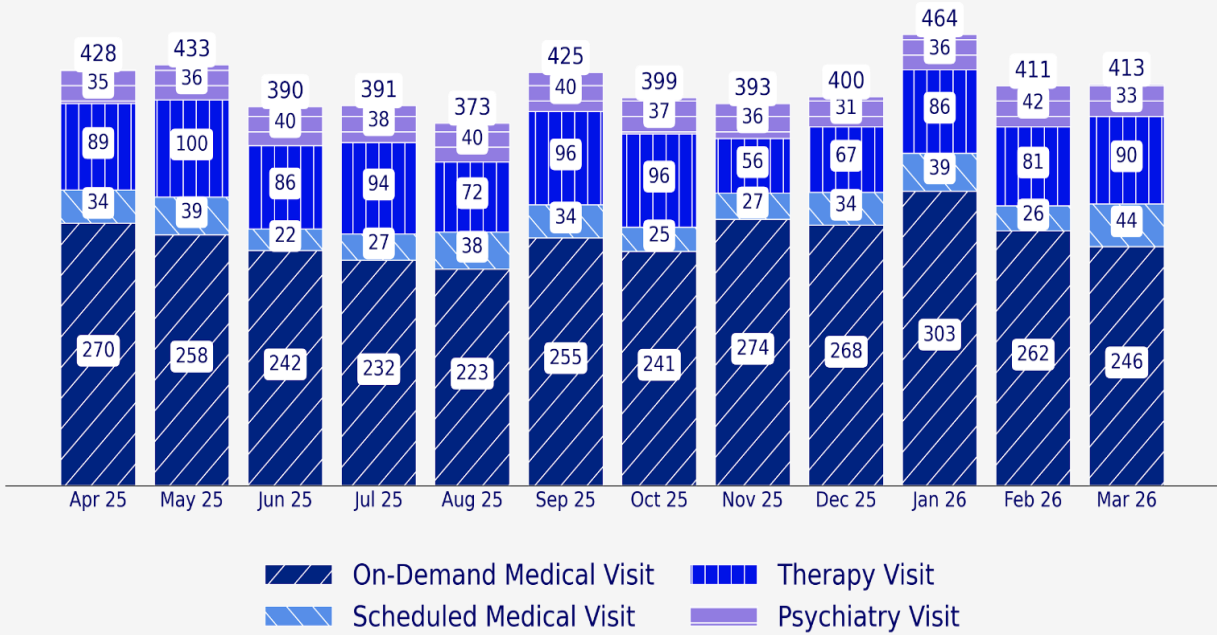
Visits Last 12 Months



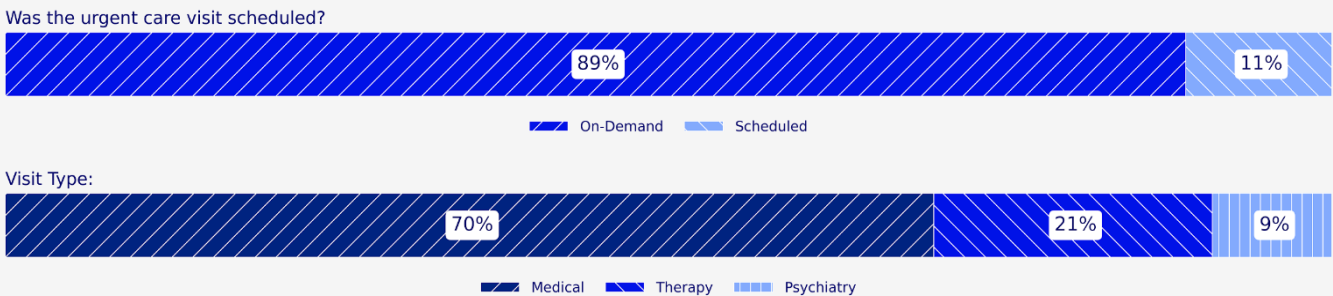
| | | | |
|-------------------------|----------------------------------|---|---|
| 28,982 | 8,490 | 3.4 | 17% |
| Visits Lifetime to Date | Unique Visitors Lifetime to Date | Avg Visits Per Visitor Lifetime to Date | Engagement Rate (Visitors/Lives) Lifetime to Date |
| 1,288 | 810 | 1.6 | 2% |
| Visits 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) - 4,920 Visits



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

2PM - 4PM

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

Supporting your population

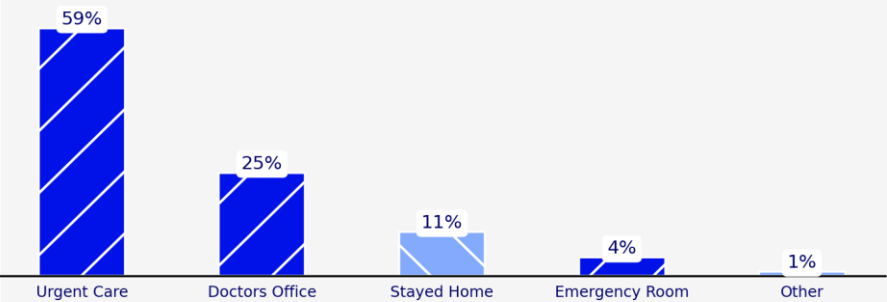
Member access, demographics, and experience

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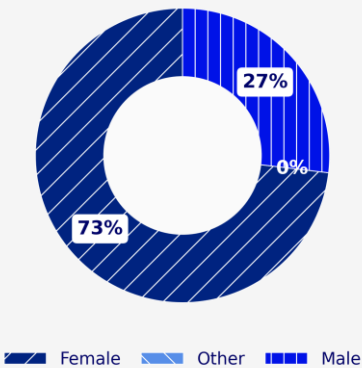
Percent Response Year to Date

Care Sites Non-Care Site

We help members avoid unnecessary in-person visits by treating their needs virtually.

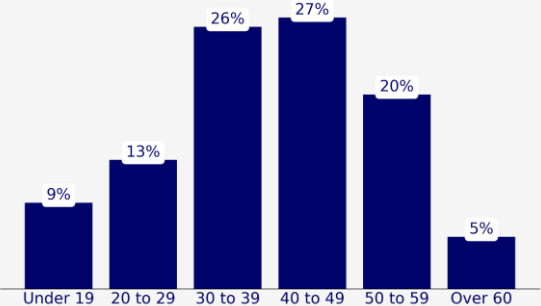


Visits by Reported Gender Year to Date



Visits by Age Year to Date

Percent Distribution



| Member Experience Metrics | March | Year to Date |
|---|-------------------|-------------------|
| Average Member Rating | 4.9 / 5 (N = 229) | 4.9 / 5 (N = 719) |
| Median Wait Time for On-Demand Medical Appointments | 16.0 min | 9.2 min |
| Median Days to Scheduled Appointment (BH) | 12.0 days | 12.0 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 | 116 |
| Cough | 105 |
| Urinary tract infection (UTI) | 88 |
| Sore throat | 73 |
| Nasal congestion | 63 |
| Anxiety | 60 |
| Influenza | 44 |
| Eye issue | 39 |
| Other injury | 35 |
| Rash | 35 |

Member Conditions

Top 10 Diagnoses

| ICD-10 Diagnoses | Visits
Year to Date |
|----------------------------------|------------------------|
| Other upper respiratory infect.. | 325 |
| Anxiety disorders | 247 |
| Mood disorders | 134 |
| Bacterial infection; unspecifi.. | 93 |
| Adjustment disorders | 87 |
| Urinary tract infections | 86 |
| Administrative/social admission | 52 |
| Influenza | 48 |
| Inflammation; infection of eye.. | 42 |
| Viral infection | 41 |

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

| | | | |
|---|--|---------------------------------------|---|
| 503
Prescriptions
This Month | 84%
of Medical and
Psychiatry visits
resulted in a
prescription order
Year to Date | 15
Lab Orders
This Month | 2%
of Medical visits
resulted in a lab order
Year to Date |
|---|--|---------------------------------------|---|

Top Prescriptions and Testing Orders

| Top Prescriptions | Count (YTD) |
|--------------------------------|-------------|
| benzonatate 200 mg capsule | 120 |
| amoxicillin 875 mg-potassium c | 89 |
| albuterol sulfate hfa 90 mcg/a | 75 |
| nitrofurantoin monohydrate/mac | 65 |
| fluticasone propionate 50 mcg/ | 63 |
| prednisone 20 mg tablet | 56 |
| azelastine 137 mcg (0.1 %) nas | 48 |
| doxycycline hyclate 100 mg cap | 41 |
| fluconazole 150 mg tablet | 35 |
| ipratropium bromide 42 mcg (0. | 32 |

| Top Labs | Count (YTD) |
|---|-------------|
| urinalysis complete, reflex culture | 10 |
| cmp, serum or plasma | 4 |
| o&p (ova & parasites), stool | 3 |
| cbc w/ auto diff | 3 |
| salmonella sp + shigella sp, culture, stool | 3 |
| unlisted lab | 2 |
| c diff toxin a+b, qualitative, stool | 2 |
| tsh + free t4, serum | 2 |
| lipid panel, serum | 2 |
| h pylori ag, stool | 2 |

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Data & Metric Definitions

| Metric | Definition |
|------------------------------------|--|
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15.

15. Public Comment.

16.

16. Adjournment.