Stacie Weeks, JD, MPH, Director

Theresa Carsten, Executive Officer

MEETING NOTICE AND AGENDA - Amended 11/10/26

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	November 17, 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/tef-eES_pOc**

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/87049843631
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: 870 4984 3631 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. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

4. Approval of Action Minutes from the October 2, 2026 Board Meeting. (Jim Wells, Board Chair)(**For Possible Action**)

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

6. Mid-Quarter Fiscal Report. (Lynnette Aaron & Stacie Weeks, NVHA Director's Office) (Information/Discussion)

7. Discussion and possible action regarding Board and Agency Duties, Policies, and Procedures, budget expenditures for PY23, 24, 25, and possible plan design changes including: (Debbie Donaldson, Segal) (**For Possible Action**)
   a. Narrowing the network for EPO
   b. Capitated vs. deferred service payments for HPN
   c. Other network opportunities

8. Express Scripts Corrective Action Plan. (Amy Donohue & Amy Daily, Express Scripts) (Information/Discussion)

9. PY26 Claims Technology Incorporated audit findings for Willis Towers Watson. (Joni Amato, CTI) (**For Possible Action**)

10. Q4 Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR. (Joni Amato, CTI) (**For Possible Action**)

11. Acceptance of Biennial Compliance Report. (Amy Dunn, Segal) (**For Possible Action**)
    *To view full report, visit the November 17, 2026 Board Meeting page at https://www.pebp.nv.gov/meetings-events/current-board-meetings/

12. Contract Status Report. (Shannan Canfield, Quality Control Officer) (**For Possible Action**)
    - 12.1 Contract Overview
    - 12.2 New Contracts
    - 12.3 Contract Amendments
    - 12.4 Status of Current Solicitations

13. CY27 Meeting Dates. (Theresa Carsten) (**For Possible Action**)

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - 14.6 Q4 Express Scripts – Summary Report
    - 14.7 Q4 CDHP Performance Report
    - 14.8 Q4 LD PPO Performance Report
    - 14.9 Q4 EPO Performance Report
    - 14.10 Q4 HPN Performance Report
    - 14.11 Q4 Dental Performance Report
    - 14.12 Q4 WTW's Individual Marketplace (Via Benefits) Enrollment & Performance Report
    - 14.13 Q4 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. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

4.

4. Approval of Action Minutes from the October 2, 2026 Board Meeting. (Jim Wells, Board Chair)
(For Possible Action)

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
October 2, 2026

MEMBERS PRESENT IN PERSON:	Mr. Jim Wells, Board Chair Dr. Keiko Duncan, Vice Chair Mr. Jim Barnes, Member Ms. Laura Rich, Member Mr. Chris Viton, Member Dr. Blaine Harper, Member Ms. Joy Grimmer, Member
MEMBERS PRESENT VIA TELECONFERENCE:	Dr. Paul Davis, Member Mr. Tom Zumtobel, Member
FOR THE BOARD:	Mr. Jose Rivera, Deputy Attorney General
FOR STAFF:	Ms. Theresa Carsten, Executive Officer Ms. Monica McJoy, Chief Financial Officer Ms. Shannan Canfield, Quality Control Officer Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Andrew Timcheck, Milliman Stacie Weeks, NVHA Director Debbie Donaldson, Segal Amy McClendon, Segal Amy Donohue, Express Scripts Joni Amato, Claim Technologies, Inc Julie Weissman, Claim Technologies, Inc

1. Open Meeting; Roll Call.
    - Board Chair Wells opened the meeting at 9:00 a.m.

2. Public Comment.
    - Kent Ervin, RPEN
    - Bruce Blackadar, Member
    - Daniel Bubb, Member
    - Ruben Murillo, RPEN
    - Adrienne Renwick, Member
    - Michael Kagan, Member
    - Trisha Lindauer, Member
    - Steven Kohl, Member
    - Jorge Fonseca, Member
    - Doug Unger, UNLV Advisory Committee
    - Martha Hildreth, Member
    - Christine Paige, Member
    - Sue Wainscott, UNLV 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 August 20, 2026 Board Meeting. (Jim Wells, Board Chair) (**For Possible Action)**

BOARD ACTION ON ITEM 4
MOTION: Motion to approve August 20, 2026 action minutes including amendment to add Laura Rich as the person who seconded the motion for agenda item 4.
BY: Member, Jim Barnes
SECOND: Vice Chair, Keiko Duncan
VOTE: Unanimous, the motion carried

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

6. PEBP Options Report. (Stacie Weeks, NVHA Director, and Milliman staff) (Information/Discussion)

7. Strategic Planning Decisions. (PEBP Board) (**For Possible Action**)
    7.1 Disease Management and Care Coordination
    7.2 Pharmacy Benefits
    7.3 Contracting Procedures

BOARD ACTION ON ITEM 7
MOTION: Motion to move forward with improving the current contract status terms for utilization and disease management.
BY: Vice Chair, Keiko Duncan
SECOND: Member, Laura Rich
VOTE: Unanimous, the motion carried.

8. Discussion and possible action regarding plan design and the State Subsidization Policy and any necessary amendments to PEBP's Board and Agency Duties, Policies and Procedures. (Debbie Donaldson, Segal) (**For Possible Action**)

BOARD ACTION ON ITEM 8

MOTION: Motion to adopt updated tier ratios; 1% for employee, 2.2% for employee + spouse, 1.45% for employee + children, 2.65% for employee + family.
BY: Member, Laura Rich
SECOND: Vice Chair, Keiko Duncan
VOTE: Ayes: Keiko Duncan, Laura Rich, Jim Barnes, Paul Davis, Joy Grimmer
Nayes: Chris Viton, Blain Harper, Tom Zumtobel
The motion carried.

MOTION: Motion to retain employee subsidization at 93.5%, retain children at 68.5%, reduce spouses to 65.5% on the AEGIS side. Reduce base retiree subsidy from 70% to 64% and dependents from 45% to 39% on the REGI side.
BY: Vice Chair, Keiko Duncan
SECOND: Member, Joy Grimmer
VOTE: Ayes: Jim Wells, Keiko Duncan, Laura Rich, Tom Zumtobel, Joy Grimmer
Nayes: Chris Viton, Blain Harper, Paul Davis, Jim Barnes
The motion carried.

9. Contract Status Report. (Shannan Canfield, Quality Control Officer) (**For Possible Action**)
   9.1 Contract Overview
   9.2 New Contracts
   9.3 Contract Amendments
   9.4 Status of Current Solicitations

BOARD ACTION ON ITEM 9

MOTION: Motion to approve the delegation of upcoming PEBP contracts to NVHA administration.
BY: Member, Joy Grimmer
SECOND: Member, Chris Viton
VOTE: Unanimous, the motion carried

10. PY24 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by Express Scripts. (Joni Amato, CTI) (**For Possible Action**)

BOARD ACTION ON ITEM 10

MOTION: Motion to accept audit report and assess penalties against Express Scripts.
BY: Member, Laura Rich
SECOND: Vice Chair, Keiko Duncan
VOTE: Unanimous, the motion carried

11. Public Comment.
    - Davida Tyson, AFSCME

12. Adjournment.

BOARD ACTION ON ITEM 12
MOTION: Motion to adjourn at 2:55 p.m.
BY: Member, Laura Rich
SECOND: Vice Chair, Keiko Duncan
VOTE: Unanimous, the motion carried

Items to bring back:

- Segal: Provide revenue, expenses, surplus, and deficits for plan years 2023, 2024, 2025
  Review narrowing the network under EPO in the north
  Reprice capitated vs deferred service type payments in the south – comparing insurance premium tax to profit margin
  Review other network opportunities
- CFO: Enhanced fiscal report to be presented at every board meeting going forward
- Executive Officer: Flowchart for budget process
- Express Scripts: Action plan in response to CTI audit

5.

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

NEVADA HEALTH AUTHORITY

Public Employees' Benefit Program Executive Officer Board Report

Theresa Carsten

Executive Officer, PEBP

November 17, 2026

Agenda

Purpose: One sentence describing the goal of this presentation and what the audience will take away.

1	**Plan Year 2027 Available Cash on Hand**
2	**Staff Hires**
3	**PEBP Budget Flow Chart**
4	**Interim Retirement and Benefits Committee (IRBC)**
5	**HPN MLR Recommendation (For Possible Action)**
6	**Kaiser Special Enrollment Update**

NEVADA HEALTH AUTHORITY

Financial Snapshot of Cash on Hand PY 2027 - BA1338

- Revenue: $ 239.1 M
  - **Revenue: 186.6M**
  - **Beginning Cash: $52.5M**
- RX Rebates: $13.8M
- Medical/Rx Claims: $200.9M

	2027 Cash As of 11.9.26	
A	Revenue and Beginning Cash	239.1M
B	RX Rebates	13.8M
C	Medical/RX claims	200.9M
D	Available cash	52M

*Aegis/Regi transfer is part of the total Revenue and Balance Forward amount.

Formula: (A+B)-C=D

NEVADA HEALTH AUTHORITY

Key Takeaway: This snapshot includes the AEGIS and REGI transfers voted on by the board in March 2026.

2022-2027 Timeline Snapshot

- 2021 Dec- Board voted to use $26M in differential cash over PY 22, 23, and 24. This money was depleted by the end of PY23. The offset to premiums continued.
- 2022 Dec-Board voted to increase HSA/HRA at an estimated $9.3M and approved adoption of several services/contracts up to $9.5M for PY 24.
- 2024 Mar- EO noted the HPN contract increased by 12% and stated there was no additional funding to buy down premiums. The board voted buy down rates with $7.3M of catastrophic reserves for PY 25.
- 2024 Sept- EO noted that the year began with $43.6M less than expected and noted that any plan design would likely increase program costs. She presented 2 rate options and noted that neither option would fund what was projected for PY 26. She also warned that PY 27 would result in sticker shock due to reserves being depleted year over year. The board did not request rates be set to meet the needs of the program.
- 2025 Mar- At the board meeting, Segal presented on how PEBP membership health risk continues to grow as do the costs of treatment, and the EO presented that PEBP had been required to use IBNR and Cat reserves to keep the plan afloat. Stating that PY 26 rates required an increase and that PY 27 would "need a miracle" to survive plan cost increases.
- 2025 Budget Closing Document Page 42 under Participant Premium Section indicates PY 26 rates were set lower than presented during session due to updates in trend etc but that plan year 27 premiums are estimated to increase for each plan, but for the HMO/EPO premium increases of $162 to $392 were expected dependent on plan tier. **PY 27 rates for the HMO/EPO with phase in increased $379 for members in the Employee +Family tier.** *OpenExhibitDocument
- PY 2026 –State funding increased by $37M (30%). However, in PY 26 members paid 28% of costs, as PEBP YOY picked up trend and inflation costs by not increasing premiums. A 5.3% increase to PEBP was approximately $30M. As presented by Segal during the March meeting the majority of the 30% increase in revenue went to offset premiums.
- PY 27- Revenue will decrease this program year as AEGIS will decrease from $991 to $943, or $48. Additionally, member premiums will be phased in and is a loss of $30M in member premiums. Total projected loss of $36M in PY 27.

NEVADA HEALTH AUTHORITY

Staff New Hires

Janice Hadlock-Burnett,
Operations Officer
11/9/2026

Jose Rivera
Legal Counsel
12/7/2026



NEVADA HEALTH AUTHORITY

PEBP Remaining Recruitments: Chief Financial Officer, Management Analyst II, and Administrative Assistant.

Even Year Budget Activities

- Budget Kickoff starts statewide March of every even year. Agencies typically build budgets, capped at no more than 2x their base budget.
- PEBP typically submits a budget based on caseload growth, cost inflation, and current plan design, plus any enhancements or reductions known about at the time.



NEVADA HEALTH AUTHORITY

Important Note: The PEBP board must adjust member premiums or plan design to account for the subsidized AEGIS/REGI funding amounts finalized during budget approval by lawmakers if less than requested.

Interim Retirement and Benefits Committee

- Tentatively Scheduled for December 2026
- Some audits are not available for November submission to the IRBC committee and will be forwarded as PEBP staff receive them.
  - **State Retirees' Health & Welfare Benefits Fund**
  - **Fund for the Public Employee's Benefit Program**

NEVADA HEALTH AUTHORITY

HPN MLR Premium Reduction (For Possible Action)

- See Segal's attached letter.
- Recommendation: Staff recommend that the board approve a one-time premium reduction ($26.64) for members currently enrolled in HPN to be processed no later than January 2027.

NEVADA HEALTH AUTHORITY

Kaiser Special Enrollment Period Update

- CMS authorized a special enrollment period for members of the Senior Care Plus plan
- Kaiser/SCP sent a notice to members pertaining to the special enrollment period.
- PEBP staff worked with VIA Benefits and RPEN on language to educate members about working with VIA Benefits to ensure there was no lapse in coverage; while selecting new plans.

NEVADA HEALTH AUTHORITY

Thank You

NEVADA HEALTH AUTHORITY

Program Year 2022 Budget Acct 1338

Fiscal Year	Unit	Code	Description	YTD Actual
'2022	'1338	'42	'APPROPRIATIONS	$6,009,449.00
'2022	'1338	'45	'REVERSIONS	-$148,854,786.00
'2022	'1338	'47	'BEGINNING CASH	$159,011,280.00
'2022	'1338	'3817	'MEDICAL SERVICES CHARGE	$271,854.35
'2022	'1338	'4218	'PPO RX REBATES	$14,992,095.84
'2022	'1338	'4254	'MISCELLANEOUS REVENUE	$21,183.24
'2022	'1338	'4319	'NON-STATE RETIREE PREMIUM	$3,156,880.20
'2022	'1338	'4321	'NON-STATE SUBSIDY	$23,317,959.49
'2022	'1338	'4323	'STATE EMPLOYEE PREMIUM	$57,708,825.26
'2022	'1338	'4325	'STATE SUBSIDIES	$263,885,831.95
'2022	'1338	'4326	'TREASURER'S INTEREST DISTRIB	$1,075,703.16
'2022	'1338	'4611	'TRANSFER IN FED ARPA	$1,950,000.00
'2022	'1338	'4669	'TRANS FROM OTHER B/A SAME FUND	$8,557,308.00
				$391,103,584.49
				$363,061,592.74

Fiscal Yea	Category	Description	Expended
'2022	'01	'PERSONNEL SERVICES	$2,382,789.57
'2022	'02	'OUT OF STATE TRAVEL	$0.00
'2022	'03	'IN STATE TRAVEL	$1,822.42
'2022	'04	'OPERATING	$2,919,211.02
'2022	'26	'INFORMATION SERVICES	$209,394.39
'2022	'30	'TRAINING	$4,020.62
'2022	'40	'STATE EMPLOYEE INSURANCE COST	$337,171,319.97
'2022	'42	'NON STATE EMPLOYEE INS COSTS	$8,333,545.20
'2022	'44	'STATE MEDICARE RET INS COST	$39,127,338.23
'2022	'80	'DHRM COST ALLOCATION	$12,716.00
'2022	'82	'HRA RESERVE	$0.00
'2022	'84	'IBNR RESERVE	$0.00
'2022	'85	'CATASTROPHIC RESERVE	$0.00
'2022	'86	'RESERVE	$0.00
'2022	'87	'PURCHASING ASSESSMENT	$29,093.00
'2022	'88	'ST COST PLAN RECOVERY	$44,159.00
'2022	'93	'RESERVE FOR REVERSION	$868,175.00
			$391,103,584.42
			$384,632,203.40

$363,061,592.74	$384,632,203.40	-$21,570,610.66

NEVADA HEALTH AUTHORITY

Program Year 2023 Budget Acct 1338

Fiscal Yea	Code	Description	YTD Actual
'2023	'42	'APPROPRIATIONS	$6,009,449.00
'2023	'45	'REVERSIONS	-$120,714,436.00
'2023	'47	'BEGINNING CASH	$148,854,786.00
'2023	'3817	'MEDICAL SERVICES CHARGE	$170,722.63
'2023	'4218	'PPO RX REBATES	$27,042,531.62
'2023	'4254	'MISCELLANEOUS REVENUE	$36,576.39
'2023	'4319	'NON-STATE RETIREE PREMIUM	$2,874,608.97
'2023	'4321	'NON-STATE SUBSIDY	$21,830,986.65
'2023	'4323	'STATE EMPLOYEE PREMIUM	$59,860,417.68
'2023	'4325	'STATE SUBSIDIES	$272,748,396.31
'2023	'4326	'TREASURER'S INTEREST DISTRIB	$3,259,750.92
'2023	'4611	'TRANSFER IN FED ARPA	$29,387.28
			$422,003,177.45
			$384,356,941.23

Fiscal Yea	Category	Description	Expended
'2023	'01	'PERSONNEL SERVICES	$2,320,129.83
'2023	'02	'OUT OF STATE TRAVEL	$0.00
'2023	'03	'IN STATE TRAVEL	$3,172.06
'2023	'04	'OPERATING	$3,400,154.11
'2023	'26	'INFORMATION SERVICES	$289,724.76
'2023	'30	'TRAINING	$0.00
'2023	'40	'STATE EMPLOYEE INSURANCE COST	$366,101,011.68
'2023	'42	'NON STATE EMPLOYEE INS COSTS	$10,169,089.61
'2023	'44	'STATE MEDICARE RET INS COST	$38,885,342.60
'2023	'80	'DHRM COST ALLOCATION	$12,716.00
'2023	'82	'HRA RESERVE	$0.00
'2023	'84	'IBNR RESERVE	$0.00
'2023	'85	'CATASTROPHIC RESERVE	$0.00
'2023	'86	'RESERVE	$0.00
'2023	'87	'PURCHASING ASSESSMENT	$17,885.00
'2023	'88	'ST COST PLAN RECOVERY	$70,083.00
'2023	'89	'AG COST ALLOCATION PLAN	$6,538.00
'2023	'93	'RESERVE FOR REVERSION	$727,330.00
			$422,003,176.65
			$415,155,443.89

$384,356,941.23	$415,155,443.89	-$30,798,502.66

NEVADA HEALTH AUTHORITY

Program Year 2024 Budget Acct 1338

Fiscal Yea	Code	Description	YTD Actual
'2024	'42	'APPROPRIATIONS	$11,816,381.00
'2024	'45	'REVERSIONS	-$94,462,850.00
'2024	'47	'BEGINNING CASH	$120,714,437.00
'2024	'3817	'MEDICAL SERVICES CHARGE	$446,190.51
'2024	'4201	'MEDICARE PART D SUBSIDY	$0.00
'2024	'4203	'PRIOR YEAR REVENUE	$2,493,232.87
'2024	'4218	'PPO RX REBATES	$26,120,286.57
'2024	'4254	'MISCELLANEOUS REVENUE	$11,714.07
'2024	'4319	'NON-STATE RETIREE PREMIUM	$2,666,526.63
'2024	'4321	'NON-STATE SUBSIDY	$20,408,992.95
'2024	'4323	'STATE EMPLOYEE PREMIUM	$65,166,412.18
'2024	'4325	'STATE SUBSIDIES	$300,658,001.25
'2024	'4326	'TREASURER'S INTEREST DISTRIB	$5,149,192.87
			$461,188,517.90
			$415,020,219.58

Fiscal Yea	Category	Description	Expended
'2024	'01	'PERSONNEL SERVICES	$2,722,805.46
'2024	'02	'OUT OF STATE TRAVEL	$0.00
'2024	'03	'IN STATE TRAVEL	$1,307.09
'2024	'04	'OPERATING	$2,825,959.11
'2024	'26	'INFORMATION SERVICES	$88,384.23
'2024	'30	'TRAINING	$1,777.67
'2024	'40	'STATE EMPLOYEE INSURANCE COST	$408,353,811.72
'2024	'42	'NON STATE EMPLOYEE INS COSTS	$7,347,844.86
'2024	'44	'STATE MEDICARE RET INS COST	$39,765,715.22
'2024	'80	'DHRM COST ALLOCATION	$9,897.00
'2024	'82	'HRA RESERVE	$0.00
'2024	'84	'IBNR RESERVE	$0.00
'2024	'85	'CATASTROPHIC RESERVE	$0.00
'2024	'86	'RESERVE	$0.00
'2024	'87	'PURCHASING ASSESSMENT	$5,892.00
'2024	'88	'ST COST PLAN RECOVERY	$62,230.00
'2024	'89	'AG COST ALLOCATION PLAN	$2,893.00
			$461,188,517.36
			$455,467,371.80

$415,020,219.58	$455,467,371.80	-$40,447,152.22

NEVADA HEALTH AUTHORITY

Program Year 2025 Budget Acct 1338

Fiscal Yea	Code	Description	YTD Actual
'2025	'42	'APPROPRIATIONS	$12,055,061.00
'2025	'45	'REVERSIONS	-$66,888,127.00
'2025	'47	'BEGINNING CASH	$94,373,969.00
'2025	'3817	'MEDICAL SERVICES CHARGE	$180,607.79
'2025	'4218	'REBATE	$41,577,854.22
'2025	'4254	'MISCELLANEOUS REVENUE	$1,652.72
'2025	'4319	'NON-STATE RETIREE PREMIUM	$2,678,135.93
'2025	'4321	'NON-STATE SUBSIDY	$19,910,977.65
'2025	'4323	'STATE EMPLOYEE PREMIUM	$75,339,846.34
'2025	'4325	'STATE SUBSIDIES	$329,073,052.13
'2025	'4326	'TREASURER'S INTEREST DISTRIB	$3,198,576.00
			$511,501,605.78
			$468,579,866.27

Fiscal Yea	Category	Description	Expended
'2025	'01	'PERSONNEL SERVICES	$3,357,171.87
'2025	'02	'OUT OF STATE TRAVEL	$0.00
'2025	'03	'IN STATE TRAVEL	$691.95
'2025	'04	'OPERATING	$2,951,072.11
'2025	'26	'INFORMATION SERVICES	$110,382.14
'2025	'30	'TRAINING	$0.00
'2025	'40	'STATE EMPLOYEE INSURANCE COST	$457,660,867.16
'2025	'42	'NON STATE EMPLOYEE INS COSTS	$6,629,253.78
'2025	'44	'STATE MEDICARE RET INS COST	$40,695,530.00
'2025	'80	'DHRM COST ALLOCATION	$9,897.00
'2025	'82	'HRA RESERVE	$0.00
'2025	'84	'IBNR RESERVE	$0.00
'2025	'85	'CATASTROPHIC RESERVE	$0.00
'2025	'86	'RESERVE	$0.00
'2025	'87	'PURCHASING ASSESSMENT	$5,892.00
'2025	'88	'ST COST PLAN RECOVERY	$37,212.00
'2025	'89	'AG COST ALLOCATION PLAN	$43,635.00
			$511,501,605.01
			$504,985,650.94

$468,579,866.27	$504,985,650.94	-$36,405,784.67

NEVADA HEALTH AUTHORITY

Program Year 2026 Budget Acct 1338

Fiscal Yea	Code	Description	YTD Actual
'2026	'45	'REVERSIONS	-$52,552,486.00
'2026	'47	'BEGINNING CASH	$66,888,128.00
'2026	'3817	'MEDICAL SERVICES CHARGE	$602,810.59
'2026	'4156	'PENALTIES	$6,804.61
'2026	'4218	'REBATE	$37,133,744.56
'2026	'4254	'MISCELLANEOUS REVENUE	$19,500.00
'2026	'4319	'NON-STATE RETIREE PREMIUM	$2,736,949.91
'2026	'4321	'NON-STATE SUBSIDY	$19,173,849.59
'2026	'4323	'STATE EMPLOYEE PREMIUM	$84,884,821.59
'2026	'4325	'STATE SUBSIDIES	$402,815,608.83
'2026	'4326	'TREASURER'S INTEREST DISTRIB	$1,923,809.96
			$563,633,541.64
			$546,744,974.48

Fiscal Yea	Category	Description	Expended
'2026	'01	'PERSONNEL SERVICES	$3,414,823.53
'2026	'02	'OUT OF STATE TRAVEL	$0.00
'2026	'03	'IN STATE TRAVEL	$2,794.88
'2026	'04	'OPERATING	$2,882,812.23
'2026	'26	'INFORMATION SERVICES	$142,691.38
'2026	'30	'TRAINING	$3,025.48
'2026	'40	'STATE EMPLOYEE INS COST	$507,977,628.72
'2026	'42	'NON STATE EMPLOYEE INS COSTS	$7,957,636.46
'2026	'44	'STATE MEDICARE RET INS COST	$41,119,941.50
'2026	'80	'DHRM COST ALLOCATION	$25,909.00
'2026	'82	'HRA RESERVE	$0.00
'2026	'84	'IBNR RESERVE	$0.00
'2026	'85	'CATASTROPHIC RESERVE	$0.00
'2026	'86	'RESERVE	$0.00
'2026	'88	'STATEWIDE COST ALLOCATION	$39,356.00
'2026	'89	'AG COST ALLOCATION PLAN	$21,493.00
'2026	'93	'RESERVE FOR REVERSION	$45,429.00
			$563,633,541.18
			$557,055,206.68

$546,744,974.48	$557,055,206.68	-$10,310,232.20

NEVADA HEALTH AUTHORITY

Program Year 2027 Budget Acct 1338

Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'BEGINNING CASH	$52,552,487.00		'2027	'01	'PERSONNEL SERVICES	$1,181,595.96
'MEDICAL SERVICES CHARGE	$313,945.96		'2027	'02	'OUT OF STATE TRAVEL	$0.00
'PENALTIES	$6,022.51		'2027	'03	'IN STATE TRAVEL	$195.67
'REBATE	$13,883,253.81		'2027	'04	'OPERATING	$984,429.87
'MISCELLANEOUS REVENUE	$250.00		'2027	'26	'INFORMATION SERVICES	$28,800.36
'NON-STATE RETIREE PREMIUM	$802,819.69		'2027	'30	'TRAINING	$0.00
'NON-STATE SUBSIDY	$5,995,970.03		'2027	'40	'STATE EMPLOYEE INS COST	$184,116,272.95
'STATE EMPLOYEE PREMIUM	$35,248,237.98		'2027	'42	'NON STATE EMPLOYEE INS COSTS	$1,575,855.65
'STATE SUBSIDIES	$144,557,094.63		'2027	'44	'STATE MEDICARE RET INS COST	$15,214,602.70
'TREASURER'S INTEREST DISTRIB	$0.00		'2027	'80	'DHRM COST ALLOCATION	$12,954.50
			'2027	'82	'HRA RESERVE	$0.00
	$200,487,376.14		'2027	'84	'IBNR RESERVE	$0.00
			'2027	'85	'CATASTROPHIC RESERVE	$0.00
			'2027	'86	'RESERVE	$0.00
			'2027	'88	'RESERVE	$6,502.75
			'2027	'89	'AG COST ALLOCATION PLAN	$25,697.50
11/9/2026						
						$200,906,731.30

$200,487,376.14	$200,906,731.30	-$419,355.16

NEVADA HEALTH AUTHORITY

Program Year 2022 Budget Account 1368 (REGI)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Year	Category	Description	Expended
'2022	'4326	'TREASURER'S INTEREST DISTRIB	$18,641.64		'2022	'10	'RETIRED GROUP INSURANCE	$39,639,849.89
'2022	'4514	'RECEIPTS/RET EMPLOYEE INS	$39,621,208.25					
			$39,639,849.89					

Rev	Exp	Diff
$39,639,849.89	$39,639,849.89	$0.00

NEVADA HEALTH AUTHORITY

Program Year 2023 Budget Account 1368 (REGI)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2023	'4326	'TREASURER'S INTEREST DISTRIB	$87,605.08		'2023	'10	'RETIRED GROUP INSURANCE	$41,223,744.80
'2023	'4514	'RECEIPTS/RET EMPLOYEE INS	$41,136,139.72					
			$41,223,744.80					

Rev	Exp	Diff
$41,223,744.80	$41,223,744.80	$0.00

NEVADA HEALTH AUTHORITY

Program Year 2024 Budget Account 1368 (REGI)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2024	'4326	'TREASURER'S INTEREST DISTRIB	$186,802.41		'2024	'10	'RETIRED GROUP INSURANCE	$67,464,823.75
'2024	'4514	'RECEIPTS/RET EMPLOYEE INS	$67,278,021.34					
			$67,464,823.75					

Rev	Exp	Diff
$67,464,823.75	$67,464,823.75	$0.00

NEVADA HEALTH AUTHORITY

Program Year 2025 Budget Account 1368 (REGI)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2025	'45	'REVERSIONS	-$15,334,301.00		'2025	'10	'RETIRED GROUP INSURANCE	$65,220,527.83
'2025	'4326	'TREASURER'S INTEREST DISTRIB	$286,199.20		'2025	'86	'RESERVE	$0.00
'2025	'4514	'RECEIPTS/RET EMPLOYEE INS	$80,268,630.36					
								$65,220,527.83
			$65,220,528.56					

Rev	Exp	Diff
$65,220,528.56	$65,220,527.83	$0.73

NEVADA HEALTH AUTHORITY

Program Year 2026 Budget Account 1368 (REGI)

Fiscal Yea	Code	Description	YTD Actual
'2026	'45	'REVERSIONS	-$20,699,470.00
'2026	'47	'BEGINNING CASH	$15,334,302.00
'2026	'4326	'TREASURER'S INTEREST DISTRIB	$944,887.12
'2026	'4514	'RECEIPTS/RET EMPLOYEE INS	$69,397,570.62
			$64,977,289.74

Fiscal Yea	Category	Description	Expended
'2026	'10	'RETIRED GROUP INSURANCE	$64,977,289.07

Rev	Exp	Diff
$64,977,289.74	$64,977,289.07	$0.67

NEVADA HEALTH AUTHORITY

Program Year 2027- to 10/13/2026 Budget Account 1368 (REGI)

Fiscal Year	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2027	'47	'BEGINNING CASH	$20,699,471.00		'2027	'10	'RETIRED GROUP INSURANCE	$23,441,887.82
'2027	'4326	'TREASURER'S INTEREST DISTRIB	$0.00					
'2027	'4514	'RECEIPTS/RET EMPLOYEE INS	$17,054,075.49					
			$37,753,546.49					
10/13/2026								

Rev	Exp	Diff
$37,753,546.49	$23,441,887.82	$14,311,658.67

NEVADA HEALTH AUTHORITY

Program Year 2022 Budget Account 1390 (AEGIS)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2022	'45	'REVERSIONS	-$5,248,361.00		'2022	'10	'ACTIVE EMPLOYEE GROUP INSURNCE	$224,245,982.06
'2022	'47	'BEGINNING CASH	$3,464,250.00		'2022	'86	'RESERVE	$0.00
'2022	'4326	'TREASURER'S INTEREST DISTRIB	$86,050.42					
'2022	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$225,944,043.10					$224,245,982.06
			$224,245,982.52					

Rev	Exp	Diff
$224,245,982.52	$224,245,982.06	$0.46

NEVADA HEALTH AUTHORITY

Program Year 2023 Budget Account 1390 (AEGIS)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2023	'45	'REVERSIONS	-$9,652,806.00		'2023	'10	'ACTIVE EMPLOYEE GROUP INSURNCE	$231,524,651.51
'2023	'47	'BEGINNING CASH	$5,248,362.00		'2023	'86	'RESERVE	$0.00
'2023	'4326	'TREASURER'S INTEREST DISTRIB	$413,926.67					
'2023	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$235,515,169.29					$231,524,651.51
			$231,524,651.96					

Rev	Exp	Diff
$231,524,651.96	$231,524,651.51	$0.45

Program Year 2024 Budget Account 1390 (AEGIS)

Fiscal Yea	Code	Description	YTD Actual
'2024	'45	'REVERSIONS	-$11,627,568.00
'2024	'47	'BEGINNING CASH	$9,652,806.00
'2024	'4326	'TREASURER'S INTEREST DISTRIB	$602,696.90
'2024	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$234,565,243.00
			$233,193,177.90

Fiscal Yea	Category	Description	Expended
'2024	'10	'ACTIVE EMPLOYEE GROUP INSURNCE	$233,193,177.50
'2024	'86	'RESERVE	$0.00
			$233,193,177.50

Rev	Exp	Diff
$233,193,177.90	$233,193,177.50	$0.40

NEVADA HEALTH AUTHORITY

Program Year 2025 Budget Account 1390 (AEGIS)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2025	'45	'REVERSIONS	-$7,703,240.00		'2025	'10	'ACTIVE EMPLOYEE GROUP INSURNCE	$263,852,524.30
'2025	'47	'BEGINNING CASH	$11,627,569.00		'2025	'86	'RESERVE	$0.00
'2025	'4326	'TREASURER'S INTEREST DISTRIB	$776,469.39					
'2025	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$259,151,726.50					$263,852,524.30
			$263,852,524.89					

Rev	Exp	Diff
$263,852,524.89	$263,852,524.30	$0.59

NEVADA HEALTH AUTHORITY

Program Year 2026 Budget Account 1390 (AEGIS)

Fiscal Yea	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2026	'45	'REVERSIONS	-$29,393,797.00		'2026	'10	'ACTIVE EMPLOYEE GRP INS	$337,838,319.76
'2026	'47	'BEGINNING CASH	$7,703,241.00					
'2026	'4326	'TREASURER'S INTEREST DISTRIB	$739,991.12					
'2026	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$358,788,884.89					
			$337,838,320.01					

Rev	Exp	Diff
$337,838,320.01	$337,838,319.76	$0.25

NEVADA HEALTH AUTHORITY

Program Year 2027- to 10/13/2026 Budget Account 1390 (AEGIS)

Fiscal Year	Code	Description	YTD Actual		Fiscal Yea	Category	Description	Expended
'2027	'47	'BEGINNING CASH	$29,393,798.00		'2027	'10	'ACTIVE EMPLOYEE GRP INS	$90,248,150.12
'2027	'4326	'TREASURER'S INTEREST DISTRIB	$0.00					
'2027	'4542	'RECEIPTS/ACTIVE EMPLOYEE INS	$81,412,661.00					
			$110,806,459.00					
10/13/2026								

Rev	Exp	Diff
$110,806,459.00	$90,248,150.12	$20,558,308.88

NEVADA HEALTH AUTHORITY

Segal

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

Memorandum

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

From: Deborah Donaldson, FSA, MAAA

Date: November 6, 2026

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

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

On September 14, 2026, HPN notified PEBP staff that it would be issuing a rebate of $234,657.96 for the 2025 benefit plan year (i.e., calendar year 2025) and this would be paid directly to PEBP as the policyholder. The calendar year measurement period differs from PEBP's July-June plan year cycle, but this does not affect how the rebate should be calculated.

The portion required to be refunded to plan participants is to be based on enrollment and cost share provisions during the period the refund was earned. Using calendar year 2025 enrollments and premium rates, the portion to be allocated to reducing member costs is $64,256.83, based on a 27.4% member cost share of the full premium rates in calendar year 2025 for the HMO.

PEBP has the discretion to vary the subsidy by such factors as coverage tier election. But the administrative effort required to operationalize that may outweigh the intended additional precision. Therefore, our recommendation is to provide a uniform rebate to all eligible members, and PEBP has opted to provide a one-time payment as soon as administratively possible. Using the PEBP provided plan census showing 2,412 subscribers electing the HMO option in November 2026, the rebate equates to $26.64 per subscriber.

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

6.

6. Mid-Quarter Fiscal Report. (Lynnette Aaron & Stacie Weeks, NVHA Director's Office) (Information/Discussion)

NEVADA HEALTH AUTHORITY

PEBP Finances

How money flows, what we found, & what comes next

Stacie Weeks

Director, Nevada Health Authority

November 2026

Agenda

1

How PEBP is financed and how money flows

- What funds PEBP
- Three budget accounts
- Solvency and reserves

2

Key findings as of April 16, 2026

- Revenue tracking and reconciliation
- The COVID buy-down and the hole it left
- Budget workbook, rates and other issues

3

Where things stand and next steps

- The “quoted” $50.1M
- PY2027 cash vs. reserves required
- Next steps

NEVADA HEALTH AUTHORITY

NEVADA HEALTH AUTHORITY

How PEBP is financed and how money flows

Where PEBP's money comes from, how it moves through three budget accounts, and the reserves it must hold

What funds PEBP

Employer contributions

Paid by state employer groups at rates the Legislature sets: a flat amount per employee (AEGIS) and a percentage of payroll (REGI). This is how state money reaches PEBP.

Member premiums

Paid by employees and retirees. The PEBP Board sets them each plan year, so they are PEBP's main lever between sessions.

Rx rebates and other revenue

Prescription drug rebates and other revenues deposited to the Admin. Account.

PY2027 projected revenue: $544M, including AEGIS/REGI transfers (Segal, Oct. 2026)

Why the General Fund isn't a direct option

- No direct General Fund appropriation: state money arrives only through employer contributions
- Employer rates are set by the Legislature and can't be raised without legislative action
- PEBP cannot accept state contingency funds between sessions
- New state money comes only in session, e.g. the 2025 employer contribution increase

Between sessions, PEBP's only levers are benefits and member premiums.

NEVADA HEALTH AUTHORITY

Three accounts, one direction of flow

WHO PAYS

Employer groups

- DHRM Central Payroll
- NDOT
- NSHE
- Boards & Commissions
- LCB
- PERS

STATE BUDGET ACCOUNTS · MONEY HELD, NOT SPENT

AEGIS · BA 1390
Actives: flat rate per employee

REGI · BA 1368
Retirees: % of payroll

Admin. · BA 1338
Operating account; holds reserves

+ member premiums, Rx rebates

WHAT THE MONEY BUYS

Medical care
Hospitals, doctors, clinics

Pharmacy
Prescription drugs

Operations
Staff, vendors, systems

AEGIS and REGI are pass-through accounts. They collect employer contributions and transfer them monthly to the Admin.

NEVADA HEALTH AUTHORITY

What solvency means for PEBP

Solvency: having enough money set aside to pay every claim the plan already owes, with a cushion for months when claims run high.

PEBP offers both. Reserves matter most for its self-insured products, where PEBP itself carries the claims risk.

Fully insured products

- PEBP pays a fixed premium to an insurance company
- The insurer pays claims and carries the risk
- The insurer must hold the reserves

Self-insured products

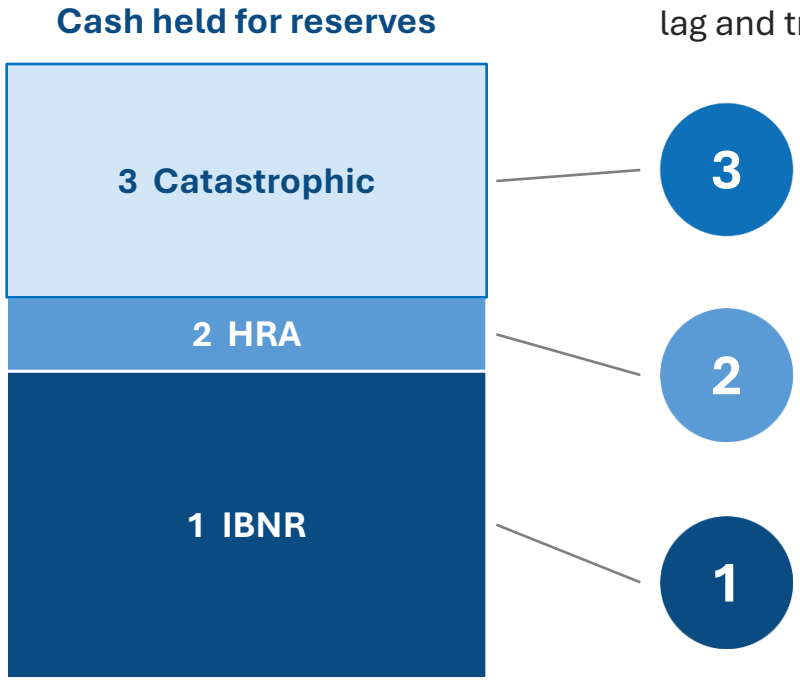
- PEBP pays members' claims directly from its own funds
- PEBP carries the risk when claims run high
- Reserves are the only cushion: no insurer, and no state contingency funds between sessions

"Not solvent" does not mean claims go unpaid. When PEBP's Executive Officer told the Board in August that PEBP is not considered solvent, she meant its reserves are not fully funded.

NEVADA HEALTH AUTHORITY

Reserves fill from the bottom up

Set by the actuary: IBNR and catastrophic amounts are based on claims experience, payment lag and trend; the HRA reserve is 80% of unused balances.



3 Catastrophic reserve

Emergency cushion for claims above projections, at least 45 days of estimated claims. Funded last.

2 HRA reserve

80% of unused CDHP and Medicare Exchange HRA balances: money members have already been promised.

1 IBNR reserve

Claims already incurred but not yet billed. These are bills PEBP already owes, so they come first.

HOW IBNR CASH PAYS A CLAIM

1 Care delivered
Member gets care; PEBP now owes the bill

→

2 Cash set aside (IBNR)
Actuary estimates unbilled claims; that much cash is held back

→

3 Claim submitted
Provider bills, weeks or months later; claim is approved

→

4 IBNR cash pays it
Held cash pays the claim; new premiums refill the reserve

NEVADA HEALTH AUTHORITY

PY2027 required amounts and PEBP's projected position are shown in part 3.

NEVADA HEALTH AUTHORITY

Key findings as of April 16, 2026

From NVHA's fiscal review memorandum to LCB and GFO, signed with PEBP's Executive Officer and CFO

Five findings

AS OF APRIL 16, 2026

1	**Revenue tracking lacked safeguards**	Collections were never checked against what each employer group owed
2	**Reconciliation procedures not followed**	Short and late contributions went uncorrected
3	**COVID buy-down accounts didn't end when funds ran out**	Placeholder accounts held back employer contributions
4	**2025–27 budget workbook inaccurate**	Workbook PEBP submitted to the Legislature overstated revenues
5	**Rate and coverage decisions or issues**	Underpriced plans, added costs and reserve use strained stability

NEVADA HEALTH AUTHORITY

Revenue tracking lacked safeguards

FINDING #1 · AEGIS EXAMPLE WITH ILLUSTRATIVE NUMBERS

Old method: start from the cash

	$950,000	received from an agency
÷	**$1,000**	approved rate per employee
=	**950**	employees assumed covered

Shortfall found: $0

The math always balances, so underpayments never show up.

New method: start from enrollment

	1,000	employees enrolled (Ariel)
×	**$1,000**	approved rate per employee
=	**$1,000,000**	owed by the agency
−	**$950,000**	actually received

$50,000 short: flagged

Posted to a running balance and followed up with the agency.

REGI had the same gap. Payroll checks were manual, some employer groups never sent retiree payroll data, and there was no running balance. The new REGI tracker multiplies payroll by the approved percentage and keeps a running balance.

NEVADA HEALTH AUTHORITY

Reconciliation processes were lacking

FINDING #2 · CONTINUING THE SLIDE 9 EXAMPLE

Finding 1 was the tool. Finding 2 was the follow-through: even a flagged shortfall only matters if someone collects it.

Before: the shortfall was never chased

$50,000 short
Agency underpays

→

No follow-up
Procedures not followed by prior staff

→

Still short
Gap carries into the next month

→

Less to pay claims
Short, late transfers strain cash flow

Now: a follow-up process is underway

$50,000 flagged
Running balance shows it

→

CFO contacts agency
Trained staff follow the procedure

→

Escalate if needed
GFO Director steps in if not fixed promptly

→

Collected and posted
Balance reconciled; money reaches Admin.

Errors ran both ways. Overpayments, including possible Central Payroll double payments, also went unreconciled and may be owed back.

New risk: CORE.NV. Since the rollout, errors in file transfers between Central Payroll and DHRM have caused more incorrect collections.

NEVADA HEALTH AUTHORITY

The buy-down left a hole: unnoticed and unfilled

FINDING #3 · FROM PEBP BOARD RECORDS AND NVHA'S REVIEW

By 2022

Board commits ~$26M of COVID-era excess to hold down costs through PY2025

End of PY2023

The excess is used up, two years early

PY2024

Rates still assume it. FY2024 opens $24M short; last $1.3M taken from the HRA reserve

PY2025

Half of the needed premium increase paid from the catastrophic reserve

Unnoticed

Ariel kept charging members the lower buy-down amounts, and placeholder accounts kept holding back employer money. No reconciliation caught it.

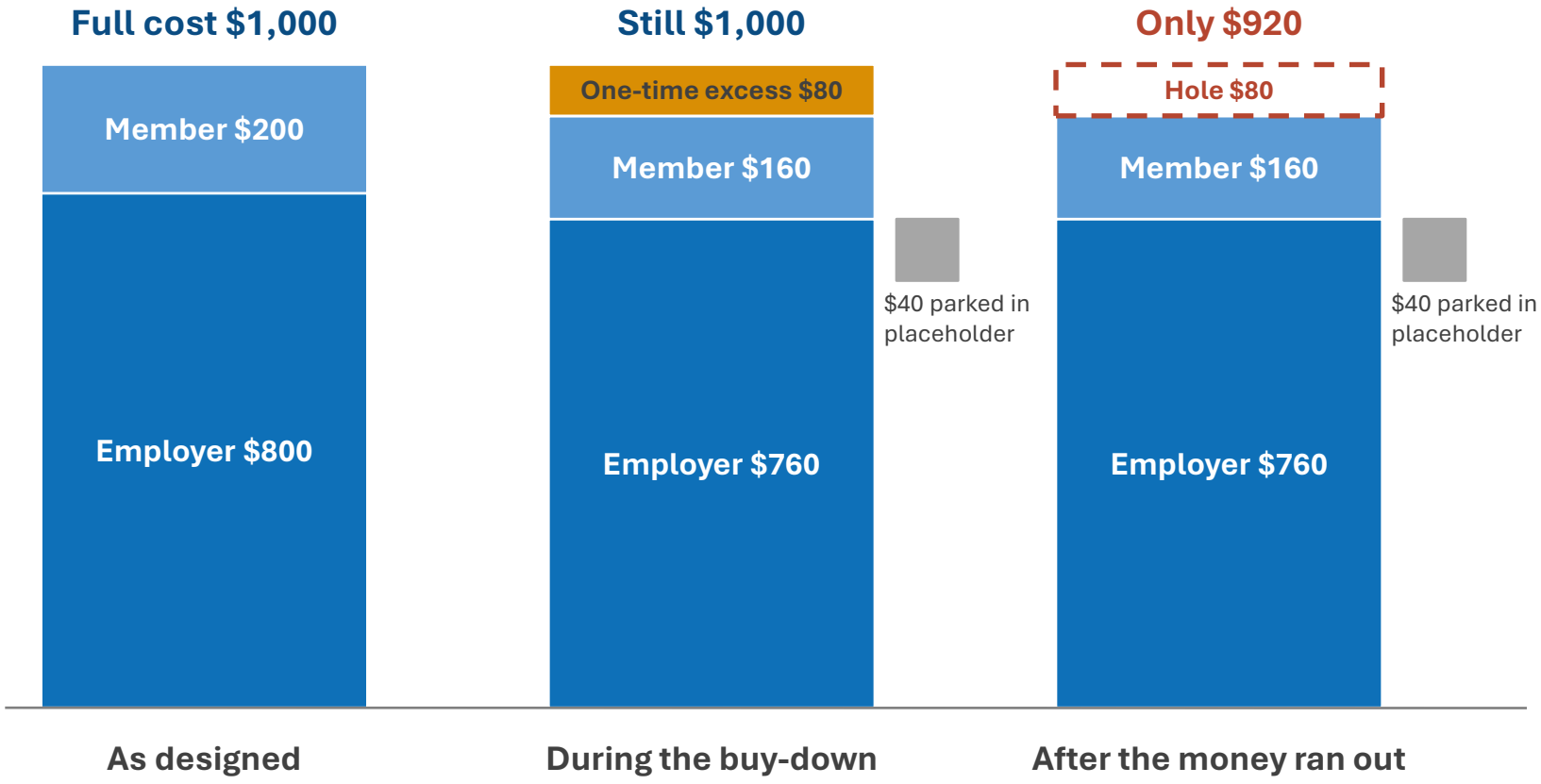
Unfilled

Instead of resetting rates to full cost, the gap was covered with one-time money: the HRA reserve, then the catastrophic reserve. Neither was replenished.

NEVADA HEALTH AUTHORITY

How the hole formed, one member at a time

FINDING #3 · ILLUSTRATIVE NUMBERS FOR ONE MEMBER, PER MONTH



Member premiums
Ariel kept charging $160 instead of $200 after the excess ran out: $40 short every month, not billed to members.

Employer contributions
Agencies paid the full $800, but $40 sat in a placeholder account in AEGIS/REGI instead of reaching the Admin. Account.

$80 hole per member
Claims still cost $1,000. Operating cash and reserves made up the gap.

Illustrative, based on the best information NVHA and PEBP staff have on how the buy-down was implemented; the dollar amounts and member/employer split are not actual. Board records show most of the ~$26M paid for restored benefits, and the placeholder accounts may have reduced collections even while the excess lasted. About $15M of placeholder money is being transferred back.

NEVADA HEALTH AUTHORITY

Recovery: ~$15M moving to pay claims

FINDING #3 · CORRECTIVE ACTION

~$31M

held in AEGIS / REGI, carried into FY2027

~$15M + ~$16M = ~$31M

after the $18.7M FY2027 payment posted early

~$15M to the Admin. Account

Approved by the Board in March 2026; pays claims



$3.7M moved, Jul.–Sept. ~$11.3M more expected

~$16M still being reconciled

With GFO and Central Payroll; not counted until settled

If PEBP revenue
Transferred with Board approval

If overpaid
Returned to the employer group

FIXES IN PLACE

Ariel corrected
Correct rates; placeholder accounts removed; buy-down no longer applied

Moved to BETS
State system now tracks Admin. Account revenue and spending

Regular reporting
AEGIS/REGI balances in Board reports starting in December

Note: in March and April 2026, PEBP and NVHA estimated $18.4M (~$14M AEGIS, $4.4M REGI) in placeholder funds as PEBP revenue. After further review, the amount approved by the Board in March for transfer came to about $15M, which is already counted in the actuary's PY2027 projections.

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PEBP’s 2025-27 budget workbook was inaccurate

FINDING #4

What we found

- BA 1338 tracker needed manual projection updates and was hard for staff to follow
- Workbook shared with LCB and GFO never updated to the budget request, despite their requests
- Approved revenues exceeded enrollment-based projections, overstating PEBP revenue
- Miscommunication with the actuary; unclear who owned the budget build workbook

Corrective action

- NVHA contractor and PEBP CFO are building a new budget build workbook
- Developed with PEBP's actuary, GFO and LCB fiscal staff
- Goal: correctly calculate need for the upcoming biennium

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Other issues that strained financial stability

FINDING #5 · RATE AND COVERAGE DECISIONS OR ISSUES SINCE 2022

Low-deductible plan underpriced

Rates approved do not appear to have been actuarially prudent. They drew members from the CDHP and EPO/HMO, forcing cross-subsidies and premium shortfalls

Benefits added on one-time money

Benefits restored with ~$26M of one-time excess. It ran out at the end of PY2023, but PY2024 rates were still built on it.

Plan losses left unaddressed

EPO/HMO lost ~$25M in each of plan years 2023 and 2024 and still ran a deficit in 2026; low-deductible plan in deficit since 2024

Reserves and new funds used for buy-downs

Mar. 2024: half of the PY2025 employee premium increase paid from the catastrophic reserve. Mar. 2025: PY2026 rates used the higher state contribution to hold employee premiums flat (state share ~93.5%), not to rebuild reserves

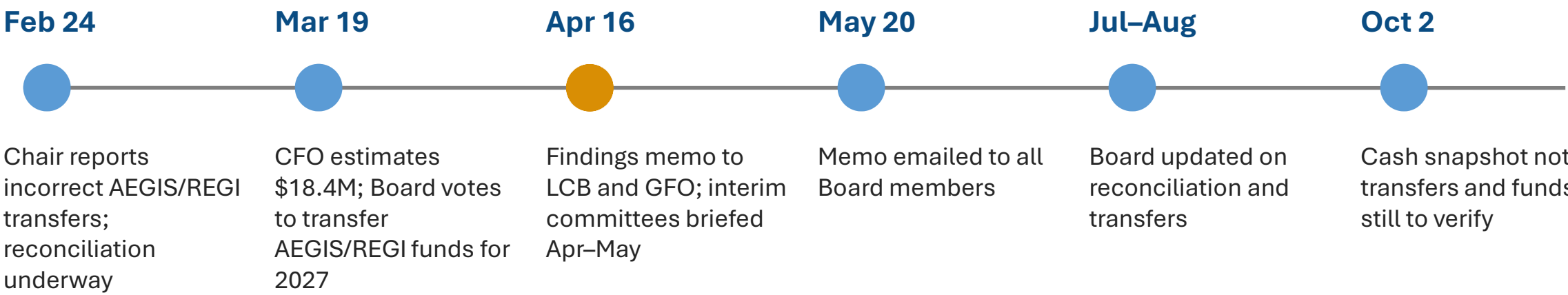
NEVADA HEALTH AUTHORITY

NEVADA HEALTH AUTHORITY

Where things stand and next steps

What has happened since the April memo, what the AEGIS/REGI balances are, and the plan from here

Reported publicly as the problems were found



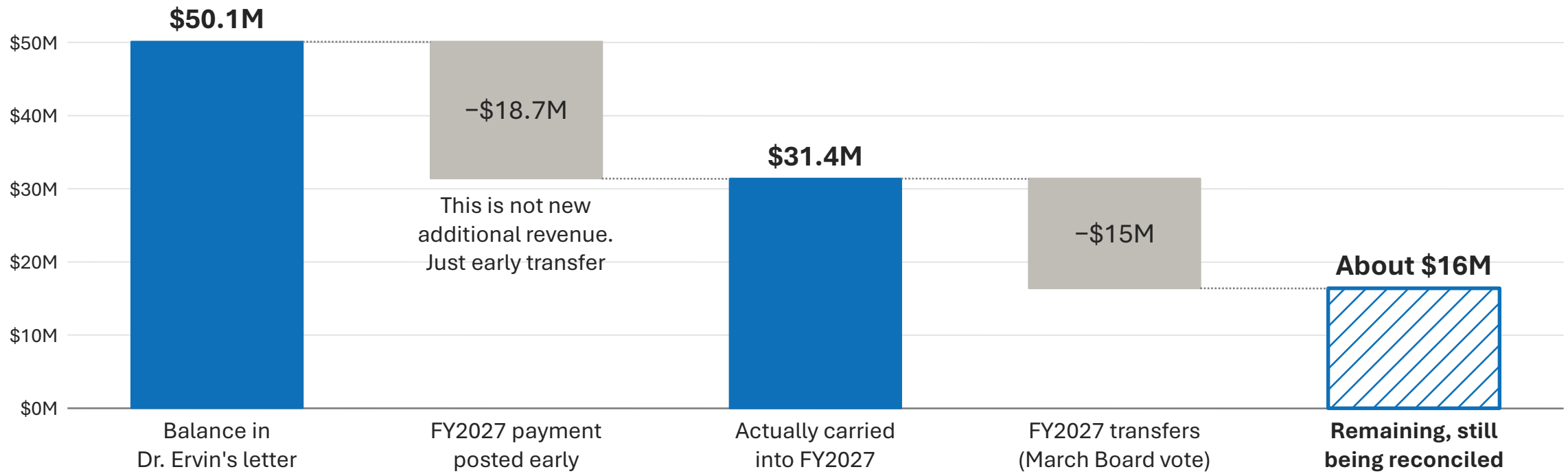
The gap: Board budget reports covered only the operating account. AEGIS and REGI balances, normally small, were not reported, so the Board could not see them build up. Starting in December, reports will include them.

NEVADA HEALTH AUTHORITY

What the “quoted” $50.1M actually represents

FY2026 ENDING BALANCES CARRIED INTO FY2027, IN MILLIONS OF DOLLARS

Why we're explaining this: Dr. Ervin's October 26 open letter cited the $50.1M as unused employer money that could offset premium increases. Most of it is already committed or not yet verified.

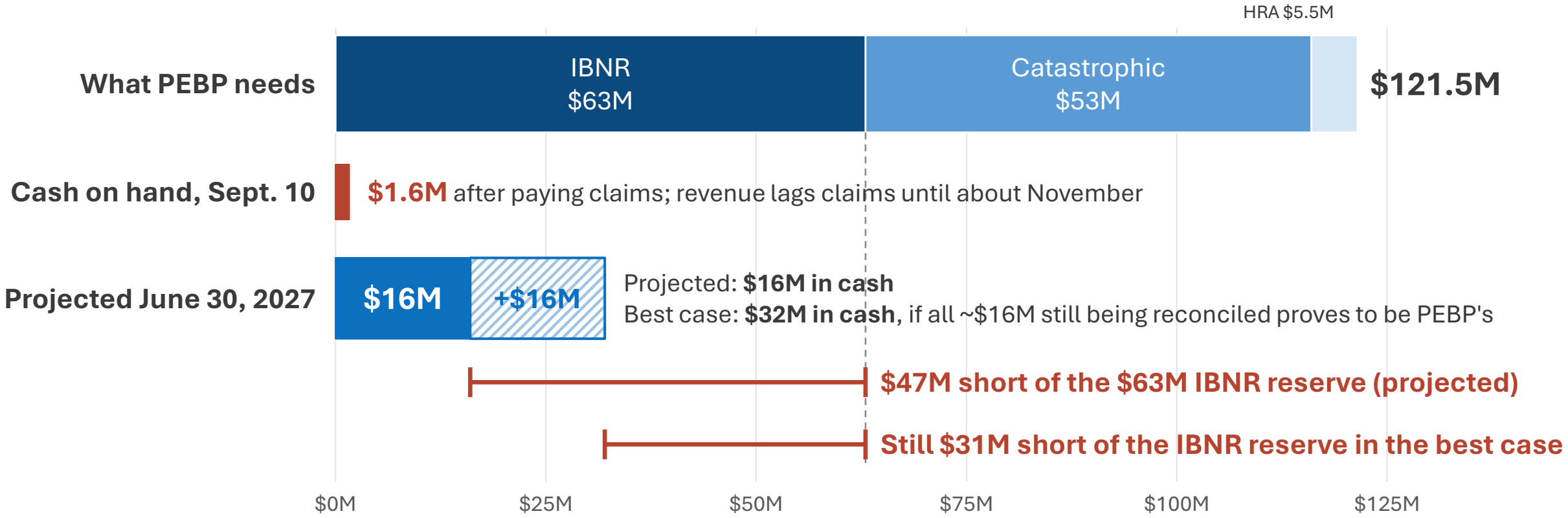


NEVADA HEALTH AUTHORITY

FY2027 transfers: $3.7M transferred July–September 2026; about $11.3M more expected by June 30, 2027. Hatched bar: may include employer overpayments to be returned; final amount set by the reconciliation audit. Sources: 2027–2029 Agency Request Budget; NVHA and PEBP fiscal staff; PEBP Executive Officer report, Oct. 2, 2026.

PY2027: $47M short of claims already owed

Projected year-end cash vs. required reserves, plan year 2027. The requested $40 million in one-time funds is for FY2028-2029



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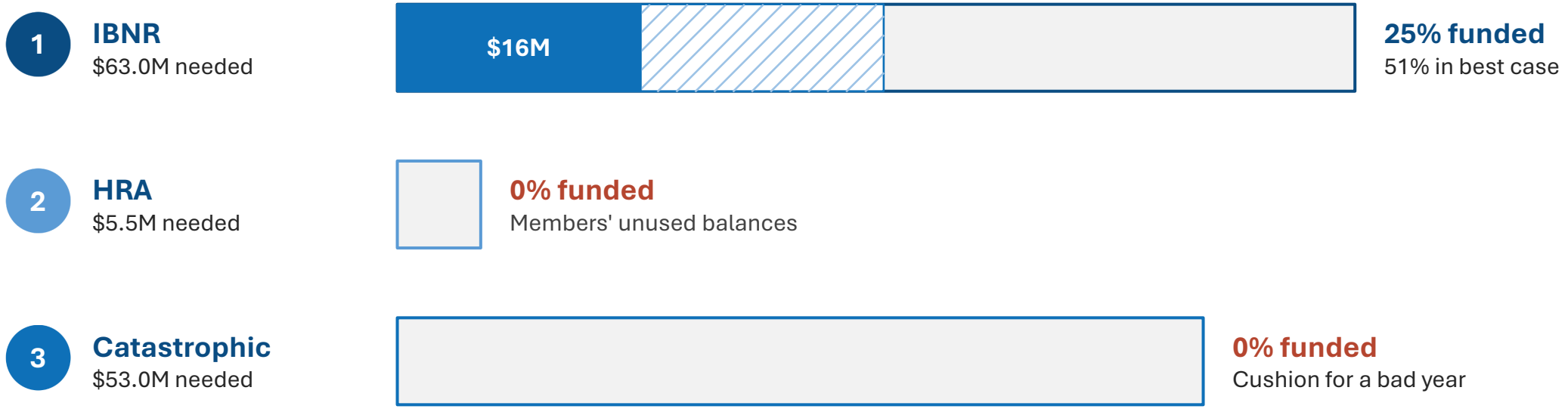
Projected cash includes the premium phase-in and this year's AEGIS/REGI transfers: about $15M, with $3.7M transferred July–September and about $11.3M more expected. IBNR = incurred but not reported claims. Reserve requirements as of the Aug. 20, 2026 Board packet. Not shown: about $7M in administrative operating cash (PEBP estimate); the Aug. 20 packet separately cites $28M in operating cash for July claims. Reserves are funded with cash, the basis Segal uses to assess solvency. Sources: Segal projection and reserve requirements, PEBP Board packets, Aug. 20 and Oct. 2, 2026.

PY2027: every reserve tier falls short

Projected funding of each required reserve on June 30, 2027, filled in priority order. Bars are drawn to the same dollar scale.



Solid: Segal's projected cash ($16M). Hatched: best case if all ~$16M still being reconciled proves to be PEBP's. Segal: actuarial solvency requires fully funded IBNR and HRA reserves ($68.5M). Not shown: about $7M in administrative operating cash (PEBP estimate). Sources: Aug. 20, 2026 Board packet; Segal and Executive Officer report, Oct. 2, 2026.

$1.6M cash on hand Sept. 10, 2026, after paying claims

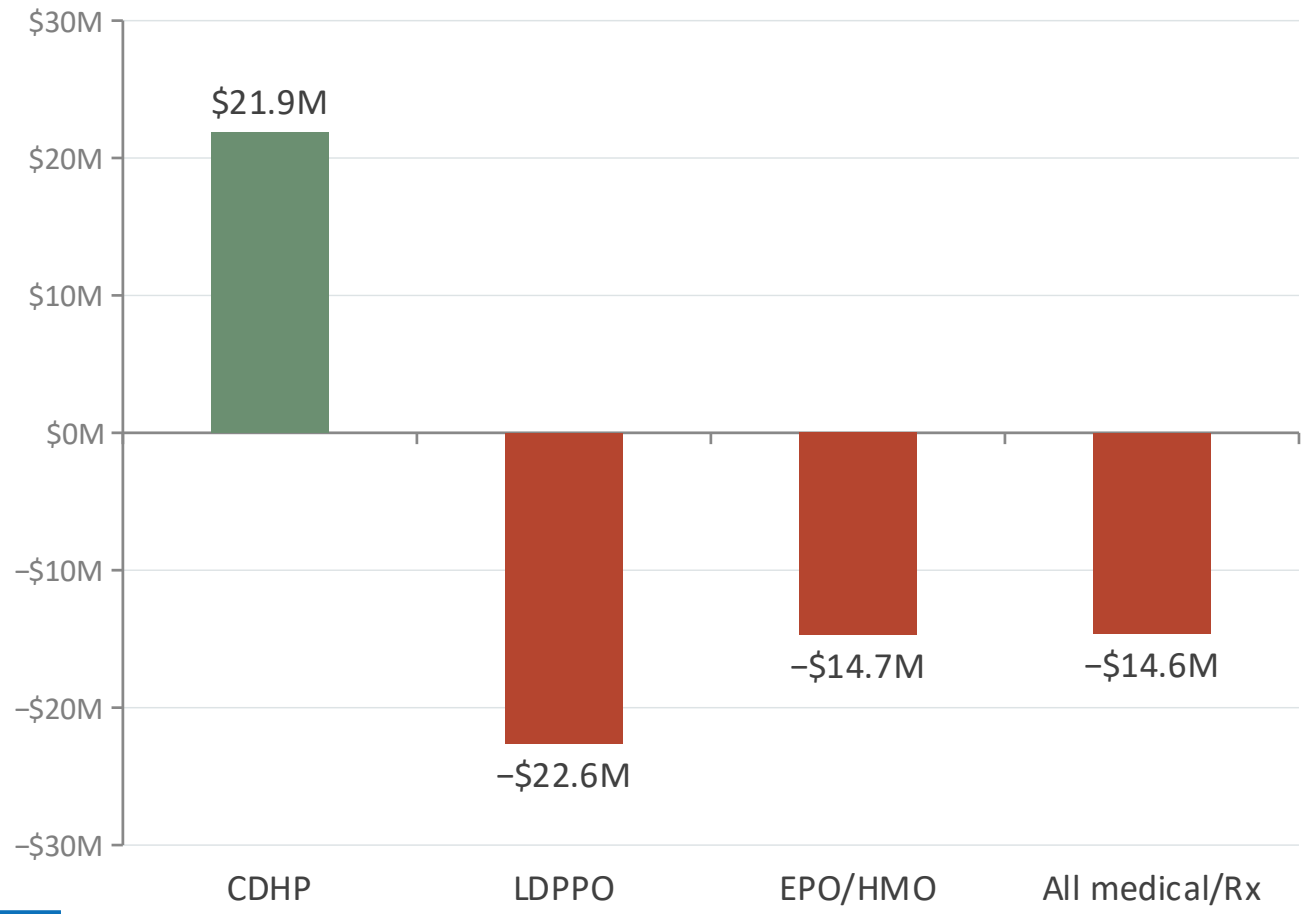
$16M projected cash June 30, 2027: 13% of the $121.5M required

$105M short of all required reserves ($89M in the best case)

NEVADA HEALTH AUTHORITY

Fixing the accounting alone won't fix the deficits

PLAN YEAR 2026 NET RESULTS BY PLAN (SEGAL) · THE DEFICITS ARE STRUCTURAL



+15% / +44%

Rate increase needed for LDPPO / EPO/HMO to match claims (Segal, Feb. 2026)

21%

of EPO members moved to the LDPPO for PY2027

6% / 11%

PY2027 cost trend, medical / pharmacy

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Next steps

Underway now

- Full AEGIS/REGI reconciliation audit with GFO: every dollar moved to PEBP or returned
- Monthly reconciliation, BETS, rebuilt budget workbook
- More NVHA fiscal oversight; new lead actuary and competitive actuarial procurement
- Segal tying FY2023–2026 results to cash

December Board

- First monthly financial report including AEGIS and REGI balances
- Reconciliation update, with any verified transfers brought for approval
- Segal to re-evaluate PY2028 phase-in steps

2027 Session

- ~$40M one-time for FY2028–2029 to rebuild reserves and funds for increased care management options for TPA contract
- Enhancement to fund the IBNR reserve at 50%
- Corrected AEGIS, REGI and revenue projections in G01
- Support for an independent legislative audit
- Upcoming TPA procurement to align with other large carrier procurements in other markets to leverage better deal with carrier and providers

NEVADA HEALTH AUTHORITY

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Questions?

Thank you for your participation!

Learn More & Stay Involved

Website: **www.pebp.nv.gov**

Contact Us

Theresa Carsten
PEBP Executive Officer
tcarsten@nvha.nv.gov

Lynnette Aaron
Deputy Director, Healthcare Financing
l.aaron@nvha.nv.gov

For accommodations or translated materials, please contact us at the information above.

NEVADA HEALTH AUTHORITY

7.

7. Discussion and possible action regarding Board and Agency Duties, Policies and Procedures, budget expenditures for PY23, 24, 25 and possible plan design changes including: (Debbie Donaldson, Segal) (**For Possible Action**)
   a. Narrowing the network for EPO
   b. Capitated vs. deferred service payments for HPN
   c. Other Network Opportunities

Stacie Weeks, JD, MPH, Director

Theresa Carsten, Executive Officer

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

Pending Board Approval
November 17, 2026

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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 guidelineswithin 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 ofthe 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 amanner 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 lawrequirements.

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 definethe duties of the Quality Control Officer with the concurrence of theBoard. 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 theBoard.
4. Be encouraged to obtain continuing education credits pertaining to the administration of group benefits for public employees as fundingis available.
5. Conduct their affairs in such a manner that they always represent thebest 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 Boardmember.
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 assignedto 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 occuroutside 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 BoardChair 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 regulatoryprovisions 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 financialsettlements relating to claims processing.

e. Representation of the Agency to other pertinent governmental bodies.

3. Consistent with Board policies and directions, the Agency shall work with the Governor's Finance Office (GFO) and the Legislative Counsel Bureau (LCB) to ensure that the Program is funded on an actuarially sound basis. The Agency shall ensure the use of funds and resources directly related to the purpose of the agency and the statutory intent for the use of those resources.

4. Ensure the Agency notifies participants of health care benefit changes as approved by the Board.

5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:

   a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.

   b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures. A review of recent Board actions and precedents and current issues being considered by the Board.

   c. An overview of the funding and rate setting process.

   d. The continuing education opportunities for the members pending available funding.

6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt

   and understanding by signing the "Acknowledgment Form for Employees."

7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.

8. The Executive Officer will provide Agency employees with relevanteducation

and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee attending a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.

9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

- Avoid the perception of misuse 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 andSecurity Statement of Understanding upon appointment/hire.

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

I. TRAVEL POLICY

1. If a member of the Board must travel, they must adhere to the State of Nevada's travel policy which may be found the State Administrative Manual in sections 0200 (Travel) and 1400 (Fleet Services)
2. Board members are subject to the same travel requirements asAgency employees and will receive a copy of the Travel Policy andProcedures during their orientation. The Travel Policy andProcedures 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 withNRS 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 chiefof the "using agency"

to the Executive Officer. The Executive Officer should ensure that accurate and detailed information and supporting documentation, within the bounds of statuteand regulation, is provided to the Board and othergoverning bodies when seeking to bid new contracts and amend existing contracts.

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

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

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

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

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

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

   a. The Executive Officer will provide an appropriate 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 andresponse 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 theparties when the original contract was entered.
c. Changes that materially alter the contract.
d. Changes in the quantity of major items or portions of work;or
e. Historically provided services under a separate contract.

C. Amendments

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

V. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

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

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

For benefit plans that are fully insured, the Program will negotiate rates withinsurance 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 asdetermined 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, inexcess 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 20~~19~~25-2027~~1~~ biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

C. DEFINITIONS

As used herein the following terms mean:

1. **Open Enrollment** – The period during which participants in theProgram 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 planoptions and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.
8. **Subsidy (Contribution)** – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:

a. Base Subsidy – For state employees, the portion of the rate paid by the employer pursuant to NRS 287.044. For retirees not on the Medicare Exchange, the portion of the rate paid by a retiree's previous employer(s) at 15 years of service pursuant to NRS 287.046.

b. Years of Service (YOS) Subsidy – The adjustment to the Base Subsidy, for participants who retired on or after January 1, 1994, based on a retiree's YOS, paid by a retiree's previous employer(s) pursuant to NRS 287.046 and NRS 287.023(4)(b).

9. **Differential Cash** – The difference between revenue and expenditures.

D. OVERVIEW OF THE BIENNIAL PROCESSES

1. **Rate Setting** – Prior to the commencement of each plan year, the Board will establish rates based upon the recommendation of the Agency and PEBP's contracted actuaries based upon a variety of factors, including, but not limited to:
   a. Established plan designs
   b. Forecast claims costs for self-insured plan(s)
   c. Forecast premium costs for fully insured plan(s)
   d. Forecast fixed expenses from plan administrative vendors
   e. Forecast PEBP internal administrative expenses
   f. Forecast required adjustments to reserves
   g. Consideration of material demographic changes
2. **Plan Design** – The Board will identify the priorities for plan design (i.e., options for changes in the plan design). These priorities may include scope of benefits offered by the plan and/or cost-sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as theplan 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 theBoard 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 Planwill be the guiding document designed to assist the Board and the Agency to develop and maintain a high-quality program of benefitsat 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 asa 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 tothe 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 thanSeptember 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 beginsin 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, withfinal 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 transmittalto 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 isnot 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-Medicareretirees 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 reportedto 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 inmethodology for projecting expenses (such as changing from claimstrends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP using the approved framework and rating

methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the medical, prescription drug, and dental cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these Duties, Policies and Procedures (see Appendix A).

Appendix A - Plan Year Rating Methodology

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

Plan Design

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

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

    OR

    Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP isequal to the HSA contribution.
  - ✓ 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 forretirees 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 isnot 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 carryoverlimit 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 fordetails.
  - ✓ 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 arenot eligible for a Medical FSA.
  - ✓ Additional Life Insurance – voluntary; fully insured
  - ✓ Long Term Care – voluntary; fully insured
  - ✓ Long Term Disability – voluntary; fully insured
  - ✓ Short Term Disability – voluntary; fully insured
  - ✓ Homeowners and Automobile Insurance – voluntary; fully insured
  - ✓ Accident/Indemnity – voluntary; fully insured
  - ✓ Legal Support – voluntary, fully insured
  - ✓ Identify Theft Protection – voluntary, fully insured
  - ✓ Buy-Up Vision Insurance – voluntary; fully insured
  - ✓ Pet Insurance – voluntary; fully insured

Cost Projections

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

Calculate an average per participant per month rate including claims, administrative expense, HSA contribution, and general overhead costs

Consumer Driven Health Plan (CDHP)

Per Participant ***X***

Low Deductible Preferred Provider Organization Plan (LDPPO)

Per Participant ***Y***

Exclusive Provider Organization/Health Maintenance Organization Plan (EPO/HMO)

Per Participant ***Z***

Apply the following tier factors

Single	1.00	***A***
Single + Spouse	2.20	***B***
Single + Child(ren)	1.45	***C***
Single + Family	2.65	***D = B + C - 1***

	CDHP	***LDPPO***	***EPO/HMO***
Single	***AX+L***	***AY+L***	***AZ+L***
Single + Spouse	***BX+L***	***BY+L***	***BZ+L***
Single + Child(ren)	***CX+L***	***CY+L***	***CZ+L***
Single + Family	***DX+L***	***DY+L***	***DX+L***

L = Applicable life and disability costs

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 theCost Projections section above.

- Enrollment projections are based on the anticipated change in enrollment based on assumptions approved by the Executive Officer.

- The following costs, revenues and reserve adjustments will be allocated equally to allactive 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, Category86)
  - ✓ 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 withreserve policies.

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

- Reserves
  - ✓ Catastrophic Reserves will be established at a level necessary to ensure plansolvency over the long term to a set 45 days on hand.
  - ✓ IBNR Reserves will be established at a level to achieve a 95% probability thatall 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 ofplan 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 Spouse/Domestic Partner (active subsidy + 28%): 34.5%
    - Percentage applies to the spouse/domestic partner portion of the total CDHP rate, not the total rate
  - Active Employee Dependent Children (active subsidy + 25%): 31.5%
    - Percentage applies to the dependent portion of the total CDHP rate, not the total rate
  - Retirees: 36%
  - Retiree Dependents (retiree subsidy+25%): 61%
    - 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.

Segal

Nevada Public Employees' Benefits Program

PY2023-PY2026 Financial Review and EPO/HMO Considerations

November 17, 2026 / Debbie Donaldson, FSA, MAAA, Senior Vice President, Amy McClendon, FSA, MAAA, Vice President



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Agenda

PY2023-PY2026 Financial Summary Review

Plan Design Summary/Current State

EPO/HMO Design Options

Disruption

PY2023-PY2026 Financial Summary Review

PY2023-PY2026 Financial Summary Review

	PY2023	PY2024	PY2025	PY2026
Total Revenue*	$366,168,000	$385,846,000	$425,510,000	$507,993,000
Total Expenses**	$388,029,000	$436,988,000	$466,337,000	$522,627,000
Net	($21,861,000)	($51,142,000)	($40,827,000)	($14,634,000)
Avg. Enrollment[1]	30,593	31,067	32,643	32,856
Revenue PEPM***	$997	$1,035	$1,086	$1,288
Expense PEPM	$1,057	$1,172	$1,191	$1,326
Net PEPM Difference	($60)	($137)	($104)	($37)

Over the four previous plan years, NV PEBP has contributed over $128M beyond the AEGIS/REGI Subsidies to support members

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in the applicable plan year attributable to prior plan years)
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medical/Rx plan enrollment

PY2023 Financial Summary

- Total expenses exceeded medical/Rx revenue by $21.9M
- Analysis is based on the final plan year-end EMR report and may differ from other sources due to timing

	CDHP	LDPPO	EPO/HMO	Dental	Medicare HRA	Total
Total Revenue*	$158,518,000	$71,659,000	$77,604,000	$25,158,000	$33,229,000	$366,168,000
Total Expenses**	$149,560,000	$77,758,000	$103,478,000	$24,004,000	$33,229,000	$388,029,000
Net	$8,958,000	($6,099,000)	($25,874,000)	$1,154,000	$0	($21,861,000)
Avg. Enrollment	16,293	7,255	7,044	39,807	13,090	30,593[1]
Revenue PEPM***	$811	$823	$918	$53	$212	$997
Expense PEPM	$765	$893	$1,224	$50	$212	$1,057
Net PEPM Difference	$46	($70)	($306)	$2	$0	($60)

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2023 attributable to prior plan years)
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medical/Rx plan enrollment

PY2024 Financial Summary

- Total expenses exceeded medical/Rx revenue by $51.1M
- Analysis is based on the final plan year-end EMR report and may differ from other sources due to timing

	CDHP	LDPPO	EPO/HMO	Dental	Medicare HRA	Total
Total Revenue*	$148,296,000	$100,607,000	$79,535,000	$26,672,000	$30,736,000	$385,846,000
Total Expenses**	$146,819,000	$122,828,000	$107,983,000	$28,622,000	$30,736,000	$436,988,000
Net	$1,477,000	($22,221,000)	($28,448,000)	($1,950,000)	$0	($51,142,000)
Avg. Enrollment	14,617	9,854	6,596	40,169	11,999	31,067[1]
Revenue PEPM***	$845	$851	$1,005	$55	$213	$1,035
Expense PEPM	$837	$1,039	$1,364	$59	$213	$1,172
Net PEPM Difference	$8	($188)	($359)	($4)	$0	($137)

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2024 attributable to prior plan years)
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medical/Rx plan enrollment

PY2025 Financial Summary

- Total expenses exceeded medical/Rx revenue by $40.8M
- Analysis is based on the final plan year-end EMR report and may differ from other sources due to timing

	CDHP	LDPPO	EPO/HMO	Dental	Medicare HRA	Total
Total Revenue*	$151,234,000	$131,986,000	$79,713,000	$29,074,000	$33,503,000	$425,510,000
Total Expenses**	$133,659,000	$159,740,000	$109,532,000	$29,903,000	$33,503,000	$466,337,000
Net	$17,575,000	($27,754,000)	($29,819,000)	($829,000)	$0	($40,827,000)
Avg. Enrollment	14,176	12,188	6,279	41,661	12,926	32,643[1]
Revenue PEPM***	$889	$902	$1,058	$58	$216	$1,086
Expense PEPM	$786	$1,092	$1,454	$60	$216	$1,191
Net PEPM Difference	$103	($190)	($396)	($2)	$0	($104)

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2025 attributable to prior plan years)
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medical/Rx plan enrollment

PY2026 Financial Summary

- Total expenses exceeded medical/Rx revenue by $14.6M
- Analysis is based on the final plan year-end EMR report and may differ from other sources due to timing

	CDHP	LDPPO	EPO/HMO	Dental	Medicare HRA	Total
Total Revenue*	$176,047,000	$179,928,000	$87,639,000	$30,768,000	$33,612,000	$507,993,000
Total Expenses**	$154,137,000	$202,555,000	$102,384,000	$29,940,000	$33,612,000	$522,627,000
Net	$21,910,000	($22,627,000)	($14,745,000)	$828,000	$0	($14,634,000)
Avg. Enrollment	13,772	13,450	5,634	41,873	12,936	32,856[1]
Revenue PEPM***	$1,065	$1,115	$1,296	$61	$217	$1,288
Expense PEPM	$933	$1,255	$1,514	$60	$217	$1,326
Net PEPM Difference	$133	($140)	($218)	$2	$0	($37)

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2026 attributable to prior plan years)
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medical/Rx plan enrollment

Plan Design Summary/Current State

PY2027 Plan Designs - Medical

	CDHP	LDPPO	EPO	HMO
Service Area	Global	Global	Northern Nevada	Southern Nevada
HSA/HRA Contribution	$700 PEPY +$200 per dep (max 3)	N/A	N/A	N/A
Annual Deductible	$1,700 Individual $3,400 Family $3,400 Individual Family Member Deductible	$300 Individual $600 Family	$100 Individual $200 Family $100 Individual Family Member Deductible	N/A With exception of Tier 4 prescription drug coverage
Medical Coinsurance	20% after deductible	20% after deductible	20% after deductible	N/A
Out-of-Pocket Maximum	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$4,000 Individual $8,000 Family	$5,000 Individual $10,000 Family
Primary Care/ Specialist Office Visit	20% after deductible	$30/ $50 copay per visit	$20/ $40 copay per visit	$25/ $40 ($25 with referral) copay per visit
Urgent Care Visit	20% after deductible	$80 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Visit	20% after deductible	$750 copay per visit	$600 copay per visit	$600 copay per visit
In-Patient Hospital	20% after deductible	20% after deductible	$600 copay per visit	$600 copay per visit
Outpatient Surgery	20% after deductible	$500 copay per visit	$350 copay per visit	Ambulatory Facility $50 copay Hospital $350 copay
PY2027 Employee Only Premium	$55.26	$160.18	$381.24	$381.24

PY2027 Plan Designs - Rx

	CDHP	LDPPO	EPO	HMO
Preferred Generic	20% after Deductible	$10 (Retail 30) $20 (Retail 90)	$10 (Retail 30) $20 (Retail 90)	$10 (Retail 30) $25 (Mail 90)
Preferred Brand	20% after Deductible	$40 (Retail 30) $80 (Retail 90)	$40 (Retail 30) $80 (Retail 90)	$40 (Retail 30) $100 (Mail 90)
Non-formulary	100% of the cost of medication	$75 (Retail 30) $150 (Retail 90)	$75 (Retail 30) $150 (Retail 90)	$75 (Retail 30) $187.50 (Mail 90)
Specialty (30-day Supply)	30% Coinsurance after Deductible ($100 min/$250 max for drugs not on SaveOnSP program)	30% Coinsurance after Deductible ($100 min/$250 max for drugs not on SaveOnSP program)	30% Coinsurance after Deductible ($100 min/$250 max for drugs not on SaveOnSP program)	20% Coinsurance

- Actuarial Value Medical/Rx Combined
  - CDHP: 78%
  - LDPPO: 83%
  - EPO: 89%, HMO 91%

EPO/HMO Current State

- EPO/HMO is the highest cost option
  - Driven primarily by EPO
  - Current blended EPO/HMO is ~25% higher than LDPPO
  - Membership is older with higher risk scores as compared to the LDPPO and HDHP membership
- EPO/HMO participant only PY27 premium is 2.4 times higher than the LDPPO participant only premium
- Ongoing migration from EPO/HMO to LDPPO
  - EPO decreased from ~4,100 in PY21 to ~1,700 currently, with a 25% reduction in PY27 (comparing May 2026 and July 2026 enrollment)
  - Continued risk of anti-selection (i.e. those staying in the plan have most risk and those with lower risk are choosing less expensive premium options)
- HMO plan (fully insured) has produced loss ratios below 85%, creates refunds to PEBP and plan participants

PY2028 HMO Preliminary Renewal

- PY2028 initial fully insured renewal provided by HPN is an 8% increase
- Uses experience from July 2024 through June 2026
- Incorporates medical trend of 9% and Rx trend of 18%
- Includes ~17% for retention
  - i.e. administration, premium tax, and other

EPO/HMO Design Options

EPO/HMO Plan Options Summary

- **Option 1:** Move HMO to a self-funded EPO plan option (same plan in North and South)
  - Projected PY28 savings: $6M - $9M
- **Option 2:** a) Move HMO to self-funded and b) create a two-tiered in-network option for EPO in both North and South
  - Projected PY28 savings: $7M - $10M
- **Option 3:** No change
- **Option 4:** Eliminate EPO/HMO and enhance plan design for LDPPO
  - Presented and not approved in October 2026 Meeting
  - $8M projected PY28 savings

Option 1: Move HMO to Self-Funded EPO

- Integrate EPO Plan design for Medical and Rx with ESI
  - Projected PY28 medical savings: $0M - $2M
  - Projected PY28 Rx savings: $6M - $7M
  - Total projected savings: $6M - $9M
- Plan design is similar
  - Biggest change for members will be in Primary Care and Specialist visits and for small number of services (imaging, DME) subject to deductible/cost sharing
  - Same copays for 30-day scripts, slightly lower copays for 90-day scripts, and minimum/maximum for specialty drugs

Option 2: Self-funded Two-Tiered In-Network Plan Option

- EPO becomes a self-funded, two-tiered network (North and South)
  - Tier 1: Preferred in-network
    - Tier 1 is EPO plan design with enhanced copays
    - 17% of utilized provider spend is currently Tier 1 Preferred
  - Tier 2: All other in-network
    - Tier 2 has slightly higher copays than Tier 1
- Tiering is applied by evaluating cost efficiencies of providers on a risk adjusted, episode bases and incorporates quality and outcome measures aligned with HEDIS performance standards
- Maintain EPO Rx plan design
- Actuarial Value Medical/Rx Combined = 88%, assuming 17% Tier 1 utilization

Option 2: Suggested Plan Design

	EPO	Tier 1 In-Network*	Tier 2 In-Network*
Annual Deductible	$100 Individual $200 Family $100 Individual Family Member Deductible	$100 Individual $200 Family $100 Individual Family Member Deductible	$200 Individual $400 Family $300 Individual Family Member Deductible
Medical Coinsurance	20% after deductible	20% after deductible	20% after deductible
Out-of-Pocket Maximum	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family
Primary Care/ Specialist Office Visit	$20/ $40 copay per visit	$15/ $30 copay per visit	$25/ $50 copay per visit
Urgent Care Visit	$50 copay per visit	$25 copay per visit	$50 copay per visit
Emergency Room Visit	$600 copay per visit	$600 copay per visit	$600 copay per visit
In-Patient Hospital	$600 copay per visit	$600 copay per visit	$600 copay per visit
Outpatient Surgery	$350 copay per visit	$350 copay per visit	$400 copay per visit

*The in-network deductible on Tier 1 and Tier 2 are cross-accumulated

Option 2: Examples

Ex. 1

Member has 4 PCP visits and 3 Specialist visits throughout the year

Tier 1: All Visits Tier 1

- PCP: $15 copay per visit
- Specialist: $30 copay per visit

$60 PCP copay
+$90 Spec. Visit
$150 Total Member Cost

Tier 1 and 2 Combination:

- PCP: Tier 1, $15 copay per visit
- Specialist: Tier 2, $50 copay per visit

$60 PCP copay
+$150 Spec. Visit
$210 Total Member Cost

Ex. 2

Member has an imaging procedure that costs $750

- Tier 1: with no other claims the member would meet the Tier 1 Deductible plus 20% coinsurance

$100 Deductible
+ $130 Coinsurance
$230 Total Member Cost

- Tier 2: with no other claims the member would meet the Tier 2 Deductible plus 20% coinsurance

$200 Deductible
+ $110 Coinsurance
$310 Total Member Cost

Ex. 3

Member has the following visits during a hospital stay:

- 1 PCP visit
- 1 Specialist Visit
- $750 imaging
- $2,400 DME cost

Tier 1 (All visits under Tier 1)

$15 PCP Visit
$30 Spec. Visit
$100 Deductible
+ $610 Coinsurance
$755 Total Member Cost

Tier 2 (All visits under Tier 2)

$25 PCP Visit
$50 Spec. Visit
$200 Deductible
+ $590 Coinsurance
$865 Total Member Cost

Option 2: Two-Tiered In-Network Option Projected Savings

	Current Tier 1 Claim Utilization Percentage	Projected Savings After Plan Design Changes
Northern Nevada – EPO Membership	18.5%	$300,000 - $600,000
Southern Nevada – HMO Membership	16.1%	$300,000 - $400,000
Total		$600,000 - $1,000,000

The savings shown above is in addition to the plan savings shown for Option 1 based on moving from an HMO network to and EPO network

Option 3: No Change

- HMO remains fully insured
  - Segal will commence negotiations with HPN to discuss reducing PY2028 premium increase
- Anticipated that EPO/HMO plan rates will continue to escalate at a rate higher than LDPPO and CDHP as members with lower risk profile move out of this plan
  - Continued anti-selection
  - Forecasted result is a continued higher premium rate increases for EPO/HMO for both PEBP and its members

Disruption

Provider Disruption

- Virtually no disruption for HMO
  - HPN network is a subset of the United Healthcare Network
  - Disruption shows 1 member using a neuropsychologist in the amount of $1,300 last year

Match Basis	Scenario	Unique Providers	Specialty	Unique Tax IDs	Provider Name
TIN	HPN not SHO	1	Neuropsychology	1	Silver State Psychology

Source: HPN Reporting for the period July 1, 2025 through June 30, 2026

Appendix

Tier 1 Provider Counts – Northern NV PCPs

County	Family / General Practice	Internal Medicine	Specialist	Obstetrics and Gynecology	Total PCPs
Carson City	32	14	8	4	58
Churchill	5	3	3	1	12
Douglas	12	8	3	2	25
Elko	30	3	1	1	35
Humboldt	1	0	1	2	4
Lander	3	0	0	0	3
Lyon	6	0	0	1	7
Pershing	0	1	0	0	1
Storey	8	0	0	0	8
Washoe	113	112	33	15	273
White Pine	0	3	0	0	3
Total PCPs	**210**	**144**	**49**	**26**	**429**

Segal consolidated provider listing where practical to eliminate duplicate counts

Tier 1 Provider Counts – Northern NV Specialists

County	Family / General Practice	Surgery / Anesth	Condition Specific Specialists	Emergency	Oncology / Diagnostic	Pediatrics	Behavioral Health	Sports / PT / Rehab	Total Specialists
Carson City	16	30	18	2	1	3	1	0	71
Churchill	2	7	7	0	0	0	0	0	16
Douglas	6	35	14	9	0	0	0	0	64
Elko	10	11	12	0	0	0	0	0	33
Humboldt	0	19	1	0	0	1	0	0	21
Lander	0	0	1	0	0	0	0	0	1
Lyon	3	1	1	0	0	1	0	0	6
Pershing	0	0	0	2	0	0	0	0	2
Storey	5	0	1	0	0	0	0	0	6
Washoe	80	78	112	7	7	19	0	5	308
White Pine	0	5	6	0	0	0	1	0	12
Total Specialists	**122**	**186**	**173**	**20**	**8**	**24**	**2**	**5**	**540**

Segal consolidated provider listing where practical to eliminate duplicate counts

Tier 1 Provider Counts – Southern NV PCPs

County	Family / General Practice	Internal Medicine	Specialist	Obstetrics and Gynecology	Total PCPs
Clark County	68	69	69	2	208
Nye County	0	0	1	0	1
Total PCPs	**68**	**69**	**70**	**2**	**209**

Segal consolidated provider listing where practical to eliminate duplicate counts

Tier 1 Provider Counts – Southern NV Specialists

County	Internal Medicine	Surgery	Condition Specific Specialists	OB/GYN	Oncology / Diagnostic	Pediatrics	Behavioral Health	Total Specialists
Clark County	7	66	157	61	2	4	4	301
Nye County	0	0	2	1	0	0	0	3
Total Specialists	**7**	**66**	**159**	**62**	**2**	**4**	**4**	**304**

Segal consolidated provider listing where practical to eliminate duplicate counts

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- This document was prepared as part of a presentation made to Nevada PEBP on November 17, 2026 and is not complete without the remainder of presentation. Except as may be required by law, this document should not be shared, copied or quoted, in whole or in part, without the consent of Segal.

- The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, changes in medical innovation/FDA approvals, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.

8.

8. Express Scripts Corrective Action Plan. (Amy Donohue & Amy Daily, Express Scripts) (Information/Discussion)

PEBP - Guarantees Met

All 16 guarantees reported as Met, Jul 2025 – Jun 2026

Eligibility & claims operations

- **Eligibility:** Maintenance eligibility transactions processed within 2 business days of receipt.
- **Eligibility file accuracy:** 100% of usable, error-free files loaded without error.
- **HIPAA claim compliance:** 99% of claims submitted in a HIPAA-compliant format.
- **Network pharmacy decline:** No more than 5% net loss of pharmacies in the broadest network.
- **Benefit design changes:** Standard plan changes implemented within 10 calendar days.

Account management

- **Inquiry turnaround:** Client requests answered within 2 business days.
- **Staff changes:** Account team stays in place, barring promotion or termination.
- **Standard report delivery:** Quarterly reports within 45 calendar days of quarter end.
- **Account Management satisfaction:** Annual client report card on the account team.
- **ESI satisfaction:** Quarterly customer service reviews with PEBP staff.

Reporting & reviews

- **Trend Central reporting:** Monthly reports within 15 business days; quarterly within 30.
- **Guarantee report:** Compliance reported within 45 days; penalties credited within 75.
- **Billing reports:** Mailed within 5 business days of claim cycle end.
- **Fraud, waste & abuse:** Quarterly reports within 30 days, with review meetings.

Met in every reported period (Q1–Q4)

Source: 47787_25_PerformancePenalty_Jul25toJun26.pdf

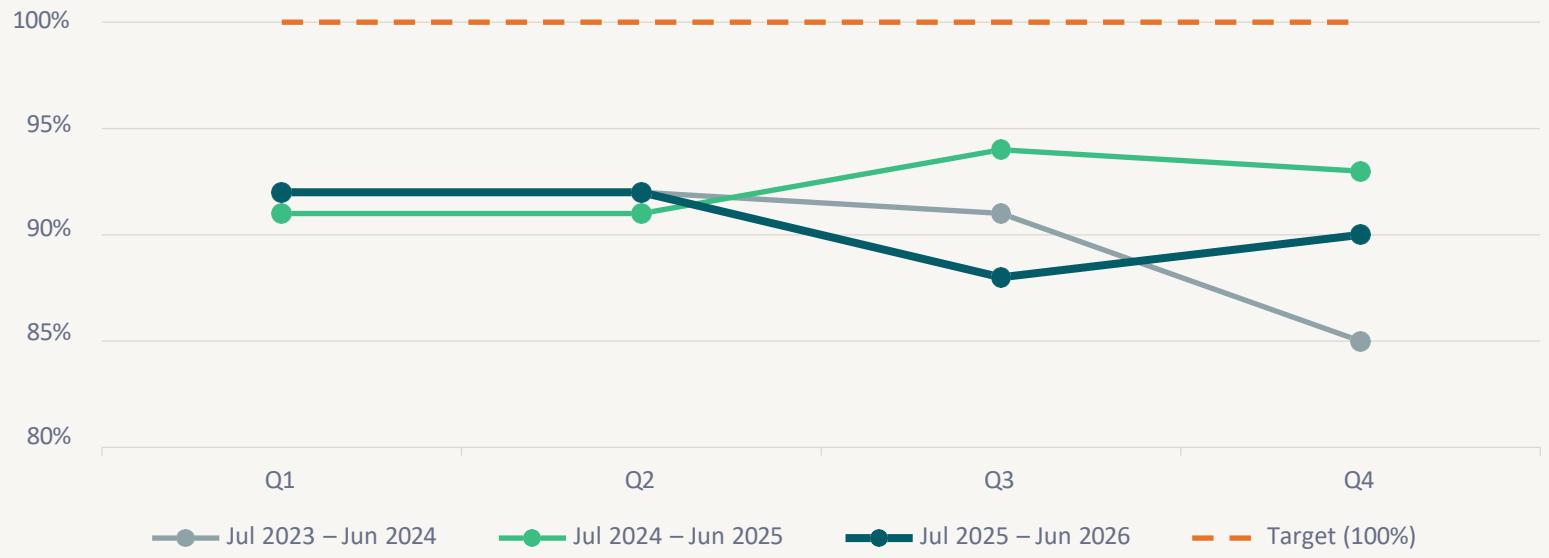
Non-Protocol Dispensing Timeliness: Jul 2023 – Jun 2026

Nevada PEBP | 2-business-day guarantee | Quarterly and year-to-date results, three years

Fiscal period	Target	Q1	Q2	Q3	Q4	YTD
Jul 2023 – Jun 2024	100%	92%	92%	91%	85%	**90%**
Jul 2024 – Jun 2025	100%	91%	91%	94%	93%	**92%**
Jul 2025 – Jun 2026	100%	92%	92%	88%	90%	**91%**

YTD vs. 100% target

- **Jul 2023 – Jun 2024: 90%**
- **Jul 2024 – Jun 2025: 92%**
- **Jul 2025 – Jun 2026: 91%**



Orange = below target.

Source: 47787_30_PerformanceGtee_Jul23toJun24.pdf; 47787_30_PerformanceGtee_Jul24toJun25.pdf; 47787_25_PerformanceGtee_Jul25toJun26.pdf

Non-Protocol Action Plan

Nevada PEBP | Order Delay Reasons

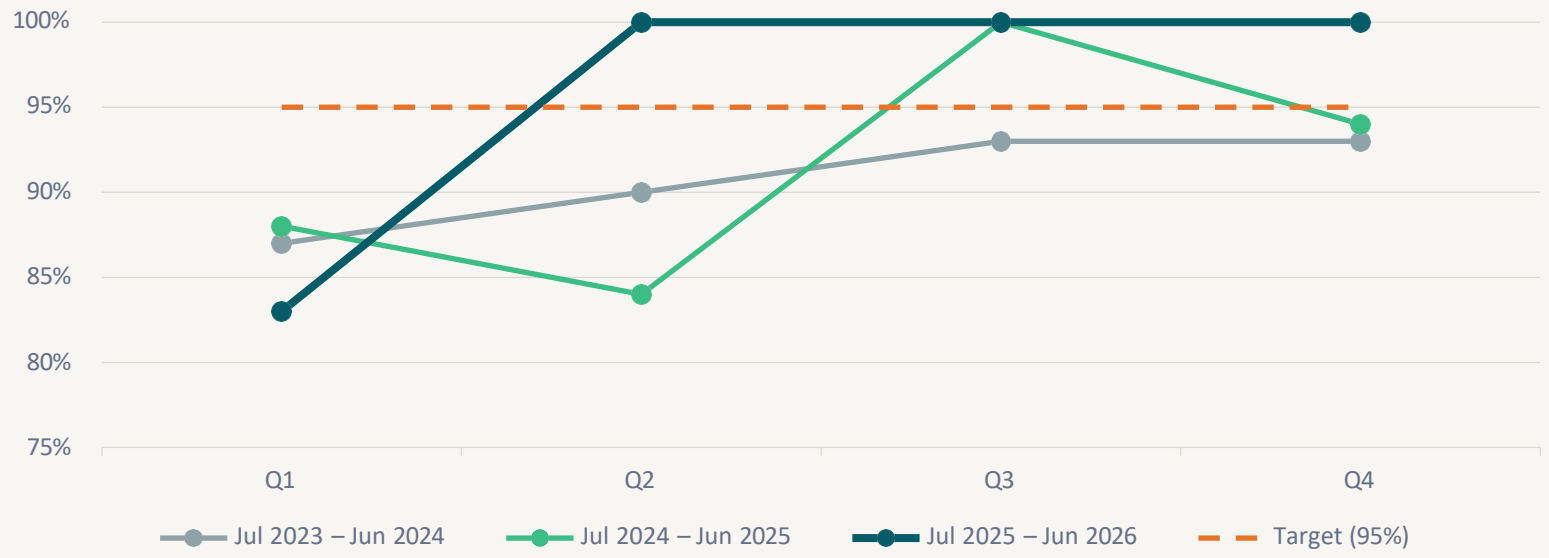
- One missed prescription will cause ESI to miss the PG
  - PG very hard to meet
  - However, we do try to push to meet this metric
  - Our typical PGs offer 100% average in 2 business days
- Reasons a prescription may not meet 2-day turnaround
  - Provider outreach to clarify prescriptions
  - Weather events (impacts shipping partners)
  - Shipping requirements (ice packaging) when there are high temperatures
  - High volume home delivery months

Source: 47787_25_PerformancePenalty_Jul25toJun26.pdf

Member Satisfaction: Jul 2023 – Jun 2026

Nevada PEBP | Quarterly and year-to-date results, three years

Fiscal period	Target	Q1	Q2	Q3	Q4	YTD
Jul 2023 – Jun 2024	95%	87%	90%	93%	93%	**90%**
Jul 2024 – Jun 2025	95%	88%	84%	100%	94%	**91%**
Jul 2025 – Jun 2026	95%	83%	100%	100%	100%	**95%**



Orange = below target.

YTD vs. 95% target

- **Jul 2023 – Jun 2024: 90% (missed)**
- **Jul 2024 – Jun 2025: 91% (missed)**
- **Jul 2025 – Jun 2026: 95% (met)**
- **Up 5 points in YTD over three years**

Source: 47787_30_PerformanceGtee_Jul23toJun24.pdf; 47787_30_PerformanceGtee_Jul24toJun25.pdf; 47787_25_PerformanceGtee_Jul25toJun26.pdf

Member Satisfaction Action Plan

- Improvement over last 3 years
- Met annual survey percentage in 25/26
- Low response rate each year
- Plan design and PEBP changes can impact quarterly and annual results as well as how many responses we receive
- Encourage PEBP utilizers to log on to www.express-scripts.com or mobile app
  - Currently at 35% for website and 19% for mobile app
  - Based on member comments more information is shared timely on web/mobile app:
    - Prior authorization status
    - In-network pharmacies
    - Makes retail to mail conversions easy
    - Cost information available to members in app or online prior to visiting Dr

Source: 47787_25_PerformancePenalty_Jul25toJun26.pdf

9.

9. PY26 Claims Technology Incorporated audit findings for Willis Towers Watson. (Joni Amato, CTI) (**For Possible Action**)

Claim Administration Audit Findings Report

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefit Plan
Administered by Via Benefits from WTW

Audit Period: July 1, 2025 – June 30, 2026

Presented to

State of Nevada Public Employees' Benefit Plan

November 17, 2026

CTI Audit Solutions

Proprietary and Confidential

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EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from CTI Audit Solutions audit of Via Benefits from WTW's) administration of the State of Nevada Public Employees' Benefit Plan (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope
CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2025 through June 30, 2026 (plan year 2026). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$15,708,137
Total Number of Claims Paid/Denied/Adjusted	155,904

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

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in our opinion:

1. Via Benefits continued to provide good service to PEBP members. It exceeded performance guarantees for five of its seven self-reported measures and met all three measures validated by the random sample audit.

2. Based on the random sample findings, CTI recommends Via Benefits provide claim processors with coaching on the errors identified during the audit, with focus on verification of claim service dates and eligible expense documentation.

Random Sample Audit Performance Guarantee Summary

Via Benefits met all three metrics for PEBP in plan year 2026; no penalty is owed.

FY 2026 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Met – 99.09%	$0
Claim Processing Payment Precision	98%	Met – 99.0%	$0
Claim Processing Turnaround Time	Average 2 business days	Met – 0.18 days	$0
		Total Penalty	**$0**

AUDIT OBJECTIVES

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

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

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

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

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

OPERATIONAL REVIEW

Objectives

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

Scope

The scope of our review included:

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

Methodology

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

Findings

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

- Via Benefits indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- Willis Towers Watson (WTW), parent company of Via Benefits, reported it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report for the period October 1, 2024 through September 30, 2026. It also provided a bridge letter dated January 2, 2026.
- The business continuity plan provided by Via Benefits included two approaches to data protection:
  1) continuous offsite replication to a second, geographically distant location and,
  2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions, member or services were outsourced. A dedicated internal team of claim processors handled all claim processing.

- Refunds and returned checks were forwarded to PEBP for deposit into PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount for which participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits indicated loss of HRA eligibility was the biggest reason for a claim overpayment; and the biggest reason for loss of eligibility was a late notification of death status.
- Via Benefits provided an overpayment report for FY2026 showing $1,022,068 in overpayments on 2,086 transactions. The total amount recovered was not indicated in the report.
- Customer service operations were available via phone Monday through Friday from 8:00 AM to 6:00 PM EST. Additionally, the online portal allowed members to submit claims, check claim status, check participant balance, support documents submittal, and view historical information.
- Via Benefits communicated with account holders via mail or email. It provided a one-time HRA welcome packet mailing upon initial qualification, digital newsletters approximately every two months, and a one-time enrollment guide mailing when a participant aged into Medicare.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties to maintain system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' Acclaim System Controls document provided a thorough overview including detail on data entry logic, duplicate logic, processing thresholds for processor levels, and overpayment logic as examples.
- Web-based security and compliance training was provided to Via Benefits staff within 90 days after hire and then annually thereafter.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

PERFORMANCE GUARANTEE VALIDATION

As part of CTI's audit of PEBP, we reviewed the self-reported Performance Guarantees included in its contract with Via Benefits. The results for plan year 2026 show guarantees were missed in FY26 Q2 for Average Speed of Answer and Quarterly Customer Satisfaction Review and a penalty of $2,000 is owed for each.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	All delivered within 15 days	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.87%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	3.19%	Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2026 Five minutes in Q2 PY 2026 Two minutes in Q3 PY 2026 Ninety seconds in Q4 PY 2026	 Q1 PY 2026 – 1:18 Q2 PY 2026– 5:16 Q3 PY 2026 – 0:34 Q4 PY 2026 – 0:15	 Met Not Met Met Met
Customer Satisfaction Quarterly Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2026– 91.06% Q2 PY 2026– 77.53% Q3 PY 2026– 86.27% Q4 PY 2026– 92.45%	Met Not Met Met Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	100%	Met
Unauthorized Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 day notification.	100%	Met

RANDOM SAMPLE AUDIT

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

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

- Claim Financial Precision
- Claim Processing Payment Precision

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

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

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

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

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

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

Performance Measure	Claims Sampled		Sampled Claims with Errors		Result
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$22,034.27	1	$202.90	99.09%
Claim Processing Payment Precision	200		2		99.00%
Claim Turnaround Time	Average 2 business days				0.18 days

Random Sample Findings Detail Report			
Audit Number	**Over/ (Under) Paid**	**Via Benefits Response**	**CTI's Conclusion**
Incorrect Denial of Eligible Expense			
1152	($202.90)	Agree.	Procedural error and underpayment remain. The sample claim was denied for not having all documentation needed to pay; however, all information was provided with submission, and claim should have paid. The claim was subsequently re-submitted by member and benefits have been paid.
Incorrect Date of Service Used			
1174	NA	Agree.	Procedural error remains. The incorrect date of service was used on the transaction.

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
1046	During review of this sample claim, CTI identified an out-of-sample claim processed with an incorrect date of service. An inaccurate date of service may prevent the system from appropriately identifying a subsequent submission as a potential duplicate, increasing the risk of duplicate payment.

ELIGIBILITY VERIFICATION

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

Description	Claim Lines	Members	Paid Amount*
Member Not on File	284	26	$33,706
Incurred After Member Benefit End Date	99	56	$15,446
Incurred Prior to Member Benefit Begin Date	3	1	$420
TOTALS	**383**	**82**	**$49,572**

**CTI notes that 0.315% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 0.5% CTI generally reports.*

PLAN YEAR 2026 RECOMMENDATIONS

Based on the findings of the plan year 2026 audit, CTI recommends:

1. Via Benefits coach its claim processors on errors identified during the audit including:
    - Incorrect denial of eligible expenses
    - Verification of claim dates of service
2. PEBP ensures receipt of penalty payments for missed performance guarantees for:
    - Customer Satisfaction Review – $2,000 for Q2 FY26
    - Customer Service Average Speed of Answer – $2,000 for Q2 FY26
3. PEBP and TELUS review eligibility screening results for potential workflow improvements to reduce payments made for ineligible members.

CONCLUSION

Based on the random audit findings, Via Benefits met the performance metrics for claim financial precision, claim processing payment precision, and claim turnaround time in FY2026.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report can be found on the following pages. Additional information submitted to CTI from Via Benefits 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.

October 12, 2026

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2025-June 2026 please see our response to the report and the auditors' recommendations below:

WTW Response:

Claim Technologies Incorporated noted that of the 200 claims reviewed there were two claims processing errors after review with the auditors, WTW agrees to the claims processing errors regarding audit number 1152 and 1174.

Observation:

-In regard to audit number 1046, we acknowledge the date of service was processed incorrectly, however, as stated the claim was out of the original scope. The error resulted in an error entry, not a duplicate payment, as the entry was related to a separate expense item.

Recommendations:

1. WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.
2. WTW will pay Nevada PEBP for the following missed performance guarantees as soon as administratively possible once the report is provided to the Nevada PEBP Board of Directors. The total penalty is $4,000.00.

Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to:		
Ninety seconds in Q1 PY 2026	Q1 PY 2026 – 1:18	Met
Five minutes in Q2 PY 2026	Q2 PY 2026– 5:16	Not Met
Two minutes in Q3 PY 2026	Q3 PY 2026 – 0:34	Met
Ninety seconds in Q4 PY 2026	Q4 PY 2026 – 0:15	Met
Customer Satisfaction Quarterly Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2026– 91.06%	Met
	Q2 PY 2026– 77.53%	Not Met
	Q3 PY 2026– 86.27%	Met
	Q4 PY 2026– 92.45%	Met

3. WTW works with TELUS Health to identify participants who have had incorrect data loaded on their accounts, which can cause participants to lose their HRA qualification and place their account into overpayment. Nevada PEBP is aware of the incorrect data that was sent to WTW and that WTW and TELUS are working together to identify impacted participants and ensure correct data is received to

update the accounts. WTW will continue to work with TELUS and Nevada PEBP on identifying solutions for data corrections.

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

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 | West Des Moines, IA 50266

10.

10. Q4 Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR. (Joni Amato, CTI) (**For Possible Action**)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefit Plan
Administered by UMR

Audit Period: April 1, 2026 – June 30, 2026
Audit Number 1.FY26.Q4

Presented to

State of Nevada Public Employees' Benefit Plan

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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 Plan (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of April 1, 2026 through June 30, 2026 (quarter 4 (Q4) 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	$87,687,803
Total Number of Claims Paid/Denied/Adjusted	258,806

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR met all 34 self-reported performance guarantees in which CTI reviewed UMR's summary reports.

2. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time met the service objective, and no penalty is owed.

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 met its target for Financial Accuracy, Overall Accuracy and Claim Turnaround Time in Q4 FY2026 and no penalty is assessed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy	99.4%	Met – 99.64%	NA	$0.00
Overall Accuracy	98.0%	Met – 98.50%	NA	$0.00
Claim Turnaround Time	92% in 14 Days	Met – 98.10%	NA	$0.00
	99% in 30 Days	Met – 99.10%	NA	$0.00
		Total Penalty	NA	**$0.00**

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	Q1 FY26	Q2 FY26	Q3 FY26	Q4 FY26
Financial Accuracy	99.4%	99.84%	99.16%	98.78%	99.64%
Overall Accuracy	98.0%	98.00%	97.50%	97.00%	98.50%
Claim Turnaround Time	92% in 14 Days	92.00%	92.90%	96.10%	98.10%
	99% in 30 Days	98.10%	98.60%	99.10%	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.

ANNUAL OPERATIONAL REVIEW

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

Scope
The scope of the Operational Review included:

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

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

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

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

- UMR indicated it maintains levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.

- UMR was audited by Baker Tilly for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2025 to December 31, 2025. A bridge letter dated April 7, 2026 was also provided noting no material changes were made to internal controls.
- UMR stated it incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR used ClearHealth to perform prepayment Diagnostic Related Grouping (DRG) verification. They used its DRG grouper software to determine if an alternate DRG code was applicable for the services billed. It also used Optum Credit Balance Recovery for post-payment DRG validation though comparison of medical records and DRG coding billed.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than the UMR total allowable amount. UMR reduced the allowable amount by the amount paid by the primary payor. UMR provided a report detailing $2,927,051 in COB savings for the PEBP plans in FY2026.
- UMR reported 97.2% of claims were received electronically during the audit period and 77.97% of claims received were auto adjudicated.
- UMR reported it used Artificial Intelligence (AI) and Machine Learning (ML) to expedite payment, reimbursement and appeals workflows as well as streamlining processes. UMR was not using AI or ML in the claim denial process.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. UMR reported it used vendors to perform overpayment recovery. No fee was charged back to PEBP for recoveries from Optum Payment Recovery Services. Optum also pursued credit balance recoveries, and a 20% fee was charged back to PEBP for those recoveries. UMR reported to CTI that it had an overpayment recovery rate of 57% and for FY2026 it reported overpayment recoveries of $935,120. UMR stated it identified 1,537 overpayments in FY26 with an outstanding balance of $1,214,045.
- UMR pursued direct reimbursement on cases still open after 120 days. Cases with totals of $100 to $350 were sent two letters and if no response was received after 61 days, the case was closed. Cases exceeding $350 were referred to its specialized recovery area for more aggressive follow-up for a minimum of 12 months. Cases exceeding $50,000 were referred to the legal department if the specialized recovery area was not successful in obtaining the refund.
- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR provided a member appeal tracking report to CTI for January through June 2026. It showed 193 appeals received; 128 appeals had the original determination upheld, 56 were overturned, two were partially overturned, and seven were pending at the time of reporting. Twenty appeals took more than 20 days to resolve.
- UMR stated its Special Investigations Unit (SIU) took a proactive approach to fraud and abuse to identify and monitor trends. The SIU created system edits, developed review procedures, and provided special training to UMR claim professionals to help them identify potential fraudulent circumstances. UMR SIU stated they worked alongside UMR Legal to collaborate with federal and state law enforcement authorities to combat fraud, waste and abuse and it appropriately referred suspected fraud, waste and abuse to law enforcement authorities for criminal prosecution and/or civil enforcement.

- We screened 100% of non-facility claims against the Office of the Inspector General's List of Excluded Individuals and Entities (OIG's LEIE) and confirmed no sanctioned providers received payment from the UMR during the audit period.
- UMR reported it received 99.87% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in the Cancer Resource Program.
- UMR provided its network savings report showing 99.9% of all dollars paid were in network with a discount savings of 68.8%. Based on the claim data provided by UMR, PEBP's members under age 65 had utilization of network or secondary network providers at 97.2% of all allowed charges and 96.0% of all claims. Discount savings indicated below:

Total of all Claims for Members Under Age 65		
Claim Type	**Provider Discount**	
Ancillary	$11,135,289.58	42.8%
Non-Facility	$194,461,055.47	55.3%
Facility Inpatient	$204,253,956.72	73.4%
Facility Outpatient	$310,311,155.24	69.3%
TOTAL	**$720,161,457.01**	**65.2%**

- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 39 NSA appeals, and 36 inquiries received for allowances made for out-of-network services. Of those, 15 appeals were overturned and 22 were upheld.
- All new employees were required to complete HIPAA training, and all employees were required to complete computer based HIPAA training annually. UMR reported no breeches during FY2026.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed Performance Guarantees included in its contract with UMR. The results for Q4 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	95.8%	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	92.6%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.5%	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%	96.9%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.8% 99.6%	Met Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	98.7%	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 95.00% Within 24 Hours	100% 100%	Met 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% 99.6%	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%	99.18%	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
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	100%	Met
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to provider using approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	100%	Met
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of	95.00%	98.91%	Met

	Metric	Service Objective	Actual	Met/ Not Met
	notification of discharge with clinical coaching and discharge planning assistance.	3 Business Days		
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	95%	Met
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	100%	Met
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No 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				
2	$1,020.24	Agree. Procedure was paid on both 05/14/26 and 06/15/26. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. Upon second review, a system issue appears to have inadvertently generated two payments for the same claim on separate dates. IT is reviewing the issue to identify the cause of the duplicate payment and prevent future occurrences.*	Procedural deficiencies and overpayments remain. The services were paid twice creating a duplicate payment.	☒ M ☐ S
3	$234.48	Agree. Claim xxxx8688 submitted with bill type 137, and was a corrected claim to replace original claim xxxx2331. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. Claim xxxx8688 has been adjusted to deny as a duplicate. Impact report identified two additional corrected claims that were paid in error, resulting in an overpayment of $1,558.74. A reporting process has been implemented to identify corrected claims that may have been paid in error. Additionally, the duplicate claims process is under review for potential system and workflow enhancements to strengthen controls and prevent similar issues from recurring.*		☒ M ☐ S
Plan Exclusions				
Reverse Sterilization				
45	$21.43	Agree. The claim will be adjusted to deny upon completion of the audit. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to*	Procedural deficiency and overpayment remain. Payment was made for an excluded expense, reversal of sterilization.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		flag claims with applicable diagnosis codes for review prior to processing.		
Marriage Counseling				
47	$75.00	Agree. The claim will be adjusted to deny upon completion of the audit. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.*	Procedural deficiency and overpayment remain. Payment was made for an excluded expense, marriage counseling.	☒ M ☐ S
Plan Limitations				
Timely Filing				
21	$385.48	Agree. Claim allowed incorrectly past timely filing. *From UMR's 9/15/26 response to the draft report: UMR agrees with finding. Upon second review, original claim was received timely and denied for primary EOB. Provider did not submit requested primary EOB until 06/1/26. Primary EOB should have been submitted 180 days from the original denial date. Claim has been adjusted and denied as past timely filing. Impact report confirmed error was limited to a single claim, with no additional claims identified. Coaching and education provided on the timely filing provisions outlined in the master plan document.*	Procedural deficiency and overpayment remain. The claim was past paid the timely filing limitation.	☒ M ☐ S
Provider Discount Error				
31	$4,645.39	Agree. Claim paid at greater than billed charges. Please see screenshot of SHO pricing below. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted with correct pricing. Impact report identified 13 additional claims with pricing discrepancies, resulting in an overpayment of $19,871.99. Staff education was completed and repricing has been restricted to senior staff.*	Procedural deficiency and overpayment remain. The contract rate was not applied to this claim. UMR allowed greater than billed charges. The allowable should have been $1,606.61 instead of $6,252.00.	☒ M ☐ S
34	Unknown	Agree. Claim paid in full at billed charges in error. *From UMR's 9/15/26 response to the draft report: UMR agrees with finding. Impact report remains in progress, and claims are continuing to be reviewed to determine the extent of any additional impact. A reporting process has been implemented to identify claims paid in full at billed charges in error.*	Procedural deficiency and overpayment remain. The in-network discount was not applied.	☒ M ☐ S
36	$299.25	Agree. Methodology used for this provider is Lesser 60% of billed or Sierra fee schedule. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted with in-network discount applied. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures.*	Procedural deficiency and overpayment remain. The in-network discount was not applied. The rate should have been $0.75 and billed charges were paid.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Preventive Services				
Denied				
16	($102.06)	Agree. Services performed in VA Medial Center should have been allowed. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. The claim has been adjusted to allow charges. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Staff received coaching and education on the proper handling of routine vision services provided at VA facilities, ensuring they are covered as in-network.*	Procedural deficiency and underpayment remain. The preventive service was denied in error.	☒ M ☐ S
With Deductible Applied				
17	($500.00)	Agree. Preventive colorectal screenings should not apply a copay. *From UMR's 9/15/26 response to the draft report: UMR agrees with this finding. A review found that the diagnostic procedure qualified as a preventive service; however, the outpatient surgical facility copayment was incorrectly applied during processing. The claim has been adjusted to remove the copay. Impact analysis confirms that the error was limited to a single claim, with no additional claims identified.*	Procedural deficiency and underpayment remain. A copayment was applied to the preventive service in error.	☒ M ☐ S

Preliminary Annual Eligibility Verification

CTI electronically compared dates of service for FY2026 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. CTI's screening revealed some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health and UMR for review and comment. At this time, potentially overpaid amounts have been flagged into the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$22,666.86
Payments Prior to Effective Date	$1,471.52
Payments During Gaps in Coverage	$9,735.43
After Termination Date of Employee's Coverage	$101,698.44
Subtotal	$135,572.25
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$16,502.05
Payments Prior to Effective Date	$26,601.50
Payments During Gaps in Coverage	$898.54
After Termination Date of Employee's Coverage	$79,434.94
Subtotal	$123,437.03
COMBINED TOTAL*	**$259,009.28**

**CTI notes that 0.08% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are less than 0.5% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

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

Scope

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

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

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

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based 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 $5,987,146.65. The claims sampled and reviewed revealed $32.37 in underpayments and $28,779.68 in overpayments. This reflects a weighted Financial Accuracy rate of 99.64% over the stratified sample. This is an increase in performance from the prior period. Details are provided in the following Random Sample Findings Detail Report.

UMR met the Performance Guarantee for PEBP in Q4 FY2026 of 99.40% for this measure and no penalty is due.

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 3 incorrectly paid claims and 197 correctly paid claims. This is an increase 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	1	98.50%

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 increased from the prior period, and UMR met the Performance Guarantee for PEBP in Q4 FY2026 of 98.00% for this measure. No penalty is owed. Detail is provided in the Random Sample Findings Detail Report below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	0	3	98.50%

Random Sample Findings Detail Report				
Audit No.	**Under/ Overpaid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Incorrect Provider Discount				
1095	($2.00)	Agree. The incorrect allowed amount entered resulting in an underpayment of $2.00. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with finding. This was a manual keying error. The claim has been adjusted to correct the allowed amount.*	Procedural error and underpayment remain. The allowed amount was processed on the claim as $14,110.95 and it should have been $14,112.95.	☒ M ☐ S
1107	($30.37)	Agree. We under allowed $37.96 and under paid by $30.37. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with finding. Incorrect pricing applied, resulting in an underpayment of $30.37. As the observation stay exceeded 23 hours, services should have been processed using inpatient benefits. Claim has been adjusted.*	Procedural error and underpayment remain. The allowed amount was processed on the claim as $18,035.37 and it should have been $18,073.34.	☒ M ☐ S
Coordination of Benefits Error				
1133	$28,779.68	Agree. Other insurance information was not coordinated correctly resulting in overpayment of $28,779.68. We should have paid no more than $344.58. *From UMR's 9/15/26 response to the draft report:* *UMR agrees with this finding. As the member has Medicare Part B as the primary payer, benefits should have been coordinated with Medicare and only the applicable Medicare patient responsibility amount should have been allowed. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures. Claim has been adjusted.*	Procedural error and overpayment remain. The primary insurance carrier's EOB reflect the member responsibility was $344.58. The sample claim paid $29,124.26.	☒ M ☐ S

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.

Number	Observation
2004	The provider billed D1355 (Caries-Preventive Medicament Application) 24 times for this 14-year-old member, resulting in total payments of $1,350. Based on American Dental Association (ADA) coding guidance, a standard full-mouth preventive treatment would generally be reported using D1206 (Topical Application of Fluoride Varnish) or D1208 (Topical Application of Fluoride Excluding Varnish), which typically has an allowance of approximately $50-$60 per application. Prior to payment of 24 units of D1355, supporting documentation should have been obtained to substantiate each tooth was individually treated with a non-fluoride caries-preventive medicament

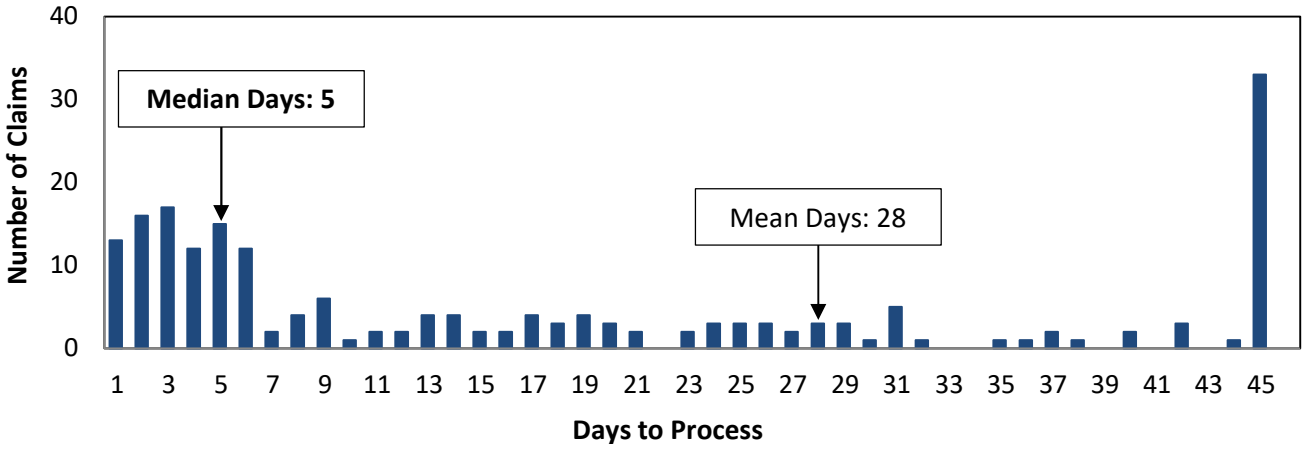
Number	Observation
	(such as silver diamine fluoride, silver nitrate, chlorhexidine varnish, or a similar agent) and that each treated tooth met the applicable clinical criteria for separate reimbursement. Documentation should also clearly demonstrate the services provided were distinct from a routine full-mouth fluoride application, which would generally be more appropriately reported using D1206 or D1208. Obtaining this documentation would be consistent with the Dental Master Policy Document (MPD), which states on page 11 – *A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply.* Absent documentation supporting the necessity of 24 separately billable D1355 applications, the payment may not meet the Dental MPD's cost-efficiency standard. UMR should consider obtaining and reviewing such documentation prior to payment of similar future claims to confirm the services meet the criteria for separate reimbursement. *From UMR's 9/15/26 response to the draft report:* *UMR disagrees with this observation. Procedure code D1355 (Caries Preventive Medicament Application - per tooth) does not require the application of dental necessity criteria. UMR's Book of Business configuration supports coverage of D1355 for eligible permanent teeth (1-32) and primary teeth (A-T). The claim adjudication aligns with configured business rules and established benefit administration guidelines.*

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 Q4 FY2026 of 92% processed within 14 days and 99% processed within 30 days and no penalty is due.

FY2026 REVIEW AND RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY2026 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2026 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy on a consistent basis.
    - The most frequent error in FY2026 was the incorrect application of provider discount and was most commonly a manual processing error.

2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
    - The most frequent improvement opportunities were identified in the categories of duplicate payments, incorrect provider discount application, and incorrect copayment application.

3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.

CONCLUSION

UMR's performance in Q4 improved and met the performance metrics for PEBP for Financial Accuracy, Overall Accuracy and Claim Turnaround in the fourth quarter of FY2026.

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 can be found on the following pages. 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

September 25, 2026

Thank you for the opportunity to respond to the review of the State of Nevada Public Employees' Benefit Program Q4Y26 audit draft report. The following is our response to the draft report completed by CTI. As part of our ongoing commitment to service excellence, UMR leadership is evaluating the resources supporting the PEBP account to ensure we have the optimal team structure in place to meet PEBP's needs and to deliver exceptional client experience.

ESAS Targeted Sample Findings

Duplicate Payments
QID 2 – UMR agrees with this finding. Upon second review, a system issue appears to have inadvertently generated two payments for the same claim on separate dates. IT is reviewing the issue to identify the cause of the duplicate payment and prevent future occurrences.

QID 3 – UMR agrees with this finding. Claim [redacted] has been adjusted to deny as a duplicate. Impact report identified two additional corrected claims that were paid in error, resulting in an overpayment of $1,558.74. A reporting process has been implemented to identify corrected claims that may have been paid in error. Additionally, the duplicate claims process is under review for potential system and workflow enhancements to strengthen controls and prevent similar issues from recurring.

Plan Exclusions – Reverse Sterilization
QID 45 – UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.

Plan Exclusions – Marriage Counseling
QID 47 – UMR agrees with this finding. The claim has been adjusted to deny the excluded service. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. A system enhancement is being implemented to flag claims with applicable diagnosis codes for review prior to processing.

Plan Limitations – Timely Filing
QID 21 – UMR agrees with this finding. Upon second review, the original claim was received timely and denied for primary EOB. The provider did not submit the requested primary EOB until 06/1/26. The primary EOB should have been submitted 180 days from the original denial date. The claim has been adjusted and denied as past timely filing. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Coaching and education provided on the timely filing provisions outlined in the master plan document.

Provider Discount Error
QID 31 – UMR agrees with this finding. The claim has been adjusted with correct pricing. Impact report identified 13 additional claims with pricing discrepancies, resulting in an overpayment of $19,871.99. Staff education was completed and repricing has been restricted to senior staff.

QID 34 – UMR agrees with this finding. Impact report remains in progress, and claims are continuing to be reviewed to determine the extent of any additional impact. A reporting process has been implemented to identify claims paid in full at billed charges in error.

QID 36 – UMR agrees with this finding. The claim has been adjusted with in-network discount applied. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures.

Preventive Services – Denied
QID 16 – UMR agrees with this finding. The claim has been adjusted to allow charges. Impact report confirmed that the error was limited to a single claim, with no additional claims identified. Staff received coaching and education on the proper handling of routine vision services provided at VA facilities, ensuring they are covered as in-network.

Preventive Services – Denied
QID 17 – UMR agrees with this finding. A review found that the diagnostic procedure qualified as a preventive service; however, the outpatient surgical facility copayment was incorrectly applied during processing. The claim has been adjusted to remove the copay. Impact analysis confirms that the error was limited to a single claim, with no additional claims identified.

Random Sample Findings

Incorrect Provider Discount
Sample 1095 – UMR agrees with this finding. This was a manual keying error. The claim has been adjusted to correct the allowed amount.

Sample 1107 – UMR agrees with this finding. Incorrect pricing was applied, resulting in an underpayment of $30.37. As the observation stay exceeded 23 hours, the services should have been processed using inpatient benefits. The claim has been adjusted.

Coordination of Benefits Error
Sample 1133 – UMR agrees with this finding. As the member has Medicare Part B as the primary payer, benefits should have been coordinated with Medicare only allowing the applicable Medicare patient responsibility amount. Additional training was provided for processing staff to address the identified error and reinforce correct processing procedures. The claim has been adjusted.

Observations
Sample 2004 - UMR disagrees with this observation. Procedure code D1355 (Caries Preventive Medicament Application - per tooth) does not require the application of dental necessity criteria. UMR's Book of Business configuration supports coverage of D1355 for eligible permanent teeth (1-32) and primary teeth (A-T). The claim adjudication aligns with configured business rules and established benefit administration guidelines.

Eligibility Audit

Page 15
UMR is working with CTI, Telus Health, and PEBP to review and validate the potentially overpaid amounts identified in the annual eligibility audit. UMR will share its findings directly with PEBP Executive Staff in advance of the Board Meeting.

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,

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

11.

11. Acceptance of Biennial Compliance Report.
(Amy Dunn, Segal)
(**For Possible Action**)
*To view full report, visit the November 17, 2026 Board Meeting page at https://www.pebp.nv.gov/meetings-events/current-board-meetings/

Public Employees' Benefits Program

Biennial Compliance Review

Summary of Findings

November 2026

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Segal

Executive Summary

- **Scope:** Segal reviewed selected PEBP plan documents and administrative processes for compliance with federal and Nevada tax and employee-benefit requirements for the July 1, 2026–June 30, 2027 plan year.
- **Required notices:** Update and clarify key federal notices, including the July 2026 CHIPRA model notice, access to Qualified Medical Child Support Order procedures, and any notices applicable to disease-management programs.
- **Document alignment:** Reconcile inconsistencies among plan documents, Master Plan Documents, and Summaries of Benefits and Coverage, particularly for vision benefits, maternity benefits for dependent daughters, and physician references.
- **Key federal compliance requirements:** Consider removing the age-22 limit on autism treatment, exempt emergency inter-facility air ambulance transfers from prior authorization and clarify coverage of routine patient costs for qualifying clinical trials for life threatening conditions.
- **Key Nevada requirements:** Clarify coverage for audio-only behavioral-health telehealth and for prevention, testing, treatment, medications, and maternity-related services involving HIV, hepatitis C, and sexually transmitted diseases.
- **Prescription-drug protections:** Clarify coverage for certain substance-use-disorder medications. Address cancer step-therapy exemption procedures, emergency prescription access procedures during disaster declaration, procedures for synchronized refill of chronic medications, and early refills of covered topical ophthalmic products.
- **Priority action:** Update and align plan language, notices, and administrative procedures to reduce compliance risk and accurately reflect current federal guidance and Nevada law.

Disclaimer

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12.

12. Contract Status Report. (Shannan Canfield, Quality Control Officer) (**For Possible Action**)
    - 12.1 Contract Overview
    - 12.2 New Contracts
    - 12.3 Contract Amendments
    - 12.4 Status of Current Solicitations

Stacie Weeks, JD, MPH, Director

Theresa Carsten, Executive Officer

Date: November 17, 2026
Item: 13
Title: Contract Status Report
Action Item

Summary

This report provides an overview of PEBP's current contract portfolio and ongoing contract management strategy, including anticipated new contracts, proposed amendments, and the status of active solicitations.

1. Contracts Overview

PEBP continues to coordinate contract administration and oversight with the Nevada Health Authority (NVHA) following the transition to the new agency structure. This includes aligning procurement and fiscal processes, reviewing existing contractual obligations, coordinating contract approvals and amendments, and monitoring vendor performance. PEBP is also working to ensure continuity of essential vendor services, maintain compliance with state contracting requirements, and provide appropriate oversight of contractual expenditures and deliverables.

2. New Contracts

PEBP is entering into a new contract with TELUS Health to provide a system for managing participant enrollment, eligibility, and accounting. The contract term is January 1, 2027, through December 31, 2030, the contract has a maximum not-to-exceed amount of $6,271,019 over the initial four-year term. The contract includes two optional one-year extensions, allowing PEBP to continue services beyond the initial term, subject to applicable approvals, contract terms, and funding availability.

3. Contract Amendments

PEBP is proposing a contract extension with Claims Technology (CTI) for continued independent audit and monitoring services, including HRA claims auditing, quarterly and annual UMR monitoring, and pharmacy auditing. These services support financial oversight, vendor accountability, and identification of potential claims-processing discrepancies. The pharmacy audit is estimated to require approximately 5–9 months from receipt of complete and accurate data through analysis, PBM investigation, and delivery of the final audit report. The proposed cost: $179,420. Extending the agreement will allow PEBP to maintain continuity of independent audit and monitoring services, support ongoing oversight of contracted vendors, and identify opportunities for improved accuracy, compliance, and cost containment.

4. Status of current Solicitations

PEBP continues to advance procurement activities to support program operations, improve administrative efficiencies, and ensure the availability of services necessary to administer participant benefits. The Nevada Health Authority (NVHA), through the State Purchasing Division, issued a competitive Request for Proposals on October 22, 2026, for Pharmacy Benefit Manager services for Nevada Medicaid and PEBP. The anticipated award date is June 8, 2027, subject to the Board of Examiners approval.

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	12/31/2030. Currently at GFO to go to BOE for final approval on 12/2
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 Currently with the vendor for review and signature
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

Contract Status Report. Shannan Canfield, Quality Control Officer

13.

13. CY27 Meeting Dates. (Theresa Carsten)
(**For Possible Action**)

Stacie Weeks, JD, MPH, Director

Theresa Carsten, Executive Officer

2027 PEBP Board Meeting Calendar

Meeting Dates and Topics may be subject to change

Month	Date	Major Topics - *TENTATIVE*	Location
January	**21**	• Election of Board Chair • Governor Recommended Budget Overview • Plan Year 2027 Master Plan Documents Update • Annual PEBP Appeals and Complaints Summary • Status of PEBP Contracts • Vendor reports • Strategic Plan Design	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
February	**No Meeting**		
March	**18**	• Approve plan rates for Plan Year 2027 • Plan Year 2027 Summary of Benefits and Coverage • Status of PEBP Contracts	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
April	**No Meeting**		
May	**20**	• Update on Budget Closing • Status of PEBP Contracts • Vendor Reports	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
June	**No Meeting**		
July	**22**	• Status of PEBP Contracts • Vendor reports • Actuarial report on Retiree Medicare Enrollment	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
August	**No Meeting**		
September	**23**	• Annual State of PEBP report • Plan Year 2028 plan design options discussion • Status of PEBP Contracts	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
October	**No Meeting**		
November	**18**	• Approve program design options for Plan Year 2028 • Status of PEBP Contracts • Vendor reports	**3427 Goni Rd Ste. 117 Carson City, NV 89706 Video/Teleconference**
December	**No Meeting**		

14.

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)

- 14.1 Q4 UMR – Obesity and Diabetes Care Management
- 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
- 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
- 14.4 Q4 UnitedHealthcare – Basic Life Insurance
- 14.5 Q4 Express Scripts – Utilization Report
- 14.6 Q4 Express Scripts – Summary Report
- 14.7 Q4 CDHP Performance Report
- 14.8 Q4 LD PPO Performance Report
- 14.9 Q4 EPO Performance Report
- 14.10 Q4 HPN Performance Report
- 14.11 Q4 Dental Performance Report
- 14.12 Q4 WTW's Individual Marketplace (Via Benefits) Enrollment & Performance Report
- 14.13 Q4 Doctor on Demand Engagement Report

14.1

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)

14.1 Q4 UMR – Obesity and Diabetes Care Management

NEVADA PEBP Public Employees' Benefits Program

Quarterly Plan Performance Review

OCM • 2026-4Q

UMR A UnitedHealthcare Company

RPG 5.10 • Run Date: 7/29/2026

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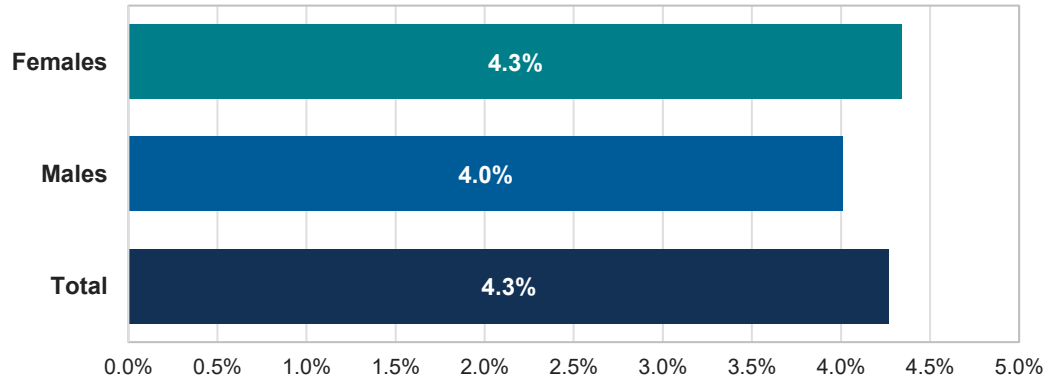
Obesity Care Management

Overview

Weight Management Summary	Females	Males	Total
Members Enrolled in OCM	310	71	**381**
Average Pounds Lost	9.2	10.4	**9.4**
Total Pounds Lost	2,843.0	736.6	**3,579.6**
% Pounds Lost	4.3%	4.0%	**4.3%**
Average Paid per Member	$6,453	$5,747	**$6,321**

- *At $526.77, Paid PMPM for OCM participants is significantly (–40.3%) lower than non-participants ($882.71)*

Average % Pounds Lost



Obesity Care Management participation is for the 2026 Plan Year with activity through 6/30/2026

Claims Date Range (for Avg. Paid per Member)**:** Service Dates 7/1/2025 - 6/30/2026, Paid through 6/30/2026

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Obesity Care Management

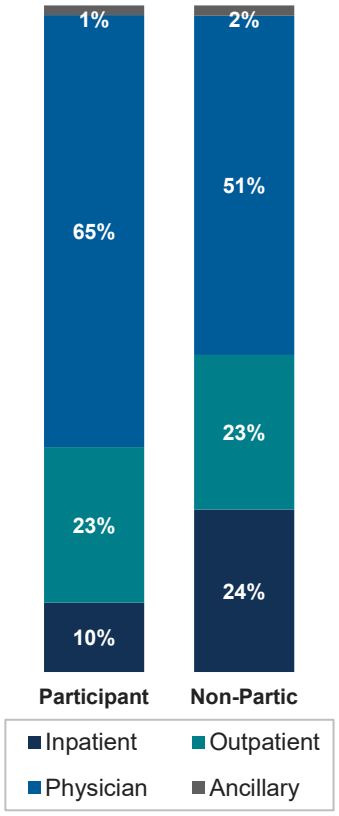
Financial & Utilization Summary

Financial Summary

Financial Measure	Participants	Non-Partic.	*Variance*
Average Enrollment			
Employees	339	481	*-29.5%*
Tot. Members	381	565	*-32.6%*
Emp to Total Ratio	1.1	1.2	*-4.3%*
Financial Summary			
Allowed	$3,127,572	$6,998,793	*-55.3%*
Plan Paid	$2,408,410	$5,984,749	*-59.8%*
Member Paid (OOP)	$419,163	$934,272	*-55.1%*
Paid PEPY*	$7,104	$12,442	*-42.9%*
Paid PMPY*	$6,321	$10,592	*-40.3%*
Paid PEPM	$592	$1,037	*-42.9%*
Paid PMPM	$527	$883	*-40.3%*
High-Cost Claimants (Med Paid $100,000+)			
# of HCCs	1	7	*-85.7%*
HCCs per 1000	2.6	12.4	*-78.8%*
Paid per HCC	$164,369	$183,511	*-10.4%*
HCC Paid % of Tot	6.8%	21.5%	*-14.6 pts*
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	$659	$2,582	*-74.5%*
Outpatient	$1,475	$2,456	*-39.9%*
Physician	$4,095	$5,388	*-24.0%*
Ancillary	$92	$166	*-44.5%*

* Annualized

Cost Distribution By Claim Type



Utilization Summary

Utilization Measure	Participants	Non-Partic.	*Variance*
Inpatient Admissions			
# of Admits	14	70	*-80.0%*
# of Admit Days	57	222	*-74.3%*
Paid per Admit	$20,732	$24,165	*-14.2%*
Paid per Admit Day	$5,092	$7,619	*-33.2%*
Admits per 1000	36.7	123.9	*-70.3%*
Average LOS	4.1	3.2	*28.4%*
Emergency Room Visits			
# of ER Visits	84	199	*-57.8%*
~ % resulting in Admit	9.5%	15.6%	*-6.1 pts*
ER Visits per Patient	1.5	1.6	*-8.9%*
ER Visits per 1000	220.5	352.2	*-37.4%*
Paid per ER Visit	$4,093	$3,462	*18.2%*
Urgent Care Visits			
# of UC Visits	169	263	*-35.7%*
UC Visits per Patient	1.6	1.6	*0.1%*
UC Visits per 1000	443.6	465.5	*-4.7%*
Paid per UC Visit	$114	$106	*7.6%*
Office Visits			
Off Visits per Patient	18.2	9.0	*101.5%*
Paid per Office Visit	$126	$102	*23.8%*
Office Visits Paid PMPY	$2,282	$898	*154.1%*
Services			
Radiology Svcs per 1000	5,606.3	7,577.0	*-26.0%*
Radiology Paid PMPY	$427	$806	*-47.1%*
Lab Services per 1000	18,225.7	22,334.5	*-18.4%*
Labs Paid PMPY	$379	$547	*-30.8%*

Non-participants are defined as members identified with a morbid obesity condition in the prior 12 months (7/1/2025 - 6/30/2026), but who are not enrolled in the Obesity Care Management program

Claims Date Range: Service Dates 7/1/2025 - 6/30/2026, Paid through 6/30/2026

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NEVADA PEBP

Public Employees' Benefits Program

Quarterly Plan Performance Review

DCM • 2026-4Q HDHP

UMR

A UnitedHealthcare Company

RPG 5.10 • Run Date: 7/29/2026

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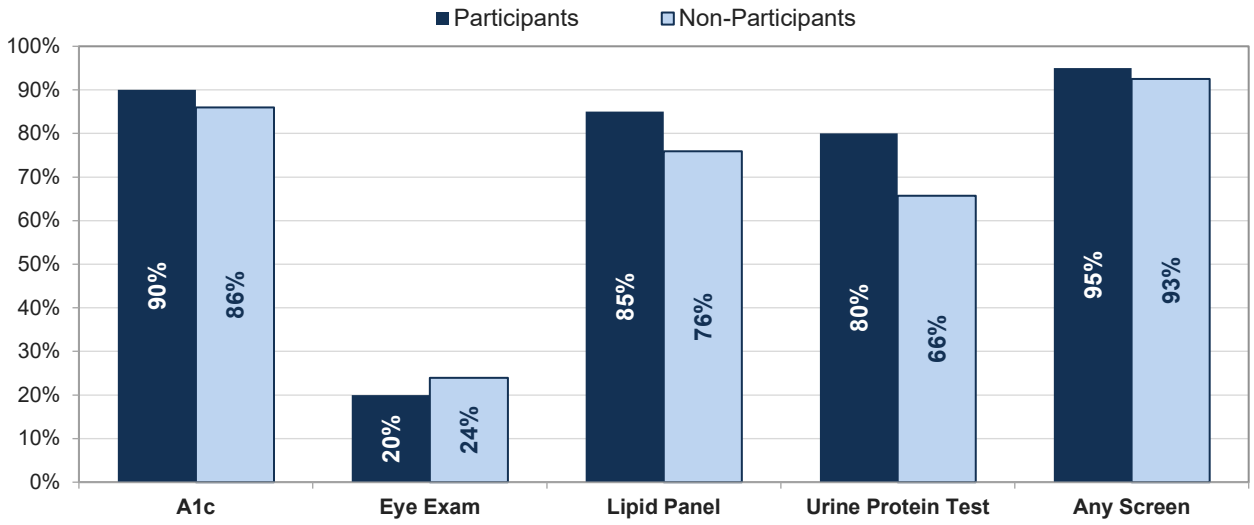
Diabetes Care Management

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	20	18	**90.0%**	1,417	1,218	**86.0%**	*4.0*
Eye Exam	20	4	**20.0%**	1,417	339	**23.9%**	*-3.9*
Lipid Panel	20	17	**85.0%**	1,417	1,076	**75.9%**	*9.1*
Urine Protein Test	20	16	**80.0%**	1,417	931	**65.7%**	*14.3*
Any Diabetes Screen	20	19	**95.0%**	1,417	1,311	**92.5%**	*2.5*



- *85.0% of DCM participants had an office visit for Diabetes, while 71.3% of non-participants had a visit*
- *10.0% of DCM participants received all four screenings, while 13.5% of non-participants did*

Diabetes Care Management participation is for the 2026 Plan Year with activity through 6/30/2026

Non-participants are defined as members identified with diabetes in the prior 12 months (7/1/2025 - 6/30/2026), but who are not enrolled in the Diabetes Care Management program

Screening Date Range: Service Dates 7/1/2025 - 6/30/2026, Paid through 6/30/2026

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Diabetes Care Management

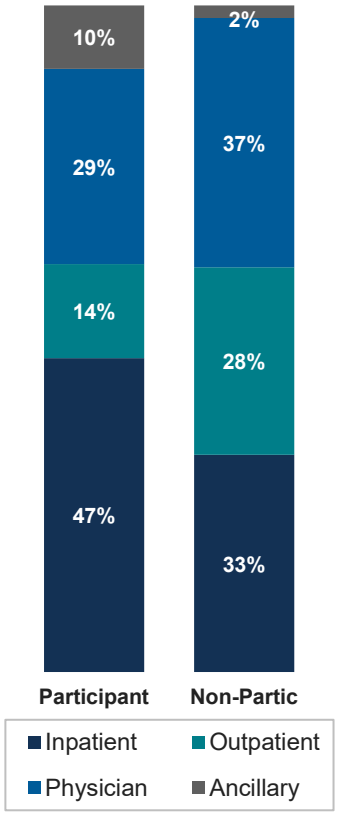
Financial & Utilization Summary

Financial Summary

Financial Measure	Participants	Non-Partic.	*Variance*
Average Enrollment			
Employees	14	1,162	*-98.8%*
Tot. Members	20	1,417	*-98.6%*
Emp to Total Ratio	1.4	1.2	*17.1%*
Financial Summary			
Allowed	$134,856	$16,235,182	*-99.2%*
Plan Paid	$108,534	$11,336,182	*-99.0%*
Member Paid (OOP)	$26,322	$2,677,083	*-99.0%*
Paid PEPY*	$7,752	$9,756	*-20.5%*
Paid PMPY*	$5,427	$8,000	*-32.2%*
Paid PEPM	$646	$813	*-20.5%*
Paid PMPM	$452	$667	*-32.2%*
High-Cost Claimants (Med Paid $100,000+)			
# of HCCs	0	17	*-100.0%*
HCCs per 1000	0.0	12.0	*-100.0%*
Paid per HCC	$0	$231,936	-
HCC Paid % of Tot	0.0%	34.8%	*-34.8 pts*
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	$2,556	$2,606	*-1.9%*
Outpatient	$764	$2,250	*-66.0%*
Physician	$1,588	$2,993	*-46.9%*
Ancillary	$518	$151	*243.9%*

* Annualized

Cost Distribution By Claim Type



Utilization Summary

Utilization Measure	Participants	Non-Partic.	*Variance*
Inpatient Admissions			
# of Admits	1	127	*-99.2%*
# of Admit Days	3	727	*-99.6%*
Paid per Admit	$59,790	$32,472	*84.1%*
Paid per Admit Day	$19,930	$5,672	*251.3%*
Admits per 1000	50.0	89.6	*-44.2%*
Average LOS	3.0	5.7	*-47.6%*
Emergency Room Visits			
# of ER Visits	2	433	*-99.5%*
~ % resulting in Admit	50.0%	20.3%	*29.7 pts*
ER Visits per Patient	1.0	1.5	*-33.3%*
ER Visits per 1000	100.0	305.6	*-67.3%*
Paid per ER Visit	$4,015	$2,928	*37.1%*
Urgent Care Visits			
# of UC Visits	2	468	*-99.6%*
UC Visits per Patient	1.0	1.6	*-36.5%*
UC Visits per 1000	100.0	330.3	*-69.7%*
Paid per UC Visit	$104	$80	*30.8%*
Office Visits			
Off Visits per Patient	4.0	7.5	*-47.7%*
Paid per Office Visit	$83	$62	*32.4%*
Office Visits Paid PMPY	$326	$456	*-28.5%*
Services			
Radiology Svcs per 1000	1,100.0	8,822.9	*-87.5%*
Radiology Paid PMPY	$169	$512	*-67.0%*
Lab Services per 1000	14,400.0	20,160.9	*-28.6%*
Labs Paid PMPY	$160	$403	*-60.3%*

Non-participants are defined as members identified with diabetes in the prior 12 months (7/1/2025 - 6/30/2026), but who are not enrolled in the Diabetes Care Management program

Claims Date Range: Service Dates 7/1/2025 - 6/30/2026, Paid through 6/30/2026

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14.2

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - **14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network**

State of Nevada Q4PY26 Network Performance Report

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	99.46%	
Q2 Results	99.11%	
Q3 Results	99.14%	
Q4 Results	99.18%	

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	99.50%	99.60%

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	0	N/A

14.3

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - **14.3 Q4 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	Apr-26	May-26	Jun-26	Average
Enrollment	52,681	52,592	52,775	52,836	52,792	52,780	52,521	52,676	52,731	52,818	52,824	52,494	**52,710**

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	Apr-26	May-26	Jun-26	Total	Average
Total Discharges	180	155	149	172	149	180	149	144	194	181	155	186	**1,994**	**166**
Total Discharges LOS	1,116	964	950	982	640	1,007	1,097	1,049	1,229	867	564	640	**11,105**	**925**
Average LOS	6.2	6.2	6.4	5.7	4.3	5.6	7.4	7.3	6.3	4.8	3.6	3.4	**5.6**	**5.6**

Out of Area, Hopital 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	Apr-26	May-26	Jun-26	Total	Average
Total Discharges	136	111	112	125	98	129	102	103	136	122	101	139	**1,414**	**118**
Total Discharges LOS	678	554	543	497	386	529	713	593	687	446	373	469	**6,468**	**539**
Average LOS	5.0	5.0	4.8	4.0	3.9	4.1	7.0	5.8	5.1	3.7	3.7	3.4	**4.6**	**4.6**

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**	**Apr-26**	**May-26**	**Jun-26**	**Total**	**Average**
Hospital	678	559	543	497	387	529	714	593	691	447	411	543	**6,592**	**549**
Hospital Rehabilitation	6	7	18	30	46	14	10	13	39	17	0	9	**209**	**19**
Skilled Nursing	38	16	0	24	19	57	0	54	17	51	41	0	**317**	**35**
Out of Area	394	389	389	434	189	407	374	389	631	353	190	187	**4,326**	**361**

Metrics	Beddays per K												
Facility Type	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Total**
Hospital	154.4	127.5	123.5	112.9	88.0	120.3	163.1	135.1	157.2	101.6	93.4	124.1	**125.1**
Hospital Rehabilitation	1.4	1.6	4.1	6.8	10.5	3.2	2.3	3.0	8.9	3.9	0.0	2.1	**4.0**
Skilled Nursing	8.7	3.7	0.0	5.5	4.3	13.0	0.0	12.3	3.9	11.6	9.3	0.0	**6.0**
Out of Area	89.7	88.8	88.5	98.6	43.0	92.5	85.5	88.6	143.6	80.2	43.2	42.7	**82.1**

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**	**Apr-26**	**May-26**	**Jun-26**	**Total**	**Average**
Hospital	134	122	111	116	96	135	101	114	136	115	109	140	**1,429**	**119**
Hospital Rehabilitation	1	1	2	2	2	1	1	1	3	1	0	1	**16**	**1**
Skilled Nursing	3	1	0	1	3	1	0	3	1	3	2	0	**18**	**2**
Out of Area	45	39	42	49	38	51	49	37	62	54	41	47	**554**	**46**

Metrics	Admits per K												
Facility Type	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Total**
Hospital	30.5	27.8	25.2	26.3	21.8	30.7	23.1	26.0	30.9	26.1	24.8	32.0	**27.1**
Hospital Rehabilitation	0.2	0.2	0.5	0.5	0.5	0.2	0.2	0.2	0.7	0.2	0.0	0.2	**0.3**
Skilled Nursing	0.7	0.2	0.0	0.2	0.7	0.2	0.0	0.7	0.2	0.7	0.5	0.0	**0.3**
Out of Area	10.3	8.9	9.6	11.1	8.6	11.6	11.2	8.4	14.1	12.3	9.3	10.7	**10.5**

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**	**Apr-26**	**May-26**	**Jun-26**	**Total**	**Average**
Hospital	12	10	13	5	10	10	6	14	9	9	3	0	**101**	**8**
Hospital Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
All Other	3	4	4	3	5	2	2	0	4	5	0	0	**32**	**3**

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS												
	Facility Name	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Total**
Hospital	CARSON TAHOE REGIONAL	1.5	4.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	**2.0**
	CARSON TAHOE REGIONAL MEDICAL	2.9	3.4	2.8	6.1	4.6	2.9	2.1	3.8	3.9	4.9	3.4	2.1	**3.6**
	CENTENNIAL HILLS HOSPITAL	5.4	3.5	3.2	3.8	3.5	2.3	2.7	2.3	8.4	2.2	3.0	3.4	**3.8**
	HENDERSON HOSPITAL	2.6	7.5	3.0	3.4	4.8	3.2	0.0	2.5	4.3	1.3	3.0	1.7	**3.2**
	LAS VEGAS VAMC	0.0	0.0	0.0	0.0	3.0	7.0	5.0	0.0	0.0	0.0	0.0	0.0	**5.0**
	MOUNTAIN VIEW HOSPITAL	3.0	6.0	4.8	2.3	2.7	5.5	3.0	8.6	2.5	1.8	2.7	5.0	**4.1**
	NORTH VISTA HOSPITAL	5.0	0.0	1.0	0.0	1.0	0.0	1.0	1.0	0.0	1.0	7.0	0.0	**2.4**
	RENOWN REGIONAL MEDICAL	7.3	6.2	6.2	3.8	5.4	4.6	14.3	6.1	5.4	3.5	4.3	3.9	**5.8**
	SOUTHERN HILLS HOSPITAL	13.5	5.5	2.8	4.0	1.7	4.0	7.3	0.0	5.0	3.8	5.7	2.9	**5.0**
	SPRING VALLEY HOSPITAL	2.6	5.8	2.5	1.8	9.5	6.0	2.0	2.5	3.5	7.3	7.0	6.0	**4.4**
	ST ROSE DOMINICAN HOSPITAL SAN	0.0	0.0	1.5	3.0	0.0	2.0	5.0	6.0	5.0	9.8	2.3	5.5	**4.6**
	ST ROSE DOMINICAN HOSPITAL	2.4	3.5	6.7	2.2	2.4	4.9	2.7	3.7	3.8	3.5	2.8	2.2	**3.3**
	SUMMERLIN HOSPITAL MEDICAL CTR	3.8	3.7	4.6	5.5	2.2	4.6	7.6	15.4	2.2	1.6	1.8	2.5	**4.4**
	SUNRISE HOSPITAL	1.6	4.3	7.4	5.6	1.1	4.6	2.0	2.3	18.4	2.4	3.0	3.8	**4.4**
	UNIVERSITY MEDICAL CENTER SO	4.4	6.7	6.3	3.0	10.0	2.9	3.3	9.2	7.3	5.0	3.0	3.3	**5.0**
	VALLEY HOSPITAL MEDICAL CTR	7.0	12.0	0.0	4.0	2.0	6.0	2.5	0.0	2.0	4.0	9.5	4.0	**5.8**
	Total	**5.0**	**5.0**	**4.8**	**4.0**	**3.9**	**4.1**	**7.0**	**5.8**	**5.1**	**3.7**	**3.7**	**3.4**	**4.6**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF	0.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	**10.0**
	ENCOMPASS HEALTH HOSPITAL OF	6.0	0.0	4.0	5.0	9.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	**7.6**
	ENCOMPASS HEALTH REHAB OF LAS	0.0	0.0	0.0	0.0	0.0	14.0	0.0	0.0	0.0	0.0	0.0	0.0	**14.5**
	HORIZON SPECIALTY HOSPITAL OF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**25.0**
	KINDRED HOSPITAL W SAHARA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**30.0**
	PAM REHABILITATION HOSPITAL OF	0.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**10.0**
	PAM SPECIALTY HOSPITAL OF LAS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.0	0.0	0.0	0.0	0.0	**13.0**
	Total	**6.0**	**0.0**	**6.0**	**30.0**	**23.0**	**7.0**	**10.0**	**13.0**	**39.0**	**8.5**	**0.0**	**0.0**	**13.3**
Skilled Nursing	HARMON HOSPITAL	0.0	0.0	0.0	0.0	13.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	**7.5**
	SANDSTONE SPRING VALLEY LLC	0.0	0.0	0.0	0.0	2.0	0.0	0.0	27.0	8.5	49.0	13.7	0.0	**20.2**
	TRELLIS CENTENNIAL	0.0	16.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**16.0**
	WELBROOK CENTENNIAL HILLS	23.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**11.5**
	Total	**38.0**	**5.3**	**0.0**	**0.0**	**4.8**	**0.0**	**0.0**	**27.0**	**8.5**	**25.5**	**13.7**	**0.0**	**17.6**
Out of Area	Out of Area	9.4	9.4	11.4	9.4	4.2	8.3	8.1	10.2	8.8	6.4	3.0	3.7	**7.5**
	Total	**9.4**	**9.4**	**11.4**	**9.4**	**4.2**	**8.3**	**8.1**	**10.2**	**8.8**	**6.4**	**3.0**	**3.7**	**7.5**

Beddays by Facility

Facility Type	Metrics	Beddays													
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL	3	4	0	1	0	0	0	6	0	0	0	0	**14**	**4**
	CARSON TAHOE REGIONAL MEDICAL	49	93	39	73	82	75	19	65	82	108	55	49	**789**	**66**
	CENTENNIAL HILLS HOSPITAL	65	21	42	15	39	16	16	9	59	11	18	41	**352**	**29**
	HENDERSON HOSPITAL	13	16	6	17	24	16	0	10	26	5	12	30	**175**	**16**
	LAS VEGAS VAMC	0	0	0	0	3	7	5	0	0	0	0	0	**15**	**5**
	MOUNTAIN VIEW HOSPITAL	6	15	43	14	8	44	15	69	21	18	53	38	**344**	**29**
	NORTH VISTA HOSPITAL	5	0	1	0	1	0	1	1	0	1	7	0	**17**	**2**
	RENOWN REGIONAL MEDICAL	359	180	212	167	118	183	457	190	278	112	103	231	**2,590**	**216**
	SOUTHERN HILLS HOSPITAL	54	33	17	8	5	12	44	0	10	19	17	20	**239**	**22**
	SPRING VALLEY HOSPITAL	23	29	5	9	19	36	12	5	7	29	28	24	**226**	**19**
	ST ROSE DOMINICAN HOSPITAL SAN	0	0	3	9	0	2	5	6	15	39	7	11	**97**	**11**
	ST ROSE DOMINICAN HOSPITAL	33	21	67	20	24	39	27	37	42	36	34	27	**407**	**34**
	SUMMERLIN HOSPITAL MEDICAL CTR	19	41	37	71	23	41	76	123	29	13	21	25	**519**	**43**
	SUNRISE HOSPITAL	11	30	52	62	9	32	12	18	92	24	9	26	**377**	**31**
	UNIVERSITY MEDICAL CENTER SO	31	40	19	27	30	20	20	46	22	20	9	13	**297**	**25**
	VALLEY HOSPITAL MEDICAL CTR	7	36	0	4	2	6	5	8	8	12	38	8	**134**	**12**
	Total	**678**	**559**	**543**	**497**	**387**	**529**	**714**	**593**	**691**	**447**	**411**	**543**	**6,592**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF	0	0	0	0	0	0	10	0	0	0	0	0	**10**	**10**
	ENCOMPASS HEALTH HOSPITAL OF	6	7	8	5	9	0	0	0	1	17	0	0	**53**	**8**
	ENCOMPASS HEALTH REHAB OF LAS	0	0	0	0	0	14	0	0	15	0	0	9	**38**	**13**
	HORIZON SPECIALTY HOSPITAL OF	0	0	0	25	0	0	0	0	0	0	0	0	**25**	**25**
	KINDRED HOSPITAL W SAHARA	0	0	0	0	37	0	0	0	23	0	0	0	**60**	**30**
	PAM REHABILITATION HOSPITAL OF	0	0	10	0	0	0	0	0	0	0	0	0	**10**	**10**
	PAM SPECIALTY HOSPITAL OF LAS	0	0	0	0	0	0	0	13	0	0	0	0	**13**	**13**
	Total	**6**	**7**	**18**	**30**	**46**	**14**	**10**	**13**	**39**	**17**	**0**	**9**	**209**	**0**
Skilled Nursing	HARMON HOSPITAL	0	0	0	0	13	0	0	0	0	2	0	0	**15**	**8**
	SANDSTONE SPRING VALLEY LLC	15	0	0	24	6	57	0	54	17	49	41	0	**263**	**33**
	TRELLIS CENTENNIAL	0	16	0	0	0	0	0	0	0	0	0	0	**16**	**16**
	WELBROOK CENTENNIAL HILLS	23	0	0	0	0	0	0	0	0	0	0	0	**23**	**23**
	Total	**38**	**16**	**0**	**24**	**19**	**57**	**0**	**54**	**17**	**51**	**41**	**0**	**317**	**0**
Out of Area	Out of Area	394	389	389	434	189	407	374	389	631	353	190	187	**4,326**	**361**
	Total	**394**	**389**	**389**	**434**	**189**	**407**	**374**	**389**	**631**	**353**	**190**	**187**	**4,326**	**0**

Admits by Facility

Facility Type	Metrics	Admits													
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL	1	1	0	1	0	0	0	3	0	0	0	0	**6**	**2**
	CARSON TAHOE REGIONAL MEDICAL	17	28	12	12	20	24	9	17	24	21	18	19	**221**	**18**
	CENTENNIAL HILLS HOSPITAL MEDICAL	14	7	10	5	10	7	6	4	9	3	9	10	**94**	**8**
	HENDERSON HOSPITAL	4	4	2	4	6	5	0	4	7	3	4	4	**47**	**4**
	LAS VEGAS VAMC	0	0	0	0	1	1	1	0	0	0	0	0	**3**	**1**
	MOUNTAIN VIEW HOSPITAL	2	4	9	5	3	10	4	10	8	9	7	9	**80**	**7**
	NORTH VISTA HOSPITAL	1	0	1	0	1	0	1	1	0	1	1	0	**7**	**1**
	RENOWN REGIONAL MEDICAL CENTER	54	28	36	39	21	42	36	36	46	30	28	50	**446**	**37**
	SOUTHERN HILLS HOSPITAL	5	6	6	2	2	3	7	0	2	5	4	8	**50**	**4**
	SPRING VALLEY HOSPITAL	7	6	2	4	3	7	4	2	3	4	4	4	**50**	**4**
	ST ROSE DOMINICAN HOSPITAL SAN	0	0	2	3	0	1	1	2	2	5	2	2	**20**	**2**
	ST ROSE DOMINICAN HOSPITAL SIENA	11	8	10	7	10	8	10	11	11	11	12	10	**119**	**10**
	SUMMERLIN HOSPITAL MEDICAL CTR	5	12	9	14	8	10	11	10	11	8	10	11	**119**	**10**
	SUNRISE HOSPITAL	5	8	8	11	6	8	5	7	8	7	3	8	**84**	**7**
	UNIVERSITY MEDICAL CENTER SO NV	7	6	4	8	4	8	4	6	2	4	3	4	**60**	**5**
	VALLEY HOSPITAL MEDICAL CTR	1	4	0	1	1	1	2	1	3	4	4	1	**23**	**2**
	Total	**134**	**122**	**111**	**116**	**96**	**135**	**101**	**114**	**136**	**115**	**109**	**140**	**1,429**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**1**
	ENCOMPASS HEALTH HOSPITAL OF	1	1	1	1	1	0	0	0	1	1	0	0	**7**	**1**
	ENCOMPASS HEALTH REHAB OF LAS	0	0	0	0	0	1	0	0	1	0	0	1	**3**	**1**
	HORIZON SPECIALTY HOSPITAL OF	0	0	0	1	0	0	0	0	0	0	0	0	**1**	**1**
	KINDRED HOSPITAL W SAHARA	0	0	0	0	1	0	0	0	1	0	0	0	**2**	**1**
	PAM REHABILITATION HOSPITAL OF	0	0	1	0	0	0	0	0	0	0	0	0	**1**	**1**
	PAM SPECIALTY HOSPITAL OF LAS	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**1**
	Total	**1**	**1**	**2**	**2**	**2**	**1**	**1**	**1**	**3**	**1**	**0**	**1**	**16**	**0**
Skilled Nursing	HARMON HOSPITAL	0	0	0	0	1	0	0	0	0	1	0	0	**2**	**1**
	SANDSTONE SPRING VALLEY LLC	1	0	0	1	2	1	0	3	1	2	2	0	**13**	**1**
	TRELLIS CENTENNIAL	0	1	0	0	0	0	0	0	0	0	0	0	**1**	**1**
	WELBROOK CENTENNIAL HILLS	2	0	0	0	0	0	0	0	0	0	0	0	**2**	**1**
	Total	**3**	**1**	**0**	**1**	**3**	**1**	**0**	**3**	**1**	**3**	**2**	**0**	**18**	**0**
Out of Area	Out of Area	45	39	42	49	38	51	49	37	62	54	41	47	**554**	**46**
	Total	**45**	**39**	**42**	**49**	**38**	**51**	**49**	**37**	**62**	**54**	**41**	**47**	**554**	**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	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
	CARSON TAHOE REGIONAL MEDICAL	1	2	1	1	2	1	0	0	2	1	0	0	**11**	**1**
	CENTENNIAL HILLS HOSPITAL MEDICAL	1	1	2	1	3	2	0	0	0	0	0	0	**10**	**1**
	HENDERSON HOSPITAL	0	1	0	0	2	0	0	1	0	0	0	0	**4**	**0**
	LAS VEGAS VAMC	0	0	0	0	0	1	0	0	0	0	0	0	**1**	**0**
	MOUNTAIN VIEW HOSPITAL	0	1	3	0	0	1	1	3	1	1	0	0	**11**	**1**
	NORTH VISTA HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
	RENOWN REGIONAL MEDICAL CENTER	7	2	3	1	2	2	2	7	1	0	1	0	**28**	**2**
	SOUTHERN HILLS HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
	SPRING VALLEY HOSPITAL	0	0	1	0	1	1	0	0	0	1	0	0	**4**	**0**
	ST ROSE DOMINICAN HOSPITAL SAN	0	0	0	0	0	0	0	0	1	2	0	0	**3**	**0**
	ST ROSE DOMINICAN HOSPITAL SIENA	0	1	2	1	0	1	1	0	2	2	1	0	**11**	**1**
	SUMMERLIN HOSPITAL MEDICAL CTR	1	1	0	0	0	0	1	1	1	1	1	0	**7**	**1**
	SUNRISE HOSPITAL	0	0	1	1	0	0	0	1	1	0	0	0	**4**	**0**
	UNIVERSITY MEDICAL CENTER SO NV	2	1	0	0	0	1	1	1	0	0	0	0	**6**	**1**
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	0	1	0	0	**1**	**0**
	Total	**12**	**10**	**13**	**5**	**10**	**10**	**6**	**14**	**9**	**9**	**3**	**0**	**101**	**0**
Out of Area	Out of Area	3	4	4	3	5	2	2	0	4	5	0	0	**32**	**3**
	Total	**3**	**4**	**4**	**3**	**5**	**2**	**2**	**0**	**4**	**5**	**0**	**0**	**32**	**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**	**Apr-26**	**May-26**	**Jun-26**	**Total**	**Average**
Hospital	CARSON TAHOE REGIONAL	0.0%	0.0%	0.0%	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	5.9%	7.1%	8.3%	8.3%	10.0%	4.2%	0.0%	0.0%	8.3%	4.8%	0.0%	0.0%	**5.0%**	**5.0%**
	CENTENNIAL HILLS HOSPITAL MEDICAL	7.1%	14.3%	20.0%	20.0%	30.0%	28.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**10.6%**	**10.6%**
	HENDERSON HOSPITAL	0.0%	25.0%	0.0%	0.0%	33.3%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	**8.5%**	**8.5%**
	LAS VEGAS VAMC	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**33.3%**	**33.3%**
	MOUNTAIN VIEW HOSPITAL	0.0%	25.0%	33.3%	0.0%	0.0%	10.0%	25.0%	30.0%	12.5%	11.1%	0.0%	0.0%	**13.8%**	**13.8%**
	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%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	13.0%	7.1%	8.3%	2.6%	9.5%	4.8%	5.6%	19.4%	2.2%	0.0%	3.6%	0.0%	**6.3%**	**6.3%**
	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%	0.0%	**0.0%**	**0.0%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	50.0%	0.0%	33.3%	14.3%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	**8.0%**	**8.0%**
	ST ROSE DOMINICAN HOSPITAL SAN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	40.0%	0.0%	0.0%	**15.0%**	**15.0%**
	ST ROSE DOMINICAN HOSPITAL SIENA	0.0%	12.5%	20.0%	14.3%	0.0%	12.5%	10.0%	0.0%	18.2%	18.2%	8.3%	0.0%	**9.2%**	**9.2%**
	SUMMERLIN HOSPITAL MEDICAL CTR	20.0%	8.3%	0.0%	0.0%	0.0%	0.0%	9.1%	10.0%	9.1%	12.5%	10.0%	0.0%	**5.9%**	**5.9%**
	SUNRISE HOSPITAL	0.0%	0.0%	12.5%	9.1%	0.0%	0.0%	0.0%	14.3%	12.5%	0.0%	0.0%	0.0%	**4.8%**	**4.8%**
	UNIVERSITY MEDICAL CENTER SO NV	28.6%	16.7%	0.0%	0.0%	0.0%	12.5%	25.0%	16.7%	0.0%	0.0%	0.0%	0.0%	**10.0%**	**10.0%**
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	**4.3%**	**4.3%**
	Total	**9.0%**	**8.2%**	**11.7%**	**4.3%**	**10.4%**	**7.4%**	**5.9%**	**12.3%**	**6.6%**	**7.8%**	**2.8%**	**0.0%**	**7.1%**	**0.0%**
Out of Area	Out of Area	6.7%	10.3%	9.5%	6.1%	13.2%	3.9%	4.1%	0.0%	6.5%	9.3%	0.0%	0.0%	**5.8%**	**5.8%**
	Total	**6.7%**	**10.3%**	**9.5%**	**6.1%**	**13.2%**	**3.9%**	**4.1%**	**0.0%**	**6.5%**	**9.3%**	**0.0%**	**0.0%**	**5.8%**	**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	Apr-26	May-26	Jun-26	YTD	Average
New Cases	275	226	265	260	204	276	228	243	303	259	254	302	**3,095**	**258**
Accepted	174	141	159	142	121	164	146	150	156	137	141	187	**1,818**	**152**
Acceptance Rate	63.3%	62.4%	60.0%	54.6%	59.3%	59.4%	64.0%	61.7%	51.5%	52.9%	55.5%	61.9%	**58.7%**	**58.7%**
Average Duration (closed	8.8	5.4	13.8	6.0	7.8	5.4	6.0	5.2	5.8	5.5	4.6	4.5	**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	Apr-26	May-26	Jun-26	YTD	Average
Open End of Month	35	35	38	32	21	32	29	38	42	38	28	28	**396**	**33**
Cases opened in the month	183	163	155	168	139	188	151	155	202	173	152	188	**2,017**	**168**
Cases closed in the month	180	155	149	172	149	180	149	144	194	181	155	186	**1,994**	**166**
Denied Days	8	16	16	11	6	3	19	27	46	9	10	18	**189**	**16**
Average LOS	6.2	6.2	6.4	5.7	4.3	5.6	7.4	7.3	6.3	4.8	3.6	3.4	**5.6**	**5.6**
NICU Open at End of Month	3	2	4	3	0	1	7	1	4	2	0	2	**29**	**2**
NICU Cases opened in the	7	4	7	7	2	7	10	3	6	3	3	5	**64**	**5**
NICU Cases closed in the	4	6	5	7	5	6	5	7	5	5	4	2	**61**	**5**
NICU Average Legth of Stay	29.5	3.8	22.8	8.7	1.8	13.5	56.8	10.3	31.4	5.6	4.0	32.0	**16.8**	**16.8**

Authorizations

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Total services reviewed	4,609	4,305	4,158	4,341	3,532	4,064	4,492	3,991	4,581	5,024	4,699	5,069	**52,865**	**4,405**
Services Approved	4,507	4,213	4,066	4,205	3,432	3,925	4,341	3,893	4,458	4,923	4,507	4,910	**51,380**	**4,282**
Approval Rate	97.8%	97.9%	97.8%	96.9%	97.2%	96.6%	96.6%	97.5%	97.3%	98.0%	95.9%	96.9%	**97.2%**	**97.2%**
Services Denied	102	92	92	136	100	139	151	98	123	101	192	159	**1,485**	**124**
Denied Charges	$71,269	$83,824	$84,870	$153,280	$68,696	$144,649	$120,151	$90,722	$98,686	$84,473	$176,494	$167,208	**$1,344,323**	**$112,027**
Denial Rate	2%	2%	2%	3%	3%	3%	3%	2%	3%	2%	4%	3%	**3%**	**3%**

Denial Reason

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Denial Reason	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**
Not medically necessary	102	90	92	119	100	139	151	97	122	101	192	159	**1,464**	**122**
Lack of information	0	2	0	17	0	0	0	0	0	0	0	0	**19**	**10**
Not medically necessary	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**1**
Network Provider Available	0	0	0	0	0	0	0	0	1	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	Apr-26	May-26	Jun-26	YTD	Average
2 or fewer days	1,185	1,011	806	761	491	579	1,039	882	1,041	1,195	1,082	1,238	**11,310**	**943**
2 or fewer Pct	64.5%	59.6%	49.2%	42.3%	34.0%	34.4%	58.4%	55.6%	58.3%	60.1%	58.5%	63.7%	**53.8%**	**53.8%**
5 or fewer days	1,271	1,209	1,192	1,204	649	759	1,351	1,100	1,353	1,520	1,351	1,609	**14,568**	**1,214**
5 or fewer Pct	69.2%	71.3%	72.8%	67.0%	44.9%	45.1%	76.0%	69.4%	75.7%	76.5%	73.1%	82.7%	**69.3%**	**69.3%**
15 or fewer Days	1,814	1,680	1,625	1,789	1,408	1,608	1,768	1,579	1,779	1,973	1,825	1,942	**20,790**	**1,733**
15 or fewer Pct	98.7%	99.1%	99.2%	99.6%	97.4%	95.5%	99.4%	99.6%	99.6%	99.3%	98.8%	99.8%	**98.9%**	**98.9%**
Over 15 days	23	15	13	8	37	76	10	7	8	14	23	3	**237**	**20**
Over 15 days Pct	1.3%	0.9%	0.8%	0.4%	2.6%	4.5%	0.6%	0.4%	0.4%	0.7%	1.2%	0.2%	**1.1%**	**1.1%**

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	Apr-26	May-26	Jun-26	YTD	Average
Stat Request	1,103	926	1,086	1,062	893	1,062	1,263	1,041	1,238	1,351	1,130	1,251	**13,406**	**1,117**

Appeals

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Appeals 1st Level	2	2	6	2	1	4	2	4	2	3	2	1	**31.00**	**2.58**
Appeals 2nd Level	0	0	1	0	0	0	0	0	0	0	0	0	**1.00**	**0.08**
Appeals 3rd Level	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**	**0.00**
Appeals Overturned	0	0	1	0	0	1	1	0	1	2	0	1	**7.00**	**0.58**
Appeals Upheld	2	0	4	4	1	3	2	4	1	1	2	0	**24.00**	**2.00**

Retro Reviews														
Month	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**YTD**	**Average**
Retros	6	19	2	6	2	3	6	5	13	0	2	7	**71**	**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**	**Apr-26**	**May-26**	**Jun-26**	**YTD**	**Average**
Call 911	1	1	3	1	2	2	0	2	5	0	0	3	**20**	**2**
ER	5	4	7	5	7	4	3	9	4	8	8	8	**72**	**6**
Information or Advice Only	3	4	3	1	2	1	2	4	1	3	0	2	**26**	**2**
Other	16	16	18	9	15	11	8	12	9	11	17	13	**155**	**13**
PCP	5	13	10	8	5	8	13	6	9	5	9	9	**100**	**8**
Poison Center	0	0	1	1	0	0	0	0	0	1	0	0	**3**	**1**
Self-Care/Home Care	3	2	5	3	2	3	4	1	3	3	3	2	**34**	**3**
Urgent Care	10	7	16	9	7	8	10	9	11	4	8	10	**109**	**9**

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.℠

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	Apr-26	May-26	Jun-26	YTD
Membership	52,681	52,592	52,775	52,836	52,792	52,780	52,521	52,676	52,731	52,818	52,824	52,494	**52,710**
Beddays per K	220.3	195.3	168.3	184.2	124.1	195.1	219.6	200.5	256.9	168.1	119.0	162.1	**184.4**
Admits per K	39.6	36.3	33.7	36.3	30.2	41.4	32.7	33.9	43.7	37.7	32.9	42.3	**36.7**
Average LOS	5.7	5.8	5.1	4.8	3.9	5.0	6.6	6.4	5.5	4.3	3.3	3.4	**5.0**
Readmits per K	3.4	3.2	3.9	1.8	3.4	2.7	1.8	3.2	3.0	3.2	0.7	0.0	**2.5**
Readmit Rate	8.6%	8.8%	11.5%	5.0%	11.3%	6.6%	5.6%	9.4%	6.8%	8.4%	2.1%	0.0%	**6.9%**

SHO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD
Beddays per K	185.2	186.1	160.7	196.3	179.4	187.5	185.8	184.6	219.5	186.6	178.6	146.0	**183.0**
Admits per K	38.7	36.6	34.9	36.9	36.4	41.1	36.2	36.7	41.2	39.7	38.1	38.0	**37.9**
Average LOS	4.7	5.2	4.6	5.2	4.9	4.7	5.1	5.2	5.0	4.4	4.5	3.2	**4.7**
Readmits per K	3.9	3.4	3.2	2.4	3.0	3.6	3.5	3.4	3.1	3.2	1.8	0.1	**2.9**
Readmit Rate	9.9%	9.3%	9.2%	6.5%	8.2%	8.8%	9.5%	9.3%	7.6%	8.0%	4.8%	0.1%	**7.6%**

SHL PPO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD
Beddays per K	165.9	181.2	169.1	157.7	144.4	130.2	125.2	149.0	155.5	154.2	110.9	165.5	**150.8**
Admits per K	46.7	46.2	42.7	37.8	35.8	40.7	34.6	40.0	41.6	41.0	33.0	43.5	**40.3**
Average LOS	3.6	4.9	4.4	4.5	5.6	3.8	4.5	3.8	4.5	5.1	3.9	5.5	**4.5**
Reamits per K	4.9	4.9	3.6	4.5	2.1	1.5	2.5	2.2	1.9	2.5	2.2	2.2	**2.9**
Readmit Rate	10.4%	10.5%	8.5%	12.0%	5.9%	3.7%	7.1%	5.4%	4.5%	6.2%	6.7%	5.1%	**7.3%**

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	Apr-26	May-26	Jun-26	Average
Enrollment	52,681	52,592	52,775	52,836	52,792	52,780	52,521	52,676	52,731	52,818	52,824	52,494	**52,710**

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	Apr-26	May-26	Jun-26	Total	Average
Total Discharges	18	18	26	27	19	21	25	31	23	13	22	21	**264**	**22**
Total Discharges LOS	89	117	288	123	208	209	248	177	183	155	186	117	**2,100**	**175**
Average LOS	4.9	6.5	11.1	4.6	10.9	10.0	9.9	5.7	8.0	11.9	8.5	5.6	**8.0**	**8.0**

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	Apr-26	May-26	Jun-26	Total	Average
Hospital	49	45	92	47	55	66	74	88	48	47	43	52	**706**	**59**
RTC	16	0	5	8	0	15	7	0	75	0	0	0	**126**	**21**
Out of Area	24	75	192	68	154	132	167	89	60	109	198	71	**1,339**	**112**

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	Apr-26	May-26	Jun-26	Total
Hospital	11.2	10.3	20.9	10.7	12.5	15.0	16.9	20.0	10.9	10.7	9.8	11.9	**13.4**
RTC	3.6	0.0	1.1	1.8	0.0	3.4	1.6	0.0	17.1	0.0	0.0	0.0	**2.4**
Out of Area	5.5	17.1	43.7	15.4	35.0	30.0	38.2	20.3	13.7	24.8	45.0	16.2	**25.4**

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	Apr-26	May-26	Jun-26	Total	Average
Hospital	11	10	19	11	13	15	13	19	13	7	10	15	**156**	**13**
RTC	1	0	1	1	0	1	1	0	2	0	0	0	**7**	**1**
Out of Area	5	8	12	9	8	9	13	12	6	10	10	12	**114**	**10**

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	Apr-26	May-26	Jun-26	Total
Hospital	2.5	2.3	4.3	2.5	3.0	3.4	3.0	4.3	3.0	1.6	2.3	3.4	**3.0**
RTC	0.2	0.0	0.2	0.2	0.0	0.2	0.2	0.0	0.5	0.0	0.0	0.0	**0.1**
Out of Area	1.1	1.8	2.7	2.0	1.8	2.0	3.0	2.7	1.4	2.3	2.3	2.7	**2.2**

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	Apr-26	May-26	Jun-26	Total	Average
Hospital	1	2	2	0	1	3	4	5	1	3	0	0	**22**	**2**
RTC	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Out of Area	0	0	1	3	1	0	1	2	1	0	1	0	**10**	**1**

Average Length of Stay by Facility

Facility Type BHO	Metrics	Average LOS												
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total
Hospital	CARSON TAHOE REGIONAL MEDICAL	1.0	0.0	7.3	2.7	4.3	5.3	2.5	7.7	2.8	19.0	3.0	3.0	**4.6**
	DESERT HOPE CENTER	0.0	2.5	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0	**5.5**
	DESERT PARKWAY BEHAVIORAL	7.0	3.0	3.0	0.0	3.0	0.0	0.0	2.0	5.5	0.0	5.0	3.5	**3.6**
	DESERT WINDS HOSPITAL	0.0	0.0	5.0	0.0	4.0	0.0	13.0	2.3	0.0	0.0	0.0	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	0.0	0.0	0.0	**4.0**
	RENO BEHAVIORAL HEALTHCARE	7.0	7.3	2.8	4.0	6.3	4.8	6.0	10.7	2.8	4.0	3.7	6.3	**5.2**
	SEVEN HILLS HOSPITAL INC	8.0	0.0	4.5	5.5	3.0	4.0	0.0	2.7	4.0	7.5	3.0	7.0	**4.5**
	SOUTHERN HILLS HOSPITAL	0.0	3.0	15.0	0.0	5.0	4.0	9.0	3.0	0.0	5.0	4.0	2.0	**4.9**
	VALLEY HOSPITAL MEDICAL CTR	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	0.0	**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	0.0	0.0	0.0	**5.7**
	Total	**7.0**	**4.0**	**5.1**	**3.4**	**4.5**	**5.2**	**6.2**	**5.2**	**3.2**	**6.7**	**3.5**	**5.0**	**4.8**
RTC	DESERT HOPE CENTER	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	**10.0**
	RENO BEHAVIORAL HEALTHCARE	0.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0	0.0	0.0	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	0.0	0.0	0.0	**24.8**
	Total	**0.0**	**0.0**	**5.0**	**8.0**	**0.0**	**15.0**	**7.0**	**0.0**	**75.0**	**0.0**	**0.0**	**0.0**	**18.0**
Out of Area	Out of Area	2.2	12.2	27.3	5.7	22.0	16.5	13.9	6.4	8.6	18.0	14.7	6.1	**11.5**
	Total	**2.2**	**12.2**	**27.3**	**5.7**	**22.0**	**16.5**	**13.9**	**6.4**	**8.6**	**18.0**	**14.7**	**6.1**	**11.5**

Beddays by Facility

Facility Type BHO	Metrics	Beddays												
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL	1	0	29	8	17	19	10	23	14	19	13	10	**163**	**15**
	DESERT HOPE CENTER	0	5	0	0	0	6	0	5	0	0	0	6	**22**	**6**
	DESERT PARKWAY BEHAVIORAL	7	9	6	0	3	0	0	2	11	0	5	7	**50**	**6**
	DESERT WINDS HOSPITAL	0	5	10	0	4	0	13	7	0	0	0	0	**39**	**8**
	NORTH VISTA HOSPITAL	4	0	0	0	0	0	0	0	0	0	0	0	**4**	**4**
	RENO BEHAVIORAL HEALTHCARE	21	23	14	28	20	25	36	32	11	8	11	19	**248**	**21**
	SEVEN HILLS HOSPITAL INC	16	0	9	11	6	4	6	16	8	15	6	7	**104**	**9**
	SOUTHERN HILLS HOSPITAL	0	3	15	0	5	4	9	3	0	5	8	2	**54**	**6**
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	4	0	0	0	**4**	**4**
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	9	0	0	8	0	0	0	0	0	1	**18**	**6**
	Total	**49**	**45**	**92**	**47**	**55**	**66**	**74**	**88**	**48**	**47**	**43**	**52**	**706**	**0**
RTC	DESERT HOPE CENTER	0	0	5	0	0	0	0	0	15	0	0	0	**20**	**10**
	RENO BEHAVIORAL HEALTHCARE	0	0	0	0	0	0	7	0	0	0	0	0	**7**	**7**
	VIRTUE RECOVERY LAS VEGAS LLC	16	0	0	8	0	15	0	0	60	0	0	0	**99**	**25**
	Total	**16**	**0**	**5**	**8**	**0**	**15**	**7**	**0**	**75**	**0**	**0**	**0**	**126**	**0**
Out of Area	Out of Area	24	75	192	68	154	132	167	89	60	109	198	71	**1,339**	**112**
	Total	**24**	**75**	**192**	**68**	**154**	**132**	**167**	**89**	**60**	**109**	**198**	**71**	**1,339**	**0**

Admits by Facility

Facility Type BHO	Metrics	Admits													
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL	1	0	5	2	4	5	3	4	4	2	3	4	**37**	**3**
	DESERT HOPE CENTER	0	2	0	0	0	1	0	1	0	0	0	1	**5**	**1**
	DESERT PARKWAY BEHAVIORAL	2	2	2	0	1	0	0	1	3	0	1	2	**14**	**2**
	DESERT WINDS HOSPITAL	0	1	2	0	1	0	2	2	0	0	0	0	**8**	**1**
	NORTH VISTA HOSPITAL	1	0	0	0	0	0	0	0	0	0	0	0	**1**	**1**
	RENO BEHAVIORAL HEALTHCARE	4	4	4	7	4	6	6	5	2	2	3	4	**51**	**4**
	SEVEN HILLS HOSPITAL INC	3	0	2	2	2	1	1	5	3	2	1	2	**24**	**2**
	SOUTHERN HILLS HOSPITAL	0	1	2	0	1	1	1	1	0	1	2	1	**11**	**1**
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**1**
	VIRTUE RECOVERY LAS VEGAS LLC	0	0	2	0	0	1	0	0	0	0	0	1	**4**	**1**
	Total	**11**	**10**	**19**	**11**	**13**	**15**	**13**	**19**	**13**	**7**	**10**	**15**	**156**	**0**
RTC	DESERT HOPE CENTER	0	0	1	0	0	0	0	0	1	0	0	0	**2**	**1**
	RENO BEHAVIORAL HEALTHCARE	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**1**
	VIRTUE RECOVERY LAS VEGAS LLC	1	0	0	1	0	1	0	0	1	0	0	0	**4**	**1**
	Total	**1**	**0**	**1**	**1**	**0**	**1**	**1**	**0**	**2**	**0**	**0**	**0**	7	**0**
Out of Area	Out of Area	5	8	12	9	8	9	13	12	6	10	10	12	**114**	**10**
	Total	**5**	**8**	**12**	**9**	**8**	**9**	**13**	**12**	**6**	**10**	**10**	**12**	**114**	**0**

Readmits by Facility

Facility Type BHO	Metrics	Readmits													
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL	0	0	0	0	1	2	1	2	1	1	0	0	**8**	**1**
	DESERT HOPE CENTER	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**0**
	DESERT PARKWAY BEHAVIORAL	1	1	0	0	0	0	0	0	0	0	0	0	**2**	**0**
	DESERT WINDS HOSPITAL	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**
	RENO BEHAVIORAL HEALTHCARE	0	0	1	0	0	1	2	1	0	0	0	0	**5**	**0**
	SEVEN HILLS HOSPITAL INC	0	0	0	0	0	0	1	1	0	1	0	0	**3**	**0**
	SOUTHERN HILLS HOSPITAL	0	1	1	0	0	0	0	0	0	1	0	0	**3**	**0**
	VALLEY HOSPITAL MEDICAL CTR	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**
	Total	**1**	**2**	**2**	**0**	**1**	**3**	**4**	**5**	**1**	**3**	**0**	**0**	22	**0**
RTC	DESERT HOPE CENTER	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
	RENO BEHAVIORAL HEALTHCARE	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**
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Out of Area	Out of Area	0	0	1	3	1	0	1	2	1	0	1	0	**10**	**1**
	Total	**0**	**0**	**1**	**3**	**1**	**0**	**1**	**2**	**1**	**0**	**1**	**0**	10	**0**

Readmits by Facility

Facility Type BHO	Metrics	Readmit Rate													
	Facility Name	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	Average
Hospital	CARSON TAHOE REGIONAL MEDICAL	0.0%	0.0%	0.0%	0.0%	25.0%	40.0%	33.3%	50.0%	25.0%	50.0%	0.0%	0.0%	**21.6%**	**21.6%**
	DESERT HOPE CENTER	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	**20.0%**	**20.0%**
	DESERT PARKWAY BEHAVIORAL	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**14.3%**	**14.3%**
	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%	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%	0.0%	**0.0%**	**0.0%**
	RENO BEHAVIORAL HEALTHCARE	0.0%	0.0%	25.0%	0.0%	0.0%	16.7%	33.3%	20.0%	0.0%	0.0%	0.0%	0.0%	**9.8%**	**9.8%**
	SEVEN HILLS HOSPITAL INC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	20.0%	0.0%	50.0%	0.0%	0.0%	**12.5%**	**12.5%**
	SOUTHERN HILLS HOSPITAL	0.0%	100.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	**27.3%**	**27.3%**
	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%	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%	0.0%	**0.0%**	**0.0%**
	Total	**9.1%**	**20.0%**	**10.5%**	**0.0%**	**7.7%**	**20.0%**	**30.8%**	**26.3%**	**7.7%**	**42.9%**	**0.0%**	**0.0%**	**14.1%**	**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%	0.0%	**0.0%**	**0.0%**
	RENO BEHAVIORAL HEALTHCARE	0.0%	0.0%	0.0%	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%	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%**	**0.0%**	**0.0%**	**0.0%**
Out of Area	Out of Area	0.0%	0.0%	8.3%	33.3%	12.5%	0.0%	7.7%	16.7%	16.7%	0.0%	10.0%	0.0%	**8.8%**	**8.8%**
	Total	**0.0%**	**0.0%**	**8.3%**	**33.3%**	**12.5%**	**0.0%**	**7.7%**	**16.7%**	**16.7%**	**0.0%**	**10.0%**	**0.0%**	**8.8%**	**0.0%**

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.℠

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	Apr-26	May-26	Jun-26	YTD	Average
Open End of Month	6	4	9	2	4	6	8	7	7	8	3	4	**68**	**6**
Cases opened in the month	17	18	32	21	21	25	27	31	21	17	20	27	**277**	**23**
Cases closed in the month	18	18	26	27	19	21	25	31	23	13	22	21	**264**	**22**
Denied Days	11	0	28	6	4	8	17	21	8	20	22	12	**157**	**13**
Average LOS	4.9	6.5	11.1	4.6	10.9	10.0	9.9	5.7	8.0	11.9	8.5	5.6	**8.0**	**8.0**

Authorizations

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Total services reviewed	20	41	41	36	60	200	97	51	36	93	79	183	**937**	**78**
Services Approved	20	33	38	27	57	162	83	45	31	85	71	165	**817**	**68**
Approval Rate	100.0%	80.5%	92.7%	75.0%	95.0%	81.0%	85.6%	88.2%	86.1%	91.4%	89.9%	90.2%	**87.2%**	**87.2%**
Services Denied	0	8	3	9	3	38	14	6	5	8	8	18	**120**	**10**
Denied Charges	$0	$1,710	$855	$946	$506	$74,075	$7,599	$12,682	$11,130	$11,435	$1,245	$15,254	**$137,436**	**$11,453**
Denial Rate	0%	20%	7%	25%	5%	19%	14%	12%	14%	9%	10%	10%	**13%**	**13%**

Denial Reason

Month	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Denial Reason	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied	Denied
Non-covered service(s)	0	0	0	0	1	0	0	0	0	0	0	**1**	**1**
Not medically necessary	7	3	8	2	31	13	6	5	7	7	17	**106**	**10**
In network provider(s)	1	0	1	0	0	1	0	0	0	1	1	**5**	**1**
Not medically necessary	0	0	0	1	2	0	0	0	1	0	0	**4**	**1**
Non-covered service(s)	0	0	0	0	1	0	0	0	0	0	0	**1**	**1**
Non-covered service	0	0	0	0	2	0	0	0	0	0	0	**2**	**2**
Not medically necessary	0	0	0	0	1	0	0	0	0	0	0	**1**	**1**

Stat

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Stat Request	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**

Appeals

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Appeals 1st Level	2	2	6	2	1	4	2	4	2	3	2	1	**31.00**	**2.58**
Appeals 2nd Level	0	0	1	0	0	0	0	0	0	0	0	0	**1.00**	**0.08**
Appeals 3rd Level	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**	**0.00**
Appeals Overturned	0	0	1	0	0	1	1	0	1	2	0	1	**7.00**	**0.58**
Appeals Upheld	2	0	4	4	1	3	2	4	1	1	2	0	**24.00**	**2.00**

Retro Reviews

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD	Average
Retros	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2026 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.℠

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	Apr-26	May-26	Jun-26	YTD
Membership	52,681	52,592	52,775	52,836	52,792	52,780	52,521	52,676	52,731	52,818	52,824	52,494	**52,710**
Beddays per K	13.7	14.6	29.1	15.2	15.2	18.9	23.3	28.2	19.8	18.4	14.5	25.1	**19.7**
Admits per K	3.2	3.2	5.7	3.9	3.4	4.5	4.6	6.4	4.1	3.0	3.2	5.5	**4.2**
Average LOS	5.5	4.2	5.3	3.5	4.4	4.6	5.7	4.8	4.4	6.8	3.7	6.2	**4.9**
Readmits per K	0.2	0.5	0.7	0.5	0.2	0.7	0.9	1.6	0.5	0.7	0.2	0.0	**0.6**
Readmit Rate	7.1%	14.3%	12.0%	11.8%	6.7%	15.0%	20.0%	25.0%	11.1%	23.1%	7.1%	0.0%	**13.1%**

SHO

Month	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD
Beddays per K	11.6	18.3	20.0	14.5	13.7	13.0	17.5	15.0	16.6	15.1	12.5	14.7	**15.2**
Admits per K	2.5	3.6	4.1	3.4	2.8	3.2	3.7	3.4	3.9	3.2	2.7	3.2	**3.3**
Average LOS	5.1	5.1	5.1	4.1	5.1	4.2	4.9	4.4	4.3	4.6	4.5	5.3	**4.7**
Readmits per K	0.3	0.5	0.5	0.3	0.2	0.4	0.5	0.5	0.4	0.4	0.3	0.0	**0.3**
Readmit Rate	10.2%	12.9%	11.1%	9.1%	7.3%	12.9%	12.3%	14.9%	9.1%	11.1%	9.3%	0.0%	**10.1%**

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

14.4

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - **14.4 Q4 UnitedHealthcare – Basic Life Insurance**

370074 State of Nevada Public Employees' Benefits Program

Life Performance Guarantees 2026 Q4 – (04/01/2026 – 06/30/2026)

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%	Met
	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%	Met
	Life Insurance - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of quarterly Basic Life Insurance Premium	100%	Met
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	77.4%	Not met
	Abandonment Rate	Less than 5% of calls will be abandoned	Call Center Statistics	.3% of quarterly Basic Life Insurance Premium	1.89%	Met

14.5

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - **14.5 Q4 Express Scripts – Utilization Report**

Nevada PEBP FY26 Q4 Report

7/1/2024 – 6/30/2026

Report Includes:

- CDHP Comparison Data from Q4 FY26 to Q4 FY25
- EPO Comparison Data from Q4 FY26 to Q4 FY25
- PPO Comparison Data from Q4 FY26 to Q4 FY25
- CDHP, EPO, PPO Breakout Data from Q4 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)
8/31/2026

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q4 FY26 to Q4 FY25

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	52,462	51,616	1.6%
Utilizing Member Count (Patients)	40,267	39,485	2.0%
Percent Utilizing (Utilization)	76.8%	76.5%	0.3

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	848,750	816,010	4.0%
Claims per Elig Member per Month (Claims PMPM)	1.35	1.32	2.3%
Total Claims for Generic (Generic ARx)	740,717	711,087	4.2%
Total Claims for Brand (Brand ARx)	108,033	104,923	3.0%
Total Claims for Multisource Brand Claims (MSB ARx)	1,652	1,963	-15.8%
Total Non-Specialty Claims	835,584	805,212	3.8%
Total Specialty Claims	13,166	10,798	21.9%
Generic % of Total Claims (GFR)	**87.3%**	**87.1%**	**0.1**
Generic Effective Rate (GCR)	99.8%	99.7%	0.1
Mail Order Claims	195,586	211,584	-7.6%
Mail Penetration Rate*	25.8%	29.2%	-3.4

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	**$140,693,678**	**$123,120,083**	**14.3%**
Total Generic Gross Cost	$12,561,600	$12,454,946	0.9%
Total Brand Gross Cost	$128,132,079	$110,665,138	15.8%
Total MSB Gross Cost	$1,372,040	$1,322,277	3.8%
Total Ingredient Cost	$137,053,464	$119,722,856	14.5%
Total Dispensing Fee	$3,608,446	$3,342,826	7.9%
Total Other (e.g. tax)	$31,768	$54,401	-41.6%
Avg Total Cost per Claim (Gross Cost/ARx)	**$165.77**	**$150.88**	**9.9%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$16.96	$17.52	-3.2%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,186.05	$1,054.73	12.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$830.53	$673.60	23.3%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q4 FY26 to Q4 FY25

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	**$20,817,955**	**$21,029,659**	**-1.0%**
Generic Cost Share	$4,289,045	$4,698,862	-8.7%
Brand Cost Share	$16,528,910	$16,330,796	1.2%
MSB Cost Share	$201,804	$232,635	-13.3%
Total Copay	$19,097,021	$19,206,797	-0.6%
Total Deductible	$1,720,933	$1,822,861	-5.6%
Avg Copay per Claim (Member Cost Share/ARx)	**$24.53**	**$25.77**	**-4.8%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$5.79	$6.61	-12.4%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$153.00	$155.65	-1.7%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$122.16	$118.51	3.1%
Copay % of Total Prescription Cost (Member Cost Share %)	**14.8%**	**17.1%**	**-2.3**

Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	**$119,875,724**	**###########**	**17.4%**
Generic Plan Cost	$8,272,555	$7,756,083	6.7%
Brand Plan Cost	$111,603,169	$94,334,341	18.3%
MSB Plan Cost	$1,170,236	$1,089,642	7.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$54,008,893	$50,003,951	8.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$65,866,831	$52,086,474	26.5%
Avg Plan Cost per Claim (Plan Cost/ARx)	$141.24	$125.11	12.9%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$11.17	$10.91	2.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$1,033.05	$899.08	14.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$708.38	$555.09	27.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$64.64	$62.10	4.1%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,002.80	$4,823.71	3.7%
Plan Cost PMPM	**$190.42**	**$164.82**	**15.5%**
Non-Specialty Plan Cost PMPM	$85.79	$80.73	6.3%
Specialty Plan Cost PMPM	$104.63	$84.09	24.4%
Specialty % of Plan Cost	54.9%	51.0%	3.9
Net Plan Cost PMPM (factoring Rebates)	**$127.01**	**$103.32**	**22.9%**
Non-Specialty Plan Cost PMPM	$49.12	$44.80	9.6%
Specialty Plan Cost PMPM	$77.90	$58.52	33.1%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q4 FY26 to Q4 FY25

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	22,356	23,015	-2.9%
Utilizing Member Count (Patients)	16,133	16,639	-3.0%
Percent Utilizing (Utilization)	72.2%	72.3%	-0.1

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	328,360	336,732	-2.5%
Claims per Elig Member per Month (Claims PMPM)	1.22	1.22	0.4%
Total Claims for Generic (Generic ARx)	289,865	297,063	-2.4%
Total Claims for Brand (Brand ARx)	38,495	39,669	-3.0%
Total Claims for Multisource Brand Claims (MSB ARx)	514	534	-3.7%
Total Non-Specialty Claims	323,427	332,461	-2.7%
Total Specialty Claims	4,933	4,271	15.5%
Generic % of Total Claims (GFR)	**88.3%**	**88.2%**	**0.1**
Generic Effective Rate (GCR)	99.8%	99.8%	0.0
Mail Order Claims	76,023	84,971	-10.5%
Mail Penetration Rate*	25.9%	28.5%	-2.5

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	**$50,807,385**	**$46,355,912**	**9.6%**
Total Generic Gross Cost	$4,035,462	$4,650,084	-13.2%
Total Brand Gross Cost	$46,771,922	$41,705,827	12.1%
Total MSB Gross Cost	$466,776	$415,739	12.3%
Total Ingredient Cost	$49,371,664	$44,943,121	9.9%
Total Dispensing Fee	$1,423,916	$1,392,547	2.3%
Total Other (e.g. tax)	$11,805	$20,244	-41.7%
Avg Total Cost per Claim (Gross Cost/ARx)	**$154.73**	**$137.66**	**12.4%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$13.92	$15.65	-11.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,215.01	$1,051.35	15.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$908.12	$778.54	16.6%

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PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q4 FY26 to Q4 FY25

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	**$9,696,916**	**$9,848,893**	**-1.5%**
Generic Cost Share	$1,683,143	$1,942,347	-13.3%
Brand Cost Share	$8,013,774	$7,906,546	1.4%
MSB Cost Share	$122,541	$171,803	-28.7%
Total Copay	$7,979,865	$8,029,327	-0.6%
Total Deductible	$1,717,051	$1,819,566	-5.6%
Avg Copay per Claim (Member Cost Share/ARx)	**$29.53**	**$29.25**	**1.0%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$5.81	$6.54	-11.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$208.18	$199.31	4.4%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$238.41	$321.73	-25.9%
Copay % of Total Prescription Cost (Member Cost Share %)	**19.1%**	**21.2%**	**-2.2**

Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	**$41,110,468**	**$36,507,019**	**12.6%**
Generic Plan Cost	$2,352,320	$2,707,737	-13.1%
Brand Plan Cost	$38,758,149	$33,799,281	14.7%
MSB Plan Cost	$344,235	$243,936	41.1%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$14,825,200	$15,339,888	-3.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$26,285,268	$21,167,130	24.2%
Avg Plan Cost per Claim (Plan Cost/ARx)	$125.20	$108.42	15.5%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$8.12	$9.12	-11.0%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$1,006.84	$852.03	18.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$669.72	$456.81	46.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$45.84	$46.14	-0.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,328.45	$4,956.01	7.5%
Plan Cost PMPM	**$153.24**	**$132.19**	**15.9%**
Non-Specialty Plan Cost PMPM	$55.26	$55.54	-0.5%
Specialty Plan Cost PMPM	$97.98	$76.64	27.8%
Specialty % of Plan Cost	63.9%	58.0%	6.0
Net Plan Cost PMPM (factoring Rebates)	**$100.72**	**$81.85**	**23.0%**
Non-Specialty Plan Cost PMPM	$26.84	$28.73	-6.6%
Specialty Plan Cost PMPM	$73.88	$53.12	39.1%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q4 FY26 vs Q4 FY25

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	4,439	5,178	-14.3%
Utilizing Member Count (Patients)	3,782	4,371	-13.5%
Percent Utilizing (Utilization)	85.2%	84.4%	0.8

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	108,292	120,843	-10.4%
Claims per Elig Member per Month (Claims PMPM)	2.03	1.94	4.5%
Total Claims for Generic (Generic ARx)	93,288	104,463	-10.7%
Total Claims for Brand (Brand ARx)	15,004	16,380	-8.4%
Total Claims for Multisource Brand Claims (MSB ARx)	256	393	-34.9%
Total Non-Specialty Claims	106,432	119,046	-10.6%
Total Specialty Claims	1,860	1,797	3.5%
Generic % of Total Claims (GFR)	**86.1%**	**86.4%**	**-0.3**
Generic Effective Rate (GCR)	99.7%	99.6%	0.1
Mail Order Claims	27,949	33,844	-17.4%
Mail Penetration Rate*	28.2%	30.8%	-2.6

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	**$19,460,135**	**$20,909,304**	**-6.9%**
Total Generic Gross Cost	$1,802,597	$1,827,871	-1.4%
Total Brand Gross Cost	$17,657,538	$19,081,433	-7.5%
Total MSB Gross Cost	$271,646	$424,956	-36.1%
Total Ingredient Cost	$18,975,721	$20,398,347	-7.0%
Total Dispensing Fee	$480,438	$502,695	-4.4%
Total Other (e.g. tax)	$3,975	$8,261	-51.9%
Avg Total Cost per Claim (Gross Cost/ARx)	**$179.70**	**$173.03**	**3.9%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$19.32	$17.50	10.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,176.86	$1,164.92	1.0%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$1,061.12	$1,081.31	-1.9%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q4 FY26 vs Q4 FY25

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	**$2,394,492**	**$3,116,628**	**-23.2%**
Generic Cost Share	$563,308	$699,477	-19.5%
Brand Cost Share	$1,831,184	$2,417,151	-24.2%
MSB Cost Share	$27,180	$26,941	0.9%
Total Copay	$2,390,610	$3,113,332	-23.2%
Total Deductible	$3,882	$3,296	17.8%
Avg Copay per Claim (Member Cost Share/ARx)	**$22.11**	**$25.79**	**-14.3%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.04	$6.70	-9.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$122.05	$147.57	-17.3%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$106.17	$68.55	54.9%
Copay % of Total Prescription Cost (Member Cost Share %)	**12.3%**	**14.9%**	**-2.6**

Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	**$17,065,642**	**$17,792,676**	**-4.1%**
Generic Plan Cost	$1,239,289	$1,128,394	9.8%
Brand Plan Cost	$15,826,354	$16,664,282	-5.0%
MSB Plan Cost	$244,466	$398,015	-38.6%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,283,144	$8,616,385	-3.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$8,782,498	$9,176,291	-4.3%
Avg Plan Cost per Claim (Plan Cost/ARx)	$157.59	$147.24	7.0%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$13.28	$10.80	23.0%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$1,054.81	$1,017.36	3.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$954.95	$1,012.76	-5.7%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$77.83	$72.38	7.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,721.77	$5,106.45	-7.5%
Plan Cost PMPM	**$320.37**	**$286.35**	**11.9%**
Non-Specialty Plan Cost PMPM	$155.50	$138.67	12.1%
Specialty Plan Cost PMPM	$164.87	$147.68	11.6%
Specialty % of Plan Cost	51.5%	51.6%	-0.1
Net Plan Cost PMPM (factoring Rebates)	**$214.63**	**$182.27**	**17.8%**
Non-Specialty Plan Cost PMPM	$91.47	$76.22	20.0%
Specialty Plan Cost PMPM	$123.16	$106.06	16.1%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q4 FY26 vs Q4 FY25

Membership Summary	FY 2026	FY 2025	Change
Member Count (Membership)	25,675	23,427	9.6%
Utilizing Member Count (Patients)	20,447	18,564	10.1%
Percent Utilizing (Utilization)	79.6%	79.2%	0.4

Claim Summary	FY 2026	FY 2025	Change
Net Claims (Total Adjusted Rx's)	412,098	358,435	15.0%
Claims per Elig Member per Month (Claims PMPM)	1.34	1.28	4.9%
Total Claims for Generic (Generic ARx)	357,564	309,561	15.5%
Total Claims for Brand (Brand ARx)	54,534	48,874	11.6%
Total Claims for Multisource Brand Claims (MSB ARx)	882	1,036	-14.9%
Total Non-Specialty Claims	405,725	353,705	14.7%
Total Specialty Claims	6,373	4,730	34.7%
Generic % of Total Claims (GFR)	**86.8%**	**86.4%**	**0.4**
Generic Effective Rate (GCR)	99.8%	99.7%	0.1
Mail Order Claims	91,614	92,769	-1.2%
Mail Penetration Rate*	25.0%	29.4%	-4.3

Claims Cost Summary	FY 2026	FY 2025	Change
Total Prescription Cost (Total Gross Cost)	**$70,426,159**	**$55,854,868**	**26.1%**
Total Generic Gross Cost	$6,723,541	$5,976,991	12.5%
Total Brand Gross Cost	$63,702,618	$49,877,877	27.7%
Total MSB Gross Cost	$633,618	$481,582	31.6%
Total Ingredient Cost	$68,706,079	$54,381,389	26.3%
Total Dispensing Fee	$1,704,092	$1,447,584	17.7%
Total Other (e.g. tax)	$15,988	$25,895	-38.3%
Avg Total Cost per Claim (Gross Cost/ARx)	**$170.90**	**$155.83**	**9.7%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$18.80	$19.31	-2.6%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,168.13	$1,020.54	14.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$718.39	$464.85	54.5%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q4 FY26 vs Q4 FY25

Member Cost Summary	FY 2026	FY 2025	Change
Total Member Cost Share	**$8,726,546**	**$8,064,138**	**8.2%**
Generic Cost Share	$2,042,594	$2,057,039	-0.7%
Brand Cost Share	$6,683,952	$6,007,099	11.3%
MSB Cost Share	$52,083	$33,891	53.7%
Total Copay	$8,726,546	$8,064,138	8.2%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$21.18**	**$22.50**	**-5.9%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$5.71	$6.65	-14.0%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$122.56	$122.91	-0.3%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$59.05	$32.71	80.5%
Copay % of Total Prescription Cost (Member Cost Share %)	**12.4%**	**14.4%**	**-2.0**

Plan Cost Summary	FY 2026	FY 2025	Change
Total Plan Cost (Plan Cost)	**$61,699,613**	**$47,790,730**	**29.1%**
Generic Plan Cost	$4,680,947	$3,919,952	19.4%
Brand Plan Cost	$57,018,666	$43,870,778	30.0%
MSB Plan Cost	$581,535	$447,691	29.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$30,900,549	$26,047,678	18.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$30,799,064	$21,743,052	41.7%
Avg Plan Cost per Claim (Plan Cost/ARx)	$149.72	$133.33	12.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$13.09	$12.66	3.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$1,045.56	$897.63	16.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$659.34	$432.13	52.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$76.16	$73.64	3.4%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,832.74	$4,596.84	5.1%
Plan Cost PMPM	**$200.26**	**$170.00**	**17.8%**
Non-Specialty Plan Cost PMPM	$100.29	$92.66	8.2%
Specialty Plan Cost PMPM	$99.96	$77.34	29.2%
Specialty % of Plan Cost	49.9%	45.5%	4.4
Net Plan Cost PMPM (factoring Rebates)	**$134.73**	**$106.94**	**26.0%**
Non-Specialty Plan Cost PMPM	$61.18	$53.63	14.1%
Specialty Plan Cost PMPM	$73.55	$53.31	38.0%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q4 FY26

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	52,462	4,439	22,356	25,675
Utilizing Member Count (Patients)	40,267	3,782	16,133	20,447
Percent Utilizing (Utilization)	76.8%	85.2%	72.2%	79.6%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	848,750	108,292	328,360	412,098
Claims per Elig Member per Month (Claims PMPM)	1.35	2.03	1.22	1.34
Total Claims for Generic (Generic Rx)	740,717	93,288	289,865	357,564
Total Claims for Brand (Brand Rx)	108,033	15,004	38,495	54,534
Total Claims for Multisource Brand Claims (MSB Rx)	1,652	256	514	882
Total Non-Specialty Claims	835,584	106,432	323,427	405,725
Total Specialty Claims	13,166	1,860	4,933	6,373
Generic % of Total Claims (GFR)	**87.3%**	**86.1%**	**88.3%**	**86.8%**
Generic Effective Rate (GCR)	99.8%	99.7%	99.8%	99.8%
Mail Order Claims	195,586	27,949	76,023	91,614
Mail Penetration Rate*	25.8%	28.2%	25.9%	25.0%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$140,693,678**	**$19,460,135**	**$50,807,385**	**$70,426,159**
Total Generic Gross Cost	$12,561,600	$1,802,597	$4,035,462	$6,723,541
Total Brand Gross Cost	$128,132,079	$17,657,538	$46,771,922	$63,702,618
Total MSB Gross Cost	$1,372,040	$271,646	$466,776	$633,618
Total Ingredient Cost	$137,053,464	$18,975,721	$49,371,664	$68,706,079
Total Dispensing Fee	$1,904,354	$480,438	$1,423,916	$1,704,092
Total Other (e.g. tax)	$31,768	$3,975	$11,805	$15,988
Avg Total Cost per Claim (Gross Cost/Rx)	**$165.77**	**$179.70**	**$154.73**	**$170.90**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$16.96	$19.32	$13.92	$18.80
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$1,186.05	$1,176.86	$1,215.01	$1,168.13
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$830.53	$1,061.12	$908.12	$718.39

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN
+ Q4 FY26

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$20,817,955**	**$2,394,492**	**$9,696,916**	**$8,726,546**
Generic Cost Share	$4,289,045	$563,308	$1,683,143	$2,042,594
Brand Cost Share	$16,528,910	$1,831,184	$8,013,774	$6,683,952
MSB Cost Share	$201,804	$27,180	$122,541	$52,083
Total Copay	$19,097,021	$2,390,610	$7,979,865	$8,726,546
Total Deductible	$1,720,933	$3,882	$1,717,051	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$24.53**	**$22.11**	**$29.53**	**$21.18**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$5.79	$6.04	$5.81	$5.71
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$153.00	$122.05	$208.18	$122.56
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$122.16	$106.17	$238.41	$59.05
Copay % of Total Prescription Cost (Member Cost Share %)	**14.8%**	**12.3%**	**19.1%**	**12.4%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$119,875,724**	**$17,065,642**	**$41,110,468**	**$61,699,613**
Generic Plan Cost	$8,272,555	$1,239,289	$2,352,320	$4,680,947
Brand Plan Cost	$111,603,169	$15,826,354	$38,758,149	$57,018,666
MSB Plan Cost	$1,170,236	$244,466	$344,235	$581,535
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$54,008,893	$8,283,144	$14,825,200	$30,900,549
Total Specialty Drug Cost (Specialty Plan Cost)	$65,866,831	$8,782,498	$26,285,268	$30,799,064
Avg Plan Cost per Claim (Plan Cost/Rx)	$141.24	$157.59	$125.20	$149.72
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$11.17	$13.28	$8.12	$13.09
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$1,033.05	$1,054.81	$1,006.84	$1,045.56
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$708.38	$954.95	$669.72	$659.34
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$64.64	$77.83	$45.84	$76.16
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$5,002.80	$4,721.77	$5,328.45	$4,832.74
Plan Cost PMPM	**$190.42**	**$320.37**	**$153.24**	**$200.26**
Non-Specialty Plan Cost PMPM	$85.79	$155.50	$55.26	$100.29
Specialty Plan Cost PMPM	$104.63	$164.87	$97.98	$99.96
Specialty % of Plan Cost	54.9%	51.5%	63.9%	49.9%
Net Plan Cost PMPM (factoring Rebates)	**$127.01**	**$214.63**	**$100.72**	**$134.73**
Non-Specialty Net Plan Cost PMPM	$49.12	$91.47	$26.84	$61.18
Specialty Net Plan Cost PMPM	$77.90	$123.16	$73.88	$73.55

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q4 FY26

State of Nevada PEBP FY2026 Q4				
Description	**Grand Total**	**EPO**	**CDHP**	**PPO**
Avg Members per Month	52,462	4,439	22,356	25,675
Pct Members Utilizing Benefit	76.8%	85.2%	72.2%	79.6%
Total Plan Cost	$ 119,875,724	$ 17,065,642	$ 41,110,468	$ 61,699,613
Total Days	22,522,115	2,943,811	8,719,342	10,858,962
Total Adjusted Rxs	848,750	108,292	328,360	412,098
Plan Cost PMPM	$ 190.42	$ 320.37	$ 153.24	$ 200.26
Plan Cost Net PMPM	$ 127.01	$ 214.63	$ 100.72	$ 134.73
Plan Cost/Day	$ 5.32	$ 5.80	$ 4.71	$ 5.68
Plan Cost per Adjusted Rx	$ 141.24	$ 157.59	$ 125.20	$ 149.72
Nbr Rxs PMPM	1.35	2.03	1.22	1.34
Generic Fill Rate	87.3%	86.1%	88.3%	86.8%
Home Delivery Utilization	25.8%	28.2%	25.9%	25.0%
Member Cost %	14.8%	12.3%	19.1%	12.4%
Specialty Percent of Plan Cost	54.9%	51.5%	63.9%	49.9%
Specialty Plan Cost PMPM	$ 104.63	$ 164.87	$ 97.98	$ 99.96
Formulary Compliance Rate	99.5%	99.4%	99.7%	99.3%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q4 FY26

State of Nevada PEBP FY2026 Q4 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	52,462	46,686	5,383	16	386
Pct Members Utilizing Benefit	76.8%	75.6%	91.8%	87.5%	95.1%
Total Plan Cost	$ 119,875,724	$ 96,790,002	$ 21,420,949	$ 46,485	$ 1,618,287
Total Days	22,522,115	17,573,020	4,379,793	11,122	558,180
Total Adjusted Rxs	848,750	669,390	158,934	393	20,033
Plan Cost PMPM	$ 190.42	$ 172.77	$ 331.61	$ 242.11	$ 349.37
Plan Cost Net PMPM	$ 127.01	$ 115.97	$ 219.66	$ 162.61	$ 166.85
Plan Cost/Day	$ 5.32	$ 5.51	$ 4.89	$ 4.18	$ 2.90
Plan Cost per Adjusted Rx	$ 141.24	$ 144.59	$ 134.78	$ 118.28	$ 80.78
Nbr Rxs PMPM	1.35	1.19	2.46	2.05	4.32
Generic Fill Rate	87.3%	87.1%	88.0%	81.4%	88.0%
Home Delivery Utilization	25.8%	23.5%	33.8%	67.8%	33.4%
Member Cost %	14.8%	14.8%	14.7%	7.5%	15.4%
Specialty Percent of Plan Cost	54.9%	54.3%	59.3%	0.0%	37.7%
Specialty Plan Cost PMPM	$ 104.63	$ 93.82	$ 196.58	$ -	$ 131.78
Formulary Compliance Rate	99.5%	99.4%	99.6%	100.0%	99.6%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q4 FY26

State of Nevada PEBP FY2026 Q4 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	22,356	19,090	2,961	10	297
Pct Members Utilizing Benefit	72.2%	69.9%	89.6%	70.0%	94.9%
Total Plan Cost	$ 41,110,468	$ 30,317,216	$ 9,565,685	$ 1,730	$ 1,225,836
Total Days	8,719,342	6,017,744	2,258,670	770	442,158
Total Adjusted Rxs	328,360	230,623	81,857	30	15,850
Plan Cost PMPM	$ 153.24	$ 132.34	$ 269.21	$ 17.30	$ 343.95
Plan Cost Net PMPM	$ 100.72	$ 88.66	$ 172.94	$ 7.05	$ 157.92
Plan Cost/Day	$ 4.71	$ 5.04	$ 4.24	$ 2.25	$ 2.77
Plan Cost per Adjusted Rx	$ 125.20	$ 131.46	$ 116.86	$ -	$ 77.34
Nbr Rxs PMPM	1.22	1.01	2.30	0.25	4.45
Generic Fill Rate	88.3%	88.0%	89.2%	70.0%	87.6%
Home Delivery Utilization	25.9%	22.6%	33.5%	0.0%	32.5%
Member Cost %	19.1%	19.6%	17.7%	15.8%	17.6%
Specialty Percent of Plan Cost	63.9%	64.3%	65.9%	0.0%	39.7%
Specialty Plan Cost PMPM	$ 97.98	$ 85.08	$ 177.53	$ -	$ 136.67
Formulary Compliance Rate	99.7%	99.7%	99.8%	100.0%	99.6%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN
+ Q4 FY26

State of Nevada PEBP FY2026 Q4 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	4,439	3,756	623	3	57
Pct Members Utilizing Benefit	85.2%	83.8%	98.9%	66.7%	93.0%
Total Plan Cost	$ 17,065,642	$ 12,164,983	$ 4,677,761	$ 19,275	$ 203,624
Total Days	2,943,811	2,206,732	665,495	4,224	67,360
Total Adjusted Rxs	108,292	81,762	23,972	147	2,411
Plan Cost PMPM	$ 320.37	$ 269.90	$ 625.70	$ 535.43	$ 297.70
Plan Cost Net PMPM	$ 214.63	$ 173.78	$ 462.18	$ 328.49	$ 194.60
Plan Cost/Day	$ 5.80	$ 5.51	$ 7.03	$ 4.56	$ 3.02
Plan Cost per Adjusted Rx	$ 157.59	$ 148.79	$ 195.13	$ 131.12	$ 84.46
Nbr Rxs PMPM	2.03	1.81	3.21	4.08	4.32
Generic Fill Rate	86.1%	85.9%	86.4%	83.0%	91.0%
Home Delivery Utilization	28.2%	26.4%	33.3%	60.2%	34.4%
Member Cost %	12.3%	12.5%	12.0%	6.2%	9.3%
Specialty Percent of Plan Cost	51.5%	47.5%	62.1%	0.0%	49.7%
Specialty Plan Cost PMPM	$ 164.87	$ 128.13	$ 388.77	$ -	$ 147.86
Formulary Compliance Rate	99.4%	99.3%	99.6%	100.0%	99.3%

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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ Q4 FY26

State of Nevada PEBP FY2026 Q4 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	25,675	23,840	1,799	5	32
Pct Members Utilizing Benefit	79.6%	79.1%	93.3%	100.0%	100.0%
Total Plan Cost	$ 61,699,613	$ 54,307,803	$ 7,177,503	$ 25,480	$ 188,827
Total Days	10,858,962	9,348,544	1,455,628	6,128	48,662
Total Adjusted Rxs	412,098	357,005	53,105	216	1,772
Plan Cost PMPM	$ 200.26	$ 189.83	$ 332.48	$ 424.66	$ 491.74
Plan Cost Net PMPM	$ 134.73	$ 128.72	$ 212.57	$ 311.51	$ 200.36
Plan Cost/Day	$ 5.68	$ 5.81	$ 4.93	$ 4.16	$ 3.88
Plan Cost per Adjusted Rx	$ 149.72	$ 152.12	$ 135.16	$ 117.96	$ 106.56
Nbr Rxs PMPM	1.34	1.25	2.46	3.60	4.61
Generic Fill Rate	86.8%	86.7%	86.9%	81.9%	87.5%
Home Delivery Utilization	25.0%	23.4%	34.6%	81.5%	40.1%
Member Cost %	12.4%	12.4%	12.1%	7.9%	6.1%
Specialty Percent of Plan Cost	49.9%	50.3%	48.5%	0.0%	11.8%
Specialty Plan Cost PMPM	$ 99.96	$ 95.40	$ 161.37	$ -	$ 57.83
Formulary Compliance Rate	99.3%	99.3%	99.4%	100.0%	99.9%

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14.6

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - **14.6 Q4 Express Scripts – Summary Report**

Nevada PEBP

Q4 FY2026

Prepared by Client Analytics

Mathew Gehrin (mgehrin@express-scripts.com)

8/31/2026

**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.*

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Hello PEBP Team,

This is the Q4 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	**$100.72**	
Utilization	$0.89	1.1%
Unit Cost	$12.58	15.4%
Member Share	$5.39	6.6%
Total Change in Plan Cost Net PMPM	**$18.86**	**23.0%**
Previous Period - Plan Cost Net PMPM	**$81.85**	

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

- **Inflammatory Conditions**: Previous ranked 2nd, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $1.24M (37.1%) to current $4.58M.
  - Plan Cost Net PMPM ↑ $4.98 (41.1%) to current $17.08.
  - Patient Count ↑ 18 to current count of 279.
  - Adjusted Rxs ↑ 132 to current count of 2,537.

- **Notable Drug Changes within Indication:**
  - **Ilaris:**
    - Previously ranked 28th , currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $476k (3,362.4%) to current $490k Plan Cost Net.
    - Plan Cost Net PMPM: ↑ $1.78 (3,464.5%) to current $1.83.
    - Patient Count ↑ 4 to current count of 5.
    - Adjusted Rxs ↑ 37 to current count of 38.
  - **Rinvoq:**
    - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $136k (37.1%) to current $503k.
    - Plan Cost Net PMPM ↑ $.55 (41.2%) to current $1.88.
    - Patient Count ↑ 4 to current count of 17.
    - Adjusted Rxs ↑ 26 to current count of 135.
  - **Cosentyx Unoready Pen:**
    - New, currently ranked 7th by Plan Cost Net.
    - Plan Cost Net New, currently $190k.

        - Plan Cost Net PMPM New, currently $0.71.
        - Patient Count New, current count of 5.
        - Adjusted Rxs New, current count of 34.

- **Blood Cell Deficiencies**: Previously ranked 13th, currently ranked 46th by Plan Cost Net.
    - Plan Cost Net ↓ $355k (-91%) to current $34k.
    - Plan Cost Net PMPM ↓ $1.28 (-91.1%) to current $0.12.
    - Patient Count ↓ 15 to current count of 6.
    - Adjusted Rxs ↓ 8 to current count of 29.

- **Notable Drug Changes within Indication:**
    - **Promacta:**
        - No Longer Utilized, previously ranked 1st by Plan Cost Net.
        - Plan Cost Net: Previously $358k.
        - Plan Cost Net PMPM: Previously $1.33.
        - Patient Count: Previously 1.
        - Adjusted Rxs: Previously 10.
    - **Other drug changes in this indication were not notable.**

- **Pulmonary Hypertension**: Previously ranked 12th, currently ranked 7th by Plan Cost Net.
    - Plan Cost Net ↑ $923k (233.3%) to current $1.32M.
    - Plan Cost Net PMPM ↑ $3.48 (243.1%) to current $4.92.
    - Patient Count ↑ 3 to current count of 7.
    - Adjusted Rxs ↑ 71 to current count of 122.

- **Notable Drug Changes within Indication:**
    - **Tyvaso DPI:**
        - New, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $564k.
        - Plan Cost Net PMPM: New, current $2.10.
        - Patient Count: New, current count of 2.
        - Adjusted Rxs: New, current count of 26.
    - **Opsynvi:**
        - Previously ranked 3rd, currently ranked 3rd by Plan Cost Net
        - Plan Cost Net ↑ $173k (543.8%) to current $205k.
        - Plan Cost Net PMPM ↑ $0.65 (562.7%) to current $0.77.
        - Patient Count ↑ 1 to current count of 2.
        - Adjusted Rxs ↑ 21 to current count of 24.
    - **Winrevair:**
        - New, currently ranked 4th by Plan Cost Net.
        - Plan Cost Net: New, current $150k.
        - Plan Cost Net PMPM: New, current $0.56.
        - Patient Count: New, current count of 2.
        - Adjusted Rxs: New, current count of 10.

- **Cancer**: Previous ranked 1st , currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $686k (19.4%) to current $4.22M.
  - Plan Cost Net PMPM ↑ $2.93 (22.9%) to current $15.72.
  - Patient Count ↓ 7 to current count of 228.
  - Adjusted Rxs ↓ 99 to current count of 1,639.

- **Notable Drug Changes within Indication:**
  - **Verzenio**
    - Previously ranked 7th, currently ranked 1st by Plan Cost Net
    - Plan Cost Net ↑ $226k (100.2%) to current $451k.
    - Plan Cost Net PMPM ↑ $0.87 (106.1%) to current $1.68.
    - Patient Count ↑ 1 to current count of 4.
    - Adjusted Rxs ↑ 15 to current count of 34.
  - **Kisqali**
    - New, currently ranked 10th by Plan Cost Net.
    - Plan Cost Net: New, current $195k.
    - Plan Cost Net PMPM: New, current $0.73.
    - Patient Count: New, current count of 2.
    - Adjusted Rxs: New, current count of 16.
  - **Tagrisso**
    - Previously ranked 3rd, currently ranked 2nd by Plan Cost Net
    - Plan Cost Net ↑ $141k (47.9%) to current $436k.
    - Plan Cost Net PMPM ↑ $0.56 (52.2%) to current $1.63.
    - Patient Count unchanged at 2.
    - Adjusted Rxs ↑ 9 to current count of 26.

- **Enzyme Deficiencies**: Previously ranked 42nd, currently ranked 13th by Plan Cost Net.
  - Plan Cost Net ↑ $380k (1,209.7%) to current $576k.
  - Plan Cost Net PMPM ↑ $1.99 (1,248.3%) to current $2.15.
  - Patient Count ↑ 4 to current count of 6.
  - Adjusted Rxs ↑ 17 to current count of 25.

- **Notable Drug Changes within Indication:**
  - **Fabrazyme:**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $463k.
    - Plan Cost Net PMPM: New, current $1.73.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 12.
  - **Other drug changes in this indication were not notable.**

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 $109.57 compared to CDHP PEBP of $100.72.
- Peer experienced Trend of 15.2%, compared to CDHP PEBP Trend of 23.0%

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$214.63**	
Utilization	$9.66	5.3%
Unit Cost	$11.63	6.4%
Member Share	$11.06	6.1%
Total Change in Plan Cost Net PMPM	**$32.35**	**17.8%**
Previous Period - Plan Cost Net PMPM	**$182.27**	

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

- **Blood Cell Deficiencies**: Previous ranked 9th, currently ranked 46th by Plan Cost Net.
  - Plan Cost Net ↓ $363k (-97.4%) to current $10k.
  - Plan Cost Net PMPM ↓ $5.82 (-97.0%) to current $0.18.
  - Patient Count ↓ 3 to current count of 1.
  - Adjusted Rxs ↓ 0 to current count of 18.

- **Notable Drug Changes within Indication:**
  - **Cablivi:**
    - Previously ranked 1st, not currently utilized.
    - Plan Cost Net: Previous, $359k.
    - Plan Cost Net PMPM: Previous, $5.77.
    - Patient Count: Previous count of 1.
    - Adjusted Rxs: Previous count of 2.
  - **Other drug changes in this indication were not notable.**

- **Diabetes**: Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $183k (-13.2%) to current $1.6M.
  - Plan Cost Net PMPM ↑ $7.15 (32.0%) to current $29.50.
  - Patient Count ↓ 66 to current count of 559.
  - Adjusted Rxs ↓ 1,086 to current count of 9,973.

- **Notable Drug Changes within Indication:**
  - **Mounjaro:**
    - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $254k (66.1%) to current $639k.
    - Plan Cost Net PMPM ↑ $5.81 (93.7%) to current $12.01.

        - Patient Count ↑ 58 to current count of 184.
        - Adjusted Rxs ↑ 482 to current count of 1,585.
    - **Other drug changes in this indication were not notable.**

- **Muscle Relaxant**: Previously ranked 60th, currently ranked 14th by Plan Cost Net.
    - Plan Cost Net ↑ $222k (4,520.7%) to current $227k.
    - Plan Cost Net PMPM ↑ $4.18 (5,289.9%) to current $4.26.
    - Patient Count ↓ 8 to current count of 470.
    - Adjusted Rxs ↓ 4 to current count of 1,865.

- **Notable Drug Changes within Indication:**
    - **Skyclarys:**
        - New, Currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $223k.
        - Plan Cost Net PMPM: New, current $4.18.
        - Patient Count: New, current count of 1.
        - Adjusted Rxs: New, current count of 7.
    - **Other drug changes in this indication were not notable.**

- **Endocrine Disorders**: Previously ranked 13th, currently ranked 23rd by Plan Cost Net.
    - Plan Cost Net ↓ $119k (-48.5%) to current $126k.
    - Plan Cost Net PMPM ↓ $1.57 (-39.9%) to current $2.37.
    - Patient Count ↓ 7 to current count of 27.
    - Adjusted Rxs ↓ 46 to current count of 185.

- **Notable Drug Changes within Indication:**
    - **Korlym:**
        - No Longer utilized, previously ranked 2nd by Plan Cost Net.
        - Plan Cost Net: Previously $81k.
        - Plan Cost Net PMPM: Previously $1.29
        - 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 $0.78.
        - Patient Count: Previous count of 1.
        - Adjusted Rxs: Previous count of 12.
    - **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 lower trend.
- Peer experienced Plan Cost Net PMPM of $173.48 compared to PEBP EPO of $214.63

- Peer experienced Trend of 19.7%, compared to PEBP EPO of 17.8%

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$134.73**	
Utilization	$6.19	5.8%
Unit Cost	$15.43	14.4%
Member Share	$6.16	5.8%
Total Change in Plan Cost Net PMPM	**$27.79**	**26.0%**
Previous Period - Plan Cost Net PMPM	**$106.94**	

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 ↑ $2.5M (57.6%) to current $6.8M.
  - Plan Cost Net PMPM ↑ $6.72 (43.8%) to current $22.07.
  - Patient Count ↑ 80 to current count of 443.
  - Adjusted Rxs ↑ 686 to current count of 3,950.

- **Notable Drug Changes within Indication:**
  - **Rinvoq:**
    - Previously ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $301k (52.0%) to current $880k.
    - Plan Cost Net PMPM ↑ $0.80 (38.7%) to current $2.86.
    - Patient Count ↑ 6 to current count of 27.
    - Adjusted Rxs ↑ 58 to current count of 232.
  - **Bimzelx Autoinjector:**
    - Previously ranked 17th, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net ↑ $293k (455.0%) to current $358k.
    - Plan Cost Net PMPM ↑ $0.93 (406.4%) to current $1.16.
    - Patient Count ↑ 7 to current count of 9.
    - Adjusted Rxs ↑ 35 to current count of 58.
  - **Adalimumab-ADBM(CF) Pen (Humira Biosimilar):**
    - Previously ranked 50th, currently ranked 6th by Plan Cost Net.
    - Plan Cost Net ↑ $281k (9,809.8%) to current $284k.
    - Plan Cost Net PMPM ↑ $0.91 (8,942.1%) to current $0.92.
    - Patient Count ↑ 37 to current count of 40.
    - Adjusted Rxs ↑ 258 to current count of 261.
  - **Stelara:**
    - Previously ranked 3rd, currently ranked 10th by Plan Cost Net.
    - Plan Cost Net ↓ $239k (-51.5%) to current $225k.
    - Plan Cost Net PMPM ↓ $0.92 (-55.8%) to current $0.73.
    - Patient Count ↓ 1 to current count of 13.
    - Adjusted Rxs ↓ 38 to current count of 107.

- **Enzyme Deficiencies**: Previously ranked 5th, currently ranked 5th by Plan Cost Net.
  - Plan Cost Net ↑ $1.1M (75.6%) to current $2.6M.
  - Plan Cost Net PMPM ↑ $3.20 (60.2%) to current $8.52.
  - Patient Count ↓ 1 to current count of 11.
  - Adjusted Rxs ↑ 54 to current count of 112.

- **Notable Drug Changes within Indication:**
  - **Yorvipath:**
    - Previously ranked 2nd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $1.1M (555.6%) to current $1.3M.
    - Plan Cost Net PMPM ↑ $3.54 (498.2%) to current $4.25.
    - Patient Count ↑ 4 to current count of 6.
    - Adjusted Rxs ↑ 55 to current count of 64.
  - **Imcivree:**
    - Previously ranked 7th, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↑ $311k (293.9%) to current $416k.
    - Plan Cost Net PMPM ↑ $0.98 (259.4%) to current $1.35.
    - Patient Count ↑ 1 to current count of 2.
    - Adjusted Rxs ↑ 11 to current count of 15.

- **Diabetes**: Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $1.2M (30.8%) to current $5.2M.
  - Plan Cost Net PMPM ↑ $2.71 (19.3%) to current $16.72.
  - Patient Count ↑ 188 to current count of 2,235.
  - Adjusted Rxs ↑ 2,350 to current count of 33,383.

- **Notable Drug Changes within Indication:**

  - **Mounjaro:**
    - Previously ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $1.0M (72.3%) to current $2.4M.
    - Plan Cost Net PMPM ↑ $2.85 (57.2%) to current $7.82.
    - Patient Count ↑ 229 to current count of 693.
    - Adjusted Rxs ↑ 2,259 to current count of 6,352.

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

- **Atopic Dermatitis**: Previously ranked 6th, currently ranked 6th by Plan Cost Net.
  - Plan Cost Net ↑ $837k (62.5%) to current $2.2M.
  - Plan Cost Net PMPM ↑ $2.30 (48.3%) to current $7.06.
  - Patient Count ↑ 186 to current count of 2,060.
  - Adjusted Rxs ↑ 594 to current count of 4,328.

- **Notable Drug Changes within Indication:**

- **Dupixent Pen:**
  - Previously ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $506k (55.3%) to current $1.4M.
  - Plan Cost Net PMPM ↑ $1.36 (41.7%) to current $4.61.
  - Patient Count ↑ 11 to current count of 74.
  - Adjusted Rxs ↑ 133 to current count of 631.

- **Dupixent Syringe:**
  - Previously ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $124k (65.5%) to current $314k.
  - Plan Cost Net PMPM ↑ $0.34 (51.1%) to current $1.02.
  - Patient Count ↑ 4 to current count of 21.
  - Adjusted Rxs ↑ 30 to current count of 128.

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 $134.73 compared to peer of $173.48.
- Peer experienced Trend of 19.7%, compared to PEBP PPO of 26.0%.

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$127.01**	
Utilization	$3.14	3.0%
Unit Cost	$14.03	13.6%
Member Share	$6.53	6.3%
Total Change in Plan Cost Net PMPM	**$23.70**	**22.9%**
Previous Period - Plan Cost Net PMPM	**$103.32**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 19.6% in Specialty patients. This resulted in a 21.1% increase in Specialty Days of Therapy, the majority of which are single source brands.

Trend was mitigated by increased rebates of 4.8%. Which reduced combine Unit Cost Trend to 13.6%.

Member Cost contributed to Trend on both Specialty and Non-Specialty drugs. This is due to increased Utilization on Specialty drugs and the utilization of more expensive Non-Specialty brand drugs (exchanging utilization of a brand drug for a more expensive brand drug) which drives Drug Mix and reduces member contributions as a percent of overall costs.

Key Statistics:

Nevada PEBP Total			
Description	Q4 FY26	Q4 FY25	Change
Average Members per Month	52,462	51,616	1.6%
Number of Unique patients	40,267	39,485	2.0%
Members Utilizing the Benefit	76.8%	76.5%	0.3
Gross Cost/Adjusted Rx	$165.77	$150.88	9.9%
Plan Spend	$119,875,724	$102,090,425	17.4%
Rebates (estimated)	$39,914,437	$38,095,754	4.8%
Plan Cost Net	$79,961,287	$63,994,671	24.9%
Plan Cost Net PMPM	$127.01	$103.32	22.9%
Non-Specialty Plan Cost Net PMPM	$85.79	$80.73	6.3%
Specialty Plan Cost Net PMPM	$104.63	$84.09	24.4%
Generic Fill Rate	87.3%	87.1%	0.1
90 Day Utilization	59.6%	59.9%	-0.3
Retail - Maintenance 90 Utilization	32.2%	29.5%	2.7
Home Delivery Utilization	25.8%	29.2%	-3.4
Member Cost Net %	14.8%	17.1%	-2.3

END OF REPORT

14.7

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - 14.6 Q4 Express Scripts – Summary Report
    - **14.7 Q4 CDHP Performance Report**



Quarterly Plan Performance Review

HDHP Plan • 2026-4Q

UMR
A UnitedHealthcare Company

RPG 5.10 • Run Date: 7/29/2026

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Report Criteria & Contents

Experience Periods*

- **2026 Plan Year (Current)**
  - 2026-4Q.1st four Quarters: Claims Paid 7/1/2025 - 6/30/2026
- **2025 Plan Year**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
  - 2025 Full Year: Claims paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

Group Data

- Data reported is for the HDHP Plan only:
- Contract = 7670-06-414946 or 7670-10-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,369 groups with approximately 8.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 6/30/2026

* 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: +15.9%
- High-Cost Claimants Paid PMPM trend: +38.9%; Non HCCs trend: +6.3%
- Top Paid Diagnostic Chapters: Health Status & Services (+16.3% Paid PMPM), Neoplasms (Cancer) (+32.0%), Musculoskeletal (+16.0%)

Membership & Demographics

- Total membership is 3.0% lower than prior period
- Employees decreased 3.1%, while Dependents were down 2.9%
- 82.4% of members had < $2,500 medical paid, with 21.1% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $27,949, which is 4.3% higher than 2025-4Q
- Paid per ER Visit was $2,562, which is 3.1% higher than 2025-4Q

Network Utilization & Savings

- 97.8% of all Medical spend dollars were to In Network providers
- The average In Network discount was 70.3%, which is 0.9 pts above the 2025 average discount of 69.4%

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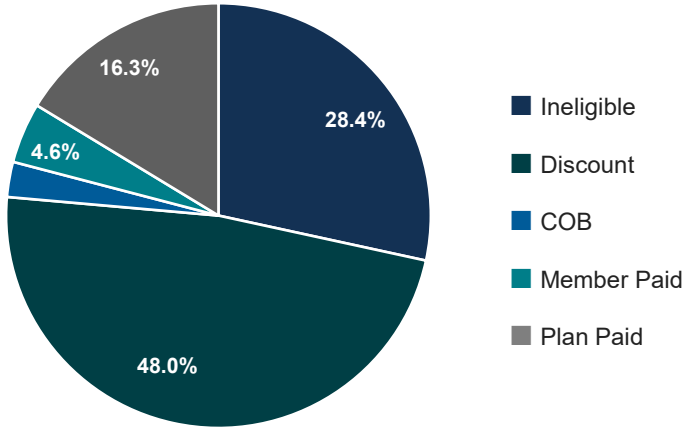
Medical Total Savings Summary

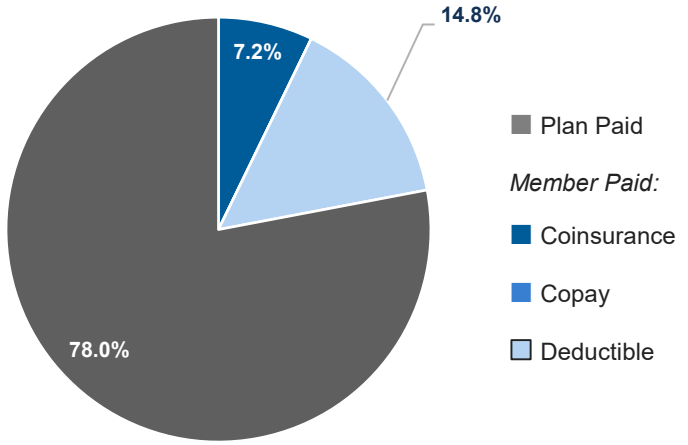
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2026-4Q Total Dollars	2026-4Q PMPM*	2025 PMPM*	*Trend*
Medical Billed	**$611,083,637**	**$2,272**	$1,981	***14.7%***
(-) Ineligible	**$173,370,138**	**$644**	$588	***9.6%***
Medical Covered	**$437,713,499**	**$1,627**	$1,393	***16.8%***
(-) Discount	**$293,006,234**	**$1,089**	$902	***20.7%***
Medical Allowed	**$144,707,265**	**$538**	$490	***9.7%***
(-) COB	**$16,322,197**	**$61**	$70	***-13.8%***
(-) Coinsurance	**$9,201,176**	**$34**	$33	***3.2%***
(-) Copay	**$220**	**$0**	$0	***-88.5%***
(-) Deductible	**$18,917,317**	**$70**	$66	***6.9%***
Total Member Paid	**$28,118,713**	**$105**	$99	***5.6%***
Total Plan Paid	**$99,608,468**	**$370**	$320	***15.9%***

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.

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Medical & Rx Paid Claims by Age Range

Age	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)						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	$2,647,119	$1,926	$9,137	$7	**$2,656,255**	**$1,933**	$2,990,456	$2,323	$1,414	$1	$2,991,870	**$2,324**	*12.6%*	*20.3%*
1	$208,040	$164	$754	$1	**$208,794**	**$165**	$211,493	$145	$4,960	$3	$216,452	**$149**	*3.7%*	*-10.0%*
2 - 4	$1,139,754	$202	$54,939	$10	**$1,194,692**	**$212**	$1,119,832	$219	$88,813	$17	$1,208,645	**$236**	*1.2%*	*11.3%*
5 - 9	$1,646,759	$132	$467,963	$38	**$2,114,722**	**$170**	$1,498,352	$124	$431,990	$36	$1,930,342	**$160**	*-8.7%*	*-6.1%*
10 - 14	$1,469,092	$92	$281,370	$18	**$1,750,462**	**$110**	$2,197,401	$140	$586,058	$37	$2,783,459	**$178**	*59.0%*	*61.9%*
15 - 19	$3,168,759	$172	$574,140	$31	**$3,742,900**	**$203**	$3,520,541	$197	$860,535	$48	$4,381,076	**$245**	*17.1%*	*20.6%*
20 - 24	$3,052,089	$132	$1,494,714	$65	**$4,546,802**	**$197**	$3,053,103	$136	$1,014,785	$45	$4,067,888	**$181**	*-10.5%*	*-8.0%*
25 - 29	$2,468,272	$153	$831,846	$52	**$3,300,118**	**$205**	$2,747,359	$166	$858,200	$52	$3,605,560	**$218**	*9.3%*	*6.6%*
30 - 34	$5,031,738	$270	$1,128,744	$60	**$6,160,483**	**$330**	$6,216,034	$350	$1,142,824	$64	$7,358,858	**$414**	*19.5%*	*25.5%*
35 - 39	$5,465,875	$270	$1,722,481	$85	**$7,188,356**	**$355**	$5,110,948	$250	$2,621,406	$128	$7,732,354	**$379**	*7.6%*	*6.8%*
40 - 44	$4,647,232	$205	$1,971,375	$87	**$6,618,607**	**$292**	$5,748,522	$256	$2,614,794	$116	$8,363,316	**$372**	*26.4%*	*27.3%*
45 - 49	$6,146,027	$296	$3,634,415	$175	**$9,780,442**	**$472**	$8,350,176	$397	$3,872,125	$184	$12,222,301	**$582**	*25.0%*	*23.4%*
50 - 54	$7,997,810	$343	$4,479,922	$192	**$12,477,732**	**$535**	$11,003,981	$511	$4,259,271	$198	$15,263,252	**$709**	*22.3%*	*32.5%*
55 - 59	$12,104,456	$480	$5,146,330	$204	**$17,250,786**	**$684**	$12,493,543	$512	$6,031,749	$247	$18,525,292	**$759**	*7.4%*	*11.0%*
60 - 64	$18,503,663	$620	$7,280,599	$244	**$25,784,262**	**$864**	$18,534,264	$675	$8,721,346	$318	$27,255,611	**$993**	*5.7%*	*14.9%*
65+	$12,927,486	$577	$7,103,137	$317	**$20,030,623**	**$895**	$14,812,463	$688	$7,606,347	$353	$22,418,809	**$1,042**	*11.9%*	*16.4%*
Total	**$88,624,170**	**$320**	**$36,181,865**	**$130**	**$124,806,035**	**$450**	**$99,608,468**	**$370**	**$40,716,618**	**$151**	**$140,325,086**	**$522**	***12.4%***	***15.9%***

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Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	6,154	*132.5%*	14,311	*-3.1%*	13,872		
Spouses	1,134	*124.8%*	2,550	*-3.6%*	2,458		
Children	2,754	*127.0%*	6,251	*-2.6%*	6,088		
Tot. Members	**10,043**	***130.1%***	**23,112**	***-3.0%***	**22,418**		
Avg. Family Size	1.6	*-1.0%*	1.6	*0.1%*	1.6	1.9	*-15.7%*
Financial Summary							
Allowed	$60,697,394	*124.1%*	$135,998,902	*6.4%*	$144,707,265		
Plan Paid	$45,860,278	*93.2%*	$88,624,170	*12.4%*	$99,608,468		
Member Paid (OOP)	$9,104,174	*201.4%*	$27,441,813	*2.5%*	$28,118,713		
Paid PEPY	$7,452	*-16.9%*	$6,193	*15.9%*	$7,180	$10,635	*-32.5%*
Paid PMPY	$4,567	*-16.0%*	$3,835	*15.9%*	$4,443	$5,546	*-19.9%*
Paid PEPM	$621	*-16.9%*	$516	*15.9%*	$598	$886	*-32.5%*
Paid PMPM	$381	*-16.0%*	$320	*15.9%*	$370	$462	*-19.9%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	148	*-13.5%*	128	*17.2%*	150		
HCCs per 1000	14.7	*-62.4%*	5.5	*20.8%*	6.7	7.3	*-8.8%*
Paid per HCC	$230,303	*-11.6%*	$203,621	*15.0%*	$234,114	$229,219	*2.1%*
HCC Paid % of Tot	74.3%	*-44.9 pts*	29.4%	*5.8 pts*	35.3%	31.4%	*3.8 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$1,574	*-39.5%*	$953	*28.5%*	$1,225	$1,333	*-8.1%*
Outpatient	$1,291	*1.1%*	$1,306	*10.8%*	$1,447	$1,604	*-9.8%*
Physician	$1,648	*-8.2%*	$1,512	*13.5%*	$1,717	$2,506	*-31.5%*
Ancillary	$53	*20.4%*	$64	*-14.1%*	$55	$102	*-46.1%*

- *With $72.8M paid, the State Active population is 73.1% of total 2026-4Q med spend*
- *On a Paid PMPM basis, State Actives are up 12.1% compared to prior year*
- *Total HDHP Plan Paid PMPM trend is +15.9%*

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.

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Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Average Enrollment										
Employees	5,026	*134.9%*	11,806	*-1.7%*	11,602	2	*244.4%*	5	*15.9%*	6
Spouses	868	*125.9%*	1,960	*-2.2%*	1,917	0	-	1	*43.9%*	1
Children	2,525	*128.1%*	5,759	*-2.0%*	5,646	0	*120.0%*	1	*-18.2%*	1
Tot. Members	**8,419**	***131.9%***	**19,526**	***-1.8%***	**19,165**	**2**	***265.2%***	**7**	***15.1%***	**8**
Avg. Family Size	1.7	*-1.3%*	1.7	*-0.1%*	1.7	1.3	*6.0%*	1.4	*-0.7%*	1.3
Financial Summary										
Allowed	$44,081,811	*107.6%*	$91,514,620	*9.6%*	$100,278,001	$41,233	*-18.8%*	$33,497	*210.2%*	$103,908
Plan Paid	$35,827,724	*84.6%*	$66,141,692	*10.1%*	$72,796,488	$38,750	*-38.9%*	$23,665	*217.9%*	$75,235
Member Paid (OOP)	$7,127,849	*197.7%*	$21,217,588	*4.6%*	$22,194,390	$2,483	*296.0%*	$9,832	*70.0%*	$16,715
Paid PEPY	$7,128	*-21.4%*	$5,602	*12.0%*	$6,275	$25,833	*-82.3%*	$4,580	*174.4%*	$12,568
Paid PMPY	$4,256	*-20.4%*	$3,387	*12.1%*	$3,798	$20,217	*-83.3%*	$3,381	*176.3%*	$9,340
Paid PEPM	$594	*-21.4%*	$467	*12.0%*	$523	$2,153	*-82.3%*	$382	*174.4%*	$1,047
Paid PMPM	$355	*-20.4%*	$282	*12.1%*	$317	$1,685	*-83.3%*	$282	*176.3%*	$778
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	110	*-20.9%*	87	*14.9%*	100	0	-	0	-	0
HCCs per 1000	13.1	*-65.9%*	4.5	*17.1%*	5.2	0.0	-	0.0	-	0.0
Paid per HCC	$245,319	*-14.3%*	$210,234	*4.6%*	$219,907	$0	-	$0	-	$0
HCC Paid % of Tot	75.3%	*-47.7 pts*	27.7%	*2.6 pts*	30.2%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,505	*-42.3%*	$868	*13.9%*	$989	$0	-	$0	-	$5,278
Outpatient	$1,180	*-3.2%*	$1,142	*12.6%*	$1,285	$10,804	*-77.3%*	$2,456	*-17.1%*	$2,037
Physician	$1,526	*-12.4%*	$1,336	*10.3%*	$1,473	$9,404	*-90.3%*	$916	*29.0%*	$1,182
Ancillary	$45	*-8.9%*	$41	*22.7%*	$51	$10	*-13.4%*	$9	*9733.3%*	$843

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Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Average Enrollment										
Employees	999	*121.4%*	2,213	*-9.5%*	2,002	127	*125.3%*	287	*-8.3%*	263
Spouses	253	*121.3%*	560	*-7.5%*	518	14	*109.7%*	29	*-25.4%*	22
Children	223	*114.9%*	479	*-10.0%*	432	5	*118.5%*	12	*-20.4%*	9
Tot. Members	**1,475**	***120.4%***	**3,252**	***-9.2%***	**2,951**	**146**	***123.6%***	**327**	***-10.2%***	**294**
Avg. Family Size	1.5	*-0.5%*	1.5	*0.3%*	1.5	1.2	*-0.8%*	1.1	*-2.1%*	1.1
Financial Summary										
Allowed	$13,965,467	*164.1%*	$36,877,665	*2.3%*	$37,737,402	$2,608,884	*190.3%*	$7,573,121	*-13.0%*	$6,587,954
Plan Paid	$9,350,764	*116.9%*	$20,280,083	*20.0%*	$24,345,860	$643,040	*238.8%*	$2,178,730	*9.7%*	$2,390,885
Member Paid (OOP)	$1,715,762	*216.4%*	$5,428,023	*-5.2%*	$5,144,424	$258,079	*204.7%*	$786,370	*-2.9%*	$763,184
Paid PEPY	$9,356	*-2.0%*	$9,166	*32.7%*	$12,162	$5,053	*50.4%*	$7,600	*19.7%*	$9,094
Paid PMPY	$6,337	*-1.6%*	$6,237	*32.3%*	$8,250	$4,392	*51.6%*	$6,656	*22.2%*	$8,137
Paid PEPM	$780	*-2.0%*	$764	*32.7%*	$1,014	$421	*50.4%*	$633	*19.7%*	$758
Paid PMPM	$528	*-1.6%*	$520	*32.3%*	$687	$366	*51.6%*	$555	*22.2%*	$678
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	37	*-5.4%*	35	*34.3%*	47	3	*100.0%*	6	*-33.3%*	4
HCCs per 1000	25.1	*-57.1%*	10.8	*48.0%*	15.9	20.5	*-10.5%*	18.3	*-25.7%*	13.6
Paid per HCC	$175,418	*14.4%*	$200,660	*31.1%*	$263,087	$175,672	*-28.8%*	$125,018	*31.7%*	$164,709
HCC Paid % of Tot	*69.4%*	*-34.8 pts*	*34.6%*	*16.2 pts*	*50.8%*	*82.0%*	*-47.5 pts*	*34.4%*	*-6.9 pts*	*27.6%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,945	*-37.2%*	$1,222	*100.1%*	$2,445	$1,849	*82.5%*	$3,374	*25.1%*	$4,220
Outpatient	$1,973	*15.3%*	$2,274	*6.0%*	$2,411	$726	*93.8%*	$1,407	*62.5%*	$2,287
Physician	$2,331	*9.0%*	$2,540	*30.7%*	$3,318	$1,671	*8.6%*	$1,816	*-16.1%*	$1,524
Ancillary	$88	*127.1%*	$200	*-62.4%*	$75	$145	*-59.6%*	$59	*80.6%*	$106

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Financial Summary – Full Year Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024	⇨	2025	⇨	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	6,154	*132.5%*	14,311	*-3.1%*	13,872		
Spouses	1,134	*124.8%*	2,550	*-3.6%*	2,458		
Children	2,754	*127.0%*	6,251	*-2.6%*	6,088		
Tot. Members	**10,043**	***130.1%***	**23,112**	***-3.0%***	**22,418**		
Avg. Family Size	1.6	*-1.0%*	1.6	*0.1%*	1.6	1.9	*-15.7%*
Financial Summary							
Allowed	$60,697,394	*124.1%*	$135,998,902	*6.4%*	$144,707,265		
Plan Paid	$45,860,278	*93.2%*	$88,624,170	*12.4%*	$99,608,468		
Member Paid (OOP)	$9,104,174	*201.4%*	$27,441,813	*2.5%*	$28,118,713		
Paid PEPY	$7,452	*-16.9%*	$6,193	*15.9%*	$7,180	$10,635	*-32.5%*
Paid PMPY	$4,567	*-16.0%*	$3,835	*15.9%*	$4,443	$5,546	*-19.9%*
Paid PEPM	$621	*-16.9%*	$516	*15.9%*	$598	$886	*-32.5%*
Paid PMPM	$381	*-16.0%*	$320	*15.9%*	$370	$462	*-19.9%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	148	*-13.5%*	128	*17.2%*	150		
HCCs per 1000	14.7	*-62.4%*	5.5	*20.8%*	6.7	7.3	*-8.8%*
Paid per HCC	$230,303	*-11.6%*	$203,621	*15.0%*	$234,114	$229,219	*2.1%*
HCC Paid % of Tot	74.3%	*-44.9 pts*	29.4%	*5.8 pts*	35.3%	31.4%	*3.8 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$1,574	*-39.5%*	$953	*28.5%*	$1,225	$1,333	*-8.1%*
Outpatient	$1,291	*1.1%*	$1,306	*10.8%*	$1,447	$1,604	*-9.8%*
Physician	$1,648	*-8.2%*	$1,512	*13.5%*	$1,717	$2,506	*-31.5%*
Ancillary	$53	*20.4%*	$64	*-14.1%*	$55	$102	*-46.1%*

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 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.

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Financial Summary – Full Year Trend

Active Members

Measure	State Active					Non-State Active				
	2024	⇨	2025	⇨	2026-4Q	2024	⇨	2025	⇨	2026-4Q
Average Enrollment										
Employees	5,026	*134.9%*	11,806	*-1.7%*	11,602	2	*244.4%*	5	*15.9%*	6
Spouses	868	*125.9%*	1,960	*-2.2%*	1,917	0	-	1	*43.9%*	1
Children	2,525	*128.1%*	5,759	*-2.0%*	5,646	0	*120.0%*	1	*-18.2%*	1
Tot. Members	**8,419**	***131.9%***	**19,526**	***-1.8%***	**19,165**	**2**	***265.2%***	**7**	***15.1%***	**8**
Avg. Family Size	1.7	*-1.3%*	1.7	*-0.1%*	1.7	1.3	*6.0%*	1.4	*-0.7%*	1.3
Financial Summary										
Allowed	$44,081,811	*107.6%*	$91,514,620	*9.6%*	$100,278,001	$41,233	*-18.8%*	$33,497	*210.2%*	$103,908
Plan Paid	$35,827,724	*84.6%*	$66,141,692	*10.1%*	$72,796,488	$38,750	*-38.9%*	$23,665	*217.9%*	$75,235
Member Paid (OOP)	$7,127,849	*197.7%*	$21,217,588	*4.6%*	$22,194,390	$2,483	*296.0%*	$9,832	*70.0%*	$16,715
Paid PEPY	$7,128	*-21.4%*	$5,602	*12.0%*	$6,275	$25,833	*-82.3%*	$4,580	*174.4%*	$12,568
Paid PMPY	$4,256	*-20.4%*	$3,387	*12.1%*	$3,798	$20,217	*-83.3%*	$3,381	*176.3%*	$9,340
Paid PEPM	$594	*-21.4%*	$467	*12.0%*	$523	$2,153	*-82.3%*	$382	*174.4%*	$1,047
Paid PMPM	$355	*-20.4%*	$282	*12.1%*	$317	$1,685	*-83.3%*	$282	*176.3%*	$778
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	110	*-20.9%*	87	*14.9%*	100	0	-	0	-	0
HCCs per 1000	13.1	*-65.9%*	4.5	*17.1%*	5.2	0.0	-	0.0	-	0.0
Paid per HCC	$245,319	*-14.3%*	$210,234	*4.6%*	$219,907	$0	-	$0	-	$0
HCC Paid % of Tot	75.3%	*-47.7 pts*	27.7%	*2.6 pts*	30.2%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,505	*-42.3%*	$868	*13.9%*	$989	$0	-	$0	-	$5,278
Outpatient	$1,180	*-3.2%*	$1,142	*12.6%*	$1,285	$10,804	*-77.3%*	$2,456	*-17.1%*	$2,037
Physician	$1,526	*-12.4%*	$1,336	*10.3%*	$1,473	$9,404	*-90.3%*	$916	*29.0%*	$1,182
Ancillary	$45	*-8.9%*	$41	*22.7%*	$51	$10	*-13.4%*	$9	*9733.3%*	$843

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Financial Summary – Full Year Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024	⇨	2025	⇨	2026-4Q	2024	⇨	2025	⇨	2026-4Q
Average Enrollment										
Employees	999	*121.4%*	2,213	*-9.5%*	2,002	127	*125.3%*	287	*-8.3%*	263
Spouses	253	*121.3%*	560	*-7.5%*	518	14	*109.7%*	29	*-25.4%*	22
Children	223	*114.9%*	479	*-10.0%*	432	5	*118.5%*	12	*-20.4%*	9
Tot. Members	**1,475**	***120.4%***	**3,252**	***-9.2%***	**2,951**	**146**	***123.6%***	**327**	***-10.2%***	**294**
Avg. Family Size	1.5	*-0.5%*	1.5	*0.3%*	1.5	1.2	*-0.8%*	1.1	*-2.1%*	1.1
Financial Summary										
Allowed	$13,965,467	*164.1%*	$36,877,665	*2.3%*	$37,737,402	$2,608,884	*190.3%*	$7,573,121	*-13.0%*	$6,587,954
Plan Paid	$9,350,764	*116.9%*	$20,280,083	*20.0%*	$24,345,860	$643,040	*238.8%*	$2,178,730	*9.7%*	$2,390,885
Member Paid (OOP)	$1,715,762	*216.4%*	$5,428,023	*-5.2%*	$5,144,424	$258,079	*204.7%*	$786,370	*-2.9%*	$763,184
Paid PEPY	$9,356	*-2.0%*	$9,166	*32.7%*	$12,162	$5,053	*50.4%*	$7,600	*19.7%*	$9,094
Paid PMPY	$6,337	*-1.6%*	$6,237	*32.3%*	$8,250	$4,392	*51.6%*	$6,656	*22.2%*	$8,137
Paid PEPM	$780	*-2.0%*	$764	*32.7%*	$1,014	$421	*50.4%*	$633	*19.7%*	$758
Paid PMPM	$528	*-1.6%*	$520	*32.3%*	$687	$366	*51.6%*	$555	*22.2%*	$678
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	37	*-5.4%*	35	*34.3%*	47	3	*100.0%*	6	*-33.3%*	4
HCCs per 1000	25.1	*-57.1%*	10.8	*48.0%*	15.9	20.5	*-10.5%*	18.3	*-25.7%*	13.6
Paid per HCC	$175,418	*14.4%*	$200,660	*31.1%*	$263,087	$175,672	*-28.8%*	$125,018	*31.7%*	$164,709
HCC Paid % of Tot	69.4%	*-34.8 pts*	34.6%	*16.2 pts*	50.8%	82.0%	*-47.5 pts*	34.4%	*-6.9 pts*	27.6%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,945	*-37.2%*	$1,222	*100.1%*	$2,445	$1,849	*82.5%*	$3,374	*25.1%*	$4,220
Outpatient	$1,973	*15.3%*	$2,274	*6.0%*	$2,411	$726	*93.8%*	$1,407	*62.5%*	$2,287
Physician	$2,331	*9.0%*	$2,540	*30.7%*	$3,318	$1,671	*8.6%*	$1,816	*-16.1%*	$1,524
Ancillary	$88	*127.1%*	$200	*-62.4%*	$75	$145	*-59.6%*	$59	*80.6%*	$106

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Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2026-4Q (7/1/2025 - 6/30/2026) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Inpatient	$16,949,955	$2,760,117	$1,214,245	**$20,924,317**	$18,956,283	$4,704,080	$2,512,950	**$26,173,314**	*25.1%*
Outpatient	$22,300,779	$6,237,552	$1,158,319	**$29,696,649**	$24,636,715	$6,135,641	$978,442	**$31,750,798**	*6.9%*
Physician	$26,084,970	$6,759,720	$1,498,171	**$34,342,861**	$28,233,194	$8,422,660	$1,369,693	**$38,025,546**	*10.7%*
Ancillary	$805,989	$144,304	$507,655	**$1,457,948**	$970,296	$168,115	$54,279	**$1,192,689**	*-18.2%*
Total	**$66,141,692**	**$15,901,692**	**$4,378,391**	$86,421,776	**$72,796,488**	**$19,430,496**	**$4,915,364**	$97,142,348	***12.4%***
PMPM	**$282.29**	**$551.25**	**$430.37**	$316.18	**$316.53**	**$755.12**	**$507.65**	$366.03	***15.8%***
Non-State Members									
Inpatient	$0	$141,870	$962,696	**$1,104,566**	$42,520	$21,835	$1,218,139	**$1,282,494**	*16.1%*
Outpatient	$17,192	$210,358	$250,235	**$477,784**	$16,406	$200,516	$471,457	**$688,378**	*44.1%*
Physician	$6,413	$185,247	$409,109	**$600,768**	$9,520	$122,604	$325,178	**$457,302**	*-23.9%*
Ancillary	$60	$13,014	$6,203	**$19,276**	$6,790	$7,187	$23,970	**$37,946**	*96.9%*
Total	**$23,665**	**$550,488**	**$1,628,241**	$2,202,395	**$75,235**	**$352,141**	**$2,038,744**	$2,466,120	***12.0%***
PMPM	**$281.73**	**$717.30**	**$515.18**	$548.95	**$778.30**	**$671.66**	**$679.19**	$680.75	***24.0%***
All Members									
Inpatient	$16,949,955	$2,901,987	$2,176,941	**$22,028,882**	$18,998,803	$4,725,915	$3,731,090	**$27,455,808**	*24.6%*
Outpatient	$22,317,971	$6,447,909	$1,408,553	**$30,174,434**	$24,653,121	$6,336,156	$1,449,899	**$32,439,176**	*7.5%*
Physician	$26,091,382	$6,944,967	$1,907,280	**$34,943,630**	$28,242,713	$8,545,263	$1,694,871	**$38,482,848**	*10.1%*
Ancillary	$806,049	$157,317	$513,858	**$1,477,225**	$977,086	$175,302	$78,248	**$1,230,636**	*-16.7%*
Total	**$66,165,358**	**$16,452,180**	**$6,006,632**	$88,624,170	**$72,871,723**	**$19,782,637**	**$6,954,108**	$99,608,468	***12.4%***
PMPM	**$282.29**	**$555.56**	**$450.47**	$319.55	**$316.73**	**$753.45**	**$548.24**	$370.27	***15.9%***

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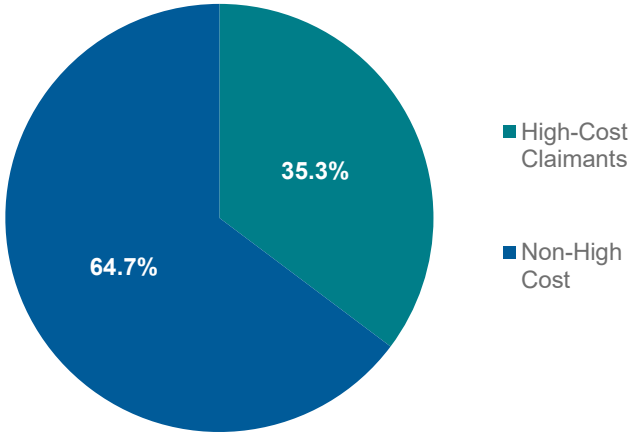
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)					
	*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	6,081	21.8%	$0	0.0%	$0	0.0%	5,665	21.1%	$0	0.0%	$0	0.0%
< $0 - $0	5,019	18.0%	-$604,577	-0.7%	$1,878,470	6.8%	4,864	18.1%	-$686,428	-0.7%	$1,946,220	6.9%
> $0 - $2,500	12,284	44.1%	$7,524,346	8.5%	$10,183,879	37.1%	11,589	43.2%	$7,133,706	7.2%	$9,964,915	35.4%
> $2,500 - $5,000	1,610	5.8%	$5,739,774	6.5%	$3,737,028	13.6%	1,691	6.3%	$6,060,159	6.1%	$3,891,383	13.8%
> $5,000 - $10,000	1,212	4.4%	$8,516,610	9.6%	$3,835,716	14.0%	1,297	4.8%	$9,080,403	9.1%	$4,159,860	14.8%
> $10,000 - $25,000	954	3.4%	$14,797,381	16.7%	$4,343,510	15.8%	968	3.6%	$15,095,297	15.2%	$4,193,238	14.9%
> $25,000 - $50,000	350	1.3%	$12,046,598	13.6%	$1,623,468	5.9%	398	1.5%	$13,427,479	13.5%	$1,972,503	7.0%
> $50,000 - $100,000	207	0.7%	$14,540,487	16.4%	$1,132,283	4.1%	208	0.8%	$14,380,744	14.4%	$1,114,858	4.0%
> $100,000	128	0.5%	$26,063,550	29.4%	$707,461	2.6%	150	0.6%	$35,117,109	35.3%	$875,736	3.1%
Total	**27,845**	**100.0%**	**$88,624,170**	**100.0%**	**$27,441,813**	**100.0%**	**26,830**	**100.0%**	**$99,608,468**	**100.0%**	**$28,118,713**	**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	72	$6,451,107	18.4%
2	Health Status & Health Services	141	$6,291,092	17.9%
3	Circulatory System	108	$3,996,217	11.4%
4	Injury, Poisoning & External Causes	83	$2,930,482	8.3%
5	Musculoskeletal System	108	$2,583,551	7.4%
6	Nervous System	91	$2,154,413	6.1%
7	Digestive System	73	$1,858,643	5.3%
8	Respiratory System	86	$1,519,720	4.3%
9	Infectious & Parasitic Diseases	48	$1,395,945	4.0%
10	Perinatal Originating Conditions	9	$1,395,216	4.0%
...	*All Others*		*$4,540,724*	*12.9%*
=	**Total**	**150**	**$35,117,109**	**100.0%**

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Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2026-4Q	*Variance*
Inpatient Admissions							
# of Admits	1,087	*-10.9%*	969	*3.9%*	1,007		
# of Admit Days	7,608	*-33.8%*	5,037	*3.8%*	5,226		
Paid per Admit	$31,595	*-15.2%*	$26,803	*4.3%*	$27,949	$29,627	*-5.7%*
Paid per Admit Day	$4,514	*14.2%*	$5,156	*4.4%*	$5,386	$5,928	*-9.1%*
Admits per 1000	108.2	*-61.3%*	41.9	*7.1%*	44.9	47.3	*-5.1%*
Average LOS	7.0	*-25.7%*	5.2	*-0.2%*	5.2	5.0	*3.8%*
Emergency Room Visits							
# of ER Visits	4,764	*-2.1%*	4,665	*8.5%*	5,063		
~ % resulting in Admit	14.1%	*-1.3 pts*	12.8%	*0.2 pts*	13.0%	10.9%	*2.2 pts*
ER Visits per Patient	1.5	*1.5%*	1.5	*4.8%*	1.6		
ER Visits per 1000	474.4	*-57.5%*	201.8	*11.9%*	225.8	220.9	*2.3%*
Paid per ER Visit	$2,304	*7.9%*	$2,486	*3.1%*	$2,562	$2,466	*3.9%*
Urgent Care Visits							
# of UC Visits	7,700	*-2.6%*	7,501	*-8.5%*	6,862		
UC Visits per Patient	1.6	*0.1%*	1.6	*-1.6%*	1.5		-
UC Visits per 1000	766.7	*-57.7%*	324.6	*-5.7%*	306.1	247.9	*23.5%*
Paid per UC Visit	$49	*12.2%*	$55	*8.5%*	$59	$119	*-50.4%*
Office Visits							
Off Visits per Patient	4.7	*4.2%*	4.9	*4.2%*	5.1		
Paid per Office Visit	$47	*8.9%*	$51	*9.4%*	$56	$98	*-42.9%*
Office Visits Paid PMPY	$415	*-53.5%*	$193	*14.4%*	$221	$386	*-42.8%*
Services							
Radiology Svcs per 1000	8,932.9	*-55.9%*	3,942.5	*13.9%*	4,491.5	3,595.1	*24.9%*
Radiology Paid PMPY	$647	*-52.3%*	$309	*6.3%*	$328		
Lab Services per 1000	22,610.3	*-53.7%*	10,466.2	*8.6%*	11,361.6	9,957.4	*14.1%*
Labs Paid PMPY	$404	*-49.8%*	$203	*9.8%*	$222		

- *Inpatient Admission rate per 1000 increased 7.1%, and amount paid per Admission is 4.3% higher than prior period*
- *ER utilization increased 11.9%, and amount paid per ER visit is 3.1% 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.

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Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Inpatient Admissions										
# of Admits	817	*-11.5%*	723	*4.6%*	756	0	-	0	-	2
# of Admit Days	5,880	*-35.8%*	3,773	*-0.4%*	3,758	0	-	0	-	10
Paid per Admit	$32,933	*-18.0%*	$27,010	*1.6%*	$27,442	$0	-	$0	-	$21,737
Paid per Admit Day	$4,576	*13.1%*	$5,176	*6.7%*	$5,521	$0	-	$0	-	$4,347
Admits per 1000	97.0	*-61.8%*	37.0	*6.5%*	39.4	0.0	-	0.0	-	248.3
Average LOS	7.2	*-27.5%*	5.2	*-4.7%*	5.0	0.0	-	0.0	-	5.0
Emergency Room Visits										
# of ER Visits	3,814	*-0.2%*	3,805	*6.4%*	4,048	5	*-80.0%*	1	*400.0%*	5
~ % resulting in Admit	12.6%	*-1.5 pts*	11.1%	*0.1 pts*	11.3%	0.0%	*0.0 pts*	0.0%	*40.0 pts*	40.0%
ER Visits per Patient	1.4	*1.1%*	1.5	*2.8%*	1.5	1.7	*-40.0%*	1.0	*66.7%*	1.7
ER Visits per 1000	453.0	*-57.0%*	194.9	*8.4%*	211.2	2,608.7	*-94.5%*	142.9	*334.5%*	620.7
Paid per ER Visit	$2,407	*5.4%*	$2,538	*5.8%*	$2,684	$4,375	*317.8%*	$18,276	*-89.4%*	$1,938
Urgent Care Visits										
# of UC Visits	6,708	*-2.0%*	6,576	*-8.1%*	6,046	4	*-25.0%*	3	*0.0%*	3
UC Visits per Patient	1.6	*0.4%*	1.6	*-3.1%*	1.5	2.0	*-50.0%*	1.0	*50.0%*	1.5
UC Visits per 1000	796.8	*-57.7%*	336.8	*-6.3%*	315.5	2,087.0	*-79.5%*	428.6	*-13.1%*	372.4
Paid per UC Visit	$49	*10.1%*	$54	*10.1%*	$59	$134	*-30.4%*	$93	*-19.1%*	$75
Office Visits										
Off Visits per Patient	4.4	*4.4%*	4.5	*4.1%*	4.7	4.0	*-50.0%*	2.0	*50.0%*	3.0
Paid per Office Visit	$48	*7.7%*	$51	*9.9%*	$56	$116	*-59.0%*	$47	*-1.2%*	$47
Office Visits Paid PMPY	$382	*-54.0%*	$176	*15.0%*	$202	$1,209	*-94.4%*	$68	*131.8%*	$157
Services										
Radiology Svcs per 1000	7,768.7	*-56.0%*	3,419.8	*18.3%*	4,045.4	15,130.4	*-91.5%*	1,285.7	*93.1%*	2,482.8
Radiology Paid PMPY	$586	*-57.6%*	$249	*7.2%*	$267	$10,895	*-92.5%*	$822	*3.8%*	$854
Lab Services per 1000	20,966.1	*-53.7%*	9,717.0	*8.2%*	10,517.0	14,608.7	*-89.2%*	1,571.4	*603.1%*	11,048.3
Labs Paid PMPY	$382	*-50.5%*	$189	*9.8%*	$208	$700	*-62.4%*	$263	*259.5%*	$946

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Utilization Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Inpatient Admissions										
# of Admits	219	*-13.7%*	189	*2.1%*	193	51	*11.8%*	57	*-1.8%*	56
# of Admit Days	1,410	*-33.4%*	939	*21.1%*	1,137	318	*2.2%*	325	*-1.2%*	321
Paid per Admit	$27,913	*4.4%*	$29,149	*15.7%*	$33,718	$25,966	*-36.9%*	$16,388	*-7.7%*	$15,131
Paid per Admit Day	$4,335	*35.3%*	$5,867	*-2.4%*	$5,724	$4,164	*-31.0%*	$2,874	*-8.2%*	$2,640
Admits per 1000	148.4	*-60.8%*	58.1	*12.5%*	65.4	348.3	*-50.0%*	174.1	*9.4%*	190.6
Average LOS	6.4	*-22.8%*	5.0	*18.6%*	5.9	6.2	*-8.6%*	5.7	*0.5%*	5.7
Emergency Room Visits										
# of ER Visits	786	*-13.2%*	682	*15.2%*	786	159	*11.3%*	177	*26.6%*	224
~ % resulting in Admit	19.0%	*1.7 pts*	20.7%	*-0.4 pts*	20.2%	27.0%	*-8.4 pts*	18.6%	*0.6 pts*	19.2%
ER Visits per Patient	1.5	*3.7%*	1.5	*9.1%*	1.7	2.1	*1.7%*	2.2	*25.0%*	2.7
ER Visits per 1000	532.7	*-60.6%*	209.7	*27.0%*	266.3	1,085.9	*-50.2%*	540.7	*41.0%*	762.3
Paid per ER Visit	$2,116	*22.8%*	$2,598	*-4.9%*	$2,470	$685	*23.1%*	$843	*-19.0%*	$683
Urgent Care Visits										
# of UC Visits	889	*-6.7%*	829	*-16.9%*	689	99	*-6.1%*	93	*33.3%*	124
UC Visits per Patient	1.5	*-0.7%*	1.5	*2.1%*	1.5	1.7	*-13.5%*	1.5	*78.7%*	2.6
UC Visits per 1000	602.5	*-57.7%*	254.9	*-8.4%*	233.5	676.2	*-58.0%*	284.1	*48.5%*	422.0
Paid per UC Visit	$47	*33.3%*	$62	*-1.2%*	$62	$48	*-21.8%*	$37	*16.5%*	$44
Office Visits										
Off Visits per Patient	5.7	*4.9%*	5.9	*3.9%*	6.2	9.4	*0.6%*	9.5	*15.5%*	11.0
Paid per Office Visit	$49	*11.8%*	$55	*8.3%*	$59	$26	*20.0%*	$31	*6.4%*	$33
Office Visits Paid PMPY	$586	*-50.7%*	$289	*14.7%*	$332	$586	*-51.6%*	$284	*22.0%*	$347
Services										
Radiology Svcs per 1000	13,618.4	*-53.6%*	6,317.1	*4.3%*	6,589.9	28,576.0	*-59.4%*	11,587.6	*8.5%*	12,571.8
Radiology Paid PMPY	$987	*-32.4%*	$667	*9.7%*	$731	$584	*-45.8%*	$316	*-12.5%*	$277
Lab Services per 1000	28,505.6	*-52.7%*	13,491.2	*8.7%*	14,660.2	57,841.8	*-56.3%*	25,298.4	*31.7%*	33,328.4
Labs Paid PMPY	$534	*-47.4%*	$281	*11.5%*	$313	$342	*-32.1%*	$232	*9.1%*	$253

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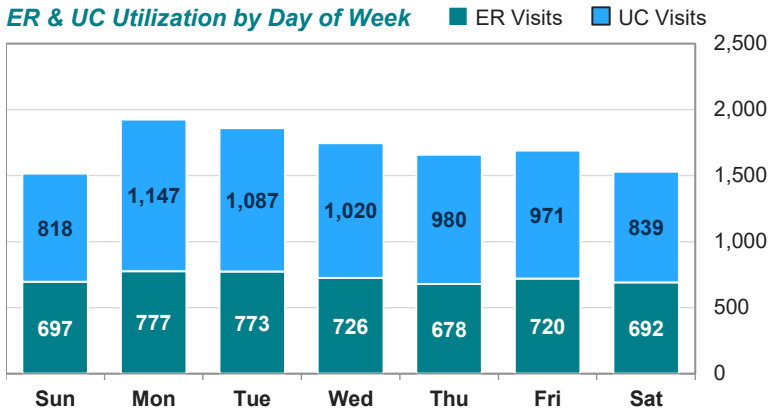
On Demand Care Summary

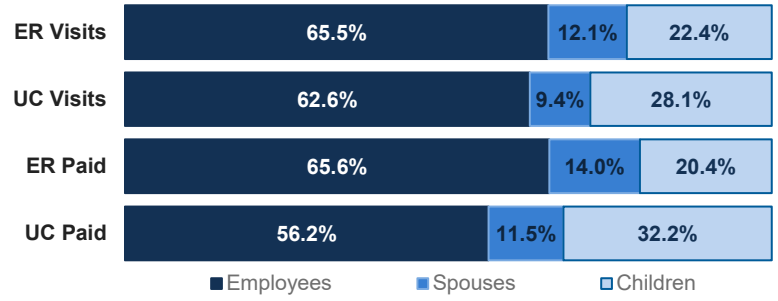
Emergency Room & Urgent Care

Measure	2025-4Q	2026-4Q	Change	UMR Norm	Variance
Emergency Room					
# of Visits	4,665	5,063	*8.5%*		
# of Patients	3,124	3,236	*3.6%*		
Total Plan Paid	$11,596,215	$12,969,498	*11.8%*		
Total Mem Paid	$5,073,309	$5,263,598	*3.8%*		
Visits per 1000	201.8	225.8	*11.9%*	220.9	*2.3%*
Paid per Visit	$2,486	$2,562	*3.1%*	$2,466	*3.9%*
Paid PMPM	$42	$48	*15.3%*	$45	*6.2%*
% ER Patients w/ Office Visit*	90.0%	91.5%	*1.6 pts*		
% Potentially Avoidable**	16.0%	16.3%	*0.2 pts*	82.3%	*-66.0 pts*
Urgent Care					
# of Visits	7,501	6,862	*-8.5%*		
# of Patients	4,805	4,467	*-7.0%*		
Total Plan Paid	$409,264	$406,406	*-0.7%*		
Total Mem Paid	$962,328	$867,907	*-9.8%*		
Visits per 1000	324.6	306.1	*-5.7%*	247.9	*23.5%*
Paid per Visit	$55	$59	*8.5%*	$119	*-50.4%*
Paid PMPM	$1	$2	*2.4%*	$2	*-38.7%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	**Total**	ER	UC	Total
Employee	3,315	4,294	**7,609**	$8,508,852	$228,483	**$8,737,335**
Spouse	612	643	**1,255**	$1,814,303	$46,925	**$1,861,228**
Child	1,136	1,925	**3,061**	$2,646,342	$130,998	**$2,777,341**
Total	**5,063**	**6,862**	**11,925**	**$12,969,498**	**$406,406**	**$13,375,904**

* 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.

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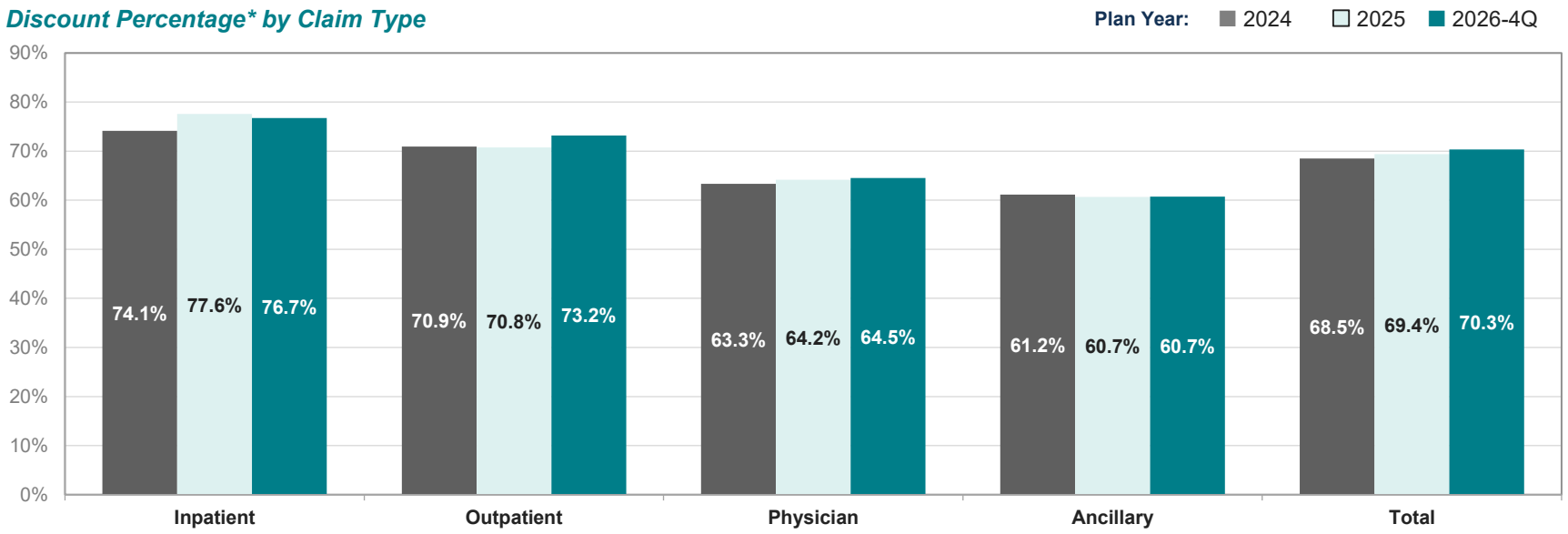
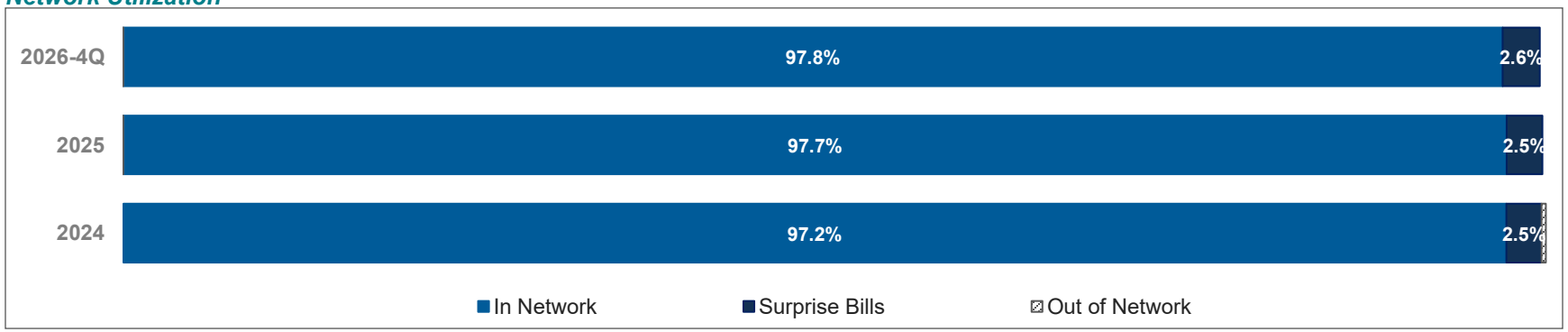
Network Summary

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.

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Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2025 (Full Year)		2026-4Q		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	13,346	$13,868,389	$10,845,530	$1,326,541	$1,696,319	$5,646,022	$8,222,367
Neoplasms	3,177	$8,496,372	2,997	$10,880,206	$8,342,432	$2,222,765	$315,009	$6,033,440	$4,846,766
Musculoskeletal System	6,235	$9,614,034	6,011	$10,815,301	$7,772,627	$2,349,045	$693,628	$6,053,000	$4,762,301
Circulatory System	4,249	$9,533,462	4,028	$10,131,319	$8,474,813	$1,282,238	$374,268	$6,326,723	$3,804,596
Injury, Poisoning & External Causes	2,881	$7,432,651	2,978	$7,949,247	$4,654,864	$1,311,947	$1,982,436	$4,486,161	$3,463,086
Digestive System	2,875	$5,633,027	2,769	$6,353,327	$4,264,924	$1,000,262	$1,088,141	$3,086,301	$3,267,026
Symptoms, Signs & Findings, NEC	8,856	$5,378,622	8,503	$6,097,029	$4,235,704	$837,233	$1,024,092	$2,650,325	$3,446,704
Nervous System	3,005	$3,876,394	3,042	$5,056,324	$3,483,124	$631,255	$941,945	$2,173,420	$2,882,904
Genitourinary System	4,241	$4,467,616	4,177	$4,317,795	$3,230,905	$779,518	$307,373	$1,487,671	$2,830,124
Mental, Behavioral & Neurodevelopmental	3,387	$3,746,998	3,456	$4,175,934	$1,844,304	$579,658	$1,751,972	$1,915,516	$2,260,419
Respiratory System	5,262	$3,232,126	4,795	$4,160,154	$3,110,654	$299,815	$749,685	$1,907,664	$2,252,490
Endocrine, Nutritional & Metabolic	6,461	$3,685,436	6,400	$3,397,135	$2,829,178	$365,810	$202,148	$1,741,624	$1,655,511
Pregnancy, Childbirth & the Puerperium	410	$2,314,674	415	$3,105,734	$2,194,472	$622,386	$288,876	$8,387	$3,097,346
Infectious & Parasitic Diseases	1,624	$2,894,059	1,405	$2,584,468	$2,066,629	$322,867	$194,972	$1,913,404	$671,064
Perinatal Originating Conditions	190	$2,082,861	205	$2,223,281	$654	$0	$2,222,628	$1,791,028	$430,847
Skin & Subcutaneous Tissue	4,810	$1,242,481	4,755	$1,231,050	$869,183	$246,436	$115,431	$598,159	$632,891
Eye and Adnexa	4,098	$895,465	3,661	$1,110,870	$786,801	$256,516	$67,553	$480,590	$630,280
Blood & Immune Disorders	967	$752,337	1,034	$929,961	$758,264	$73,949	$97,748	$366,392	$563,569
Ear and Mastoid Process	1,596	$513,866	1,470	$692,293	$256,460	$192,788	$243,044	$159,431	$532,862
Congenital Malformations & Abnormalities	271	$541,322	301	$528,650	$122,497	$82,002	$324,151	$300,198	$228,452
External Causes of Morbidity	0	$0	10	$0	$0	$0	$0	$0	$0
Total	**21,073**	**$88,624,170**	**20,292**	**$99,608,468**	**$70,144,018**	**$14,783,030**	**$14,681,420**	**$49,125,455**	**$50,481,606**

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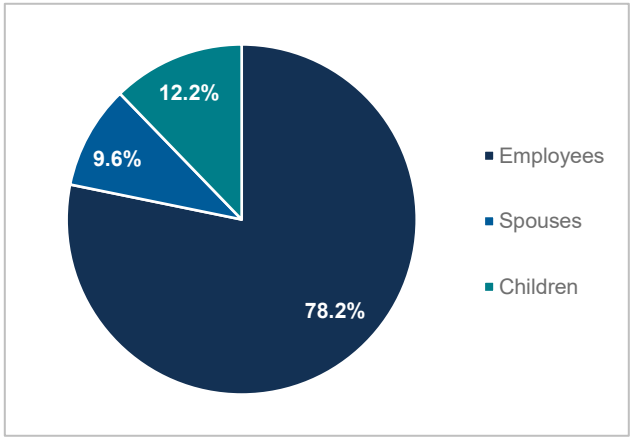
#1 Top Dx Chapter

Health Status & Health Services

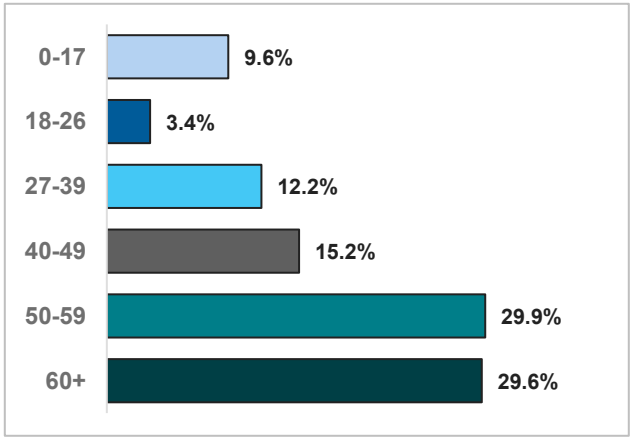
Breakout by Diagnostic Grouping & Demographics

#	Health Status & Services Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Encounter for antineoplastic therapies	78	758	$6,189,005	44.6%
2	Neoplasm-related encounters	4,146	7,702	$2,491,051	18.0%
3	Medical examination/evaluation	9,567	16,944	$2,011,223	14.5%
4	Exposure, enc, screen or contact w infectious dz	4,101	5,953	$1,100,332	7.9%
5	Contraceptive & procreative management	592	999	$476,682	3.4%
6	Other aftercare encounter	558	1,449	$423,499	3.1%
7	Implant, device or graft related encounter	474	1,467	$245,931	1.8%
8	Encount for obs & exam for conds ruled out	1,925	2,554	$179,615	1.3%
9	Other specified status	707	1,578	$157,198	1.1%
10	Family history of disease	157	219	$104,760	0.8%
11	Acquired absence of limb or organ	64	100	$84,027	0.6%
12	Organ transplant status	38	363	$78,627	0.6%
13	Enc for prophylactic measures (ex immuniz)	88	229	$55,424	0.4%
14	Encounter for prophylactic or oth procedures	49	61	$52,973	0.4%
15	Personal history of other disease	310	434	$52,540	0.4%
16	Personal history of malignant neoplasm	127	172	$35,831	0.3%
17	Other specified encounters & counseling	270	513	$35,677	0.3%
18	Encounter for administrative purposes	43	62	$28,234	0.2%
19	Genetic susceptibility to disease	17	43	$26,748	0.2%
20	Lifestyle/life management factors	60	115	$12,936	0.1%
...	*All Others*	*1,750*	*2,267*	*$26,079*	*0.2%*
=	**Total**	**13,346**	**46,381**	**$13,868,389**	**100.0%**

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



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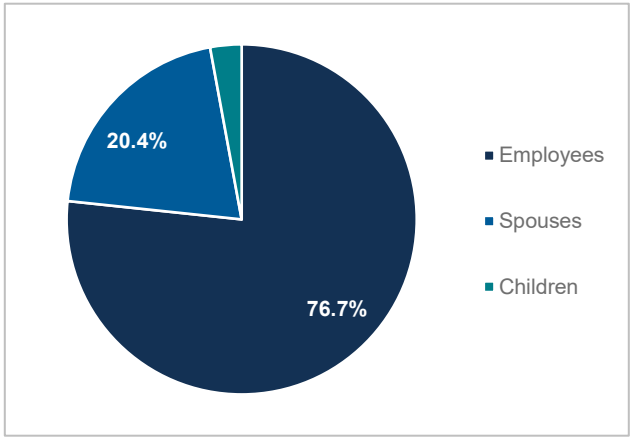
#2 Top Dx Chapter

Neoplasms (Cancer)

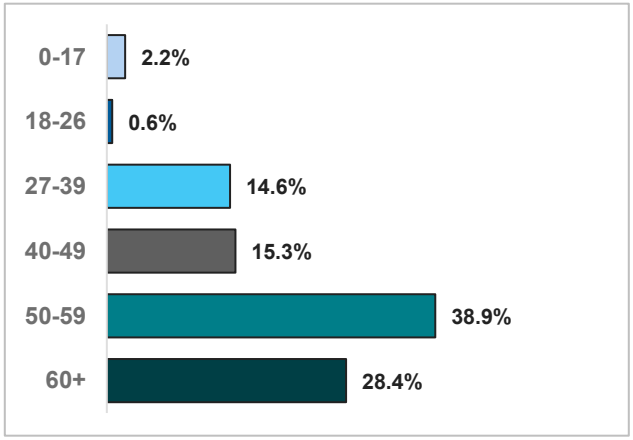
Breakout by Diagnostic Grouping & Demographics

#	Neoplasms (Cancer) Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Breast cancer	169	2,073	$1,683,942	15.5%
2	Benign neoplasms	1,882	3,178	$1,436,365	13.2%
3	Prostate cancer	111	1,109	$1,338,713	12.3%
4	Leukemia	39	545	$1,221,267	11.2%
5	Secondary malignancies	63	371	$735,017	6.8%
6	Lymphoma	41	517	$588,557	5.4%
7	Colorectal cancer	42	897	$550,500	5.1%
8	Other cancer	62	385	$496,064	4.6%
9	Ovarian cancer	16	206	$458,095	4.2%
10	Pancreatic cancer	11	367	$297,327	2.7%
11	Other gastrointestinal cancers	23	199	$286,100	2.6%
12	Multiple myeloma	10	364	$264,385	2.4%
13	Thyroid cancer	49	332	$254,122	2.3%
14	Neoplasms of unspec nature	1,161	1,938	$214,898	2.0%
15	Head & neck cancers	21	210	$213,341	2.0%
16	Brain cancer	9	80	$202,749	1.9%
17	Skin cancer	300	906	$174,351	1.6%
18	Respiratory cancers	16	163	$105,609	1.0%
19	Female reproductive	16	243	$94,235	0.9%
20	Endometrial cancer	24	122	$83,937	0.8%
...	*All Others*	*61*	*465*	*$180,632*	*1.7%*
=	**Total**	**2,997**	**16,064**	**$10,880,206**	**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 $8,680,056 – see Health Status for more details

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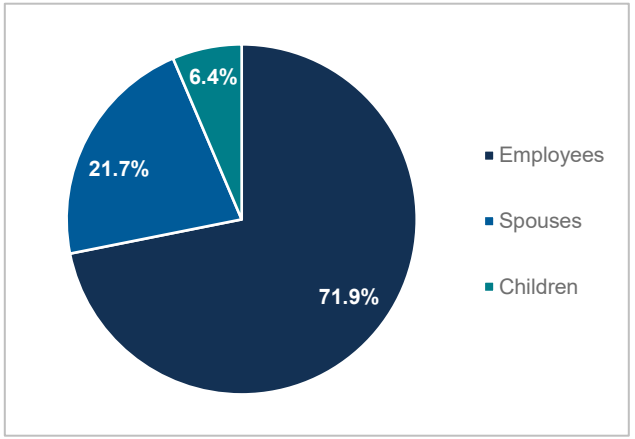
#3 Top Dx Chapter

Musculoskeletal System

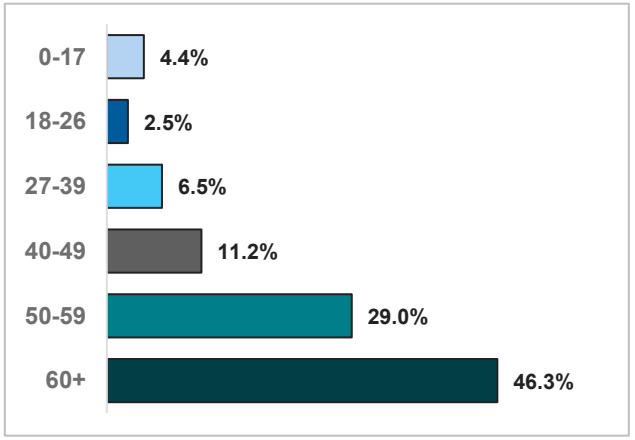
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	1,710	8,456	$3,367,596	31.1%
2	Osteoarthritis & osteoporosis	1,124	3,734	$2,355,731	21.8%
3	Tendon, tissue, muscle disorders	1,460	4,259	$1,220,743	11.3%
4	Other musculoskeletal pain	3,377	13,857	$1,148,063	10.6%
5	Joint disorders & fractures	483	1,200	$823,603	7.6%
6	Scoliosis & oth deformities	603	1,282	$670,604	6.2%
7	Other MSK	123	648	$460,837	4.3%
8	Low back pain	822	2,898	$254,168	2.4%
9	Rheumatoid arthritis & related disease	158	732	$241,685	2.2%
10	Lupus	120	492	$220,048	2.0%
11	Biomechanical lesions	467	2,220	$36,252	0.3%
12	Gout & crystal arthropathies	138	347	$15,971	0.1%
=	**Total**	**6,011**	**43,409**	**$10,815,301**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



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Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2024 (Full Year)		2025 (Full Year)		2026-4Q		2026-4Q 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	588	$1,032,448	$0	$0	$1,031,397	$1,051
Alcohol-related disorders	124	$806,533	137	$565,545	101	$835,377	$507,722	$133,009	$179,072	$15,575
Depressive disorders	1,005	$728,698	972	$640,203	1,004	$779,865	$183,013	$9,457	$587,395	$0
Anxiety & related Disorders	1,199	$362,534	1,284	$382,098	1,340	$474,727	$45,800	$42,961	$385,966	$0
Trauma & stressor disorders	760	$288,426	836	$376,394	888	$393,226	$2,961	$30,862	$359,358	$46
Suicidal ideation, attempt or self-harm	51	$205,797	44	$79,221	44	$157,682	$33,077	$111,148	$13,457	$0
Other mental health	258	$121,588	311	$82,352	281	$147,816	$954	$58,361	$88,311	$190
Bipolar & related Disorders	172	$99,260	174	$152,956	154	$117,269	$62,637	$3,029	$51,603	$0
Schizophrenia spectrum disorders	48	$121,142	41	$59,034	42	$71,588	$18,780	$34,815	$17,993	$0
Eating disorders	30	$83,704	23	$16,533	18	$57,198	$0	$0	$57,198	$0
Obsessive compulsive disorders	54	$72,146	57	$70,219	56	$34,097	$0	$0	$34,097	$0
Cannabis-related disorders	24	$15,571	28	$13,141	24	$28,359	$0	$19,284	$9,075	$0
Opiod disorders	35	$37,710	37	$36,077	32	$25,449	$7,125	$6,174	$12,149	$0
Other substance use	106	$12,377	114	$19,144	122	$16,340	$0	$4,866	$11,475	$0
Stimulant disorders	7	$21,155	12	$6,892	11	$4,492	$0	$1,314	$3,178	$0
Total	**3,269**	**$4,218,922**	**3,387**	**$3,746,998**	**3,456**	**$4,175,934**	**$862,069**	**$455,279**	**$2,841,724**	**$16,862**

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Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	47	2.1	*-4.1%*	29	1.3	*-6.5%*	$8,569	85.1	510.6
Asthma	544	24.0	*-10.4%*	212	9.4	*-6.6%*	$5,991	57.0	437.5
Atrial Fibrillation	244	10.8	*4.7%*	177	7.8	*7.9%*	$40,395	307.4	680.3
Blood Disorders	988	43.6	*10.6%*	451	19.9	*14.2%*	$21,551	179.1	561.7
CAD	402	17.8	*7.5%*	191	8.4	*-3.0%*	$20,665	179.1	353.2
COPD	97	4.3	*-10.2%*	62	2.7	*-8.8%*	$34,374	381.4	845.4
Cancer	1,668	73.7	*-4.4%*	858	37.9	*-5.4%*	$19,335	103.1	224.2
Chronic Pain	117	5.2	*-13.3%*	60	2.6	*-3.2%*	$52,254	606.8	1,418.8
CHF	96	4.2	*-3.0%*	62	2.7	*8.8%*	$47,912	520.8	916.7
Demyelinating Diseases	58	2.6	*-6.5%*	40	1.8	*2.6%*	$25,322	155.2	620.7
Depression	940	41.5	*-0.2%*	637	28.1	*-1.5%*	$10,648	143.6	342.6
Diabetes	1,495	66.0	*-2.2%*	1,010	44.6	*-1.2%*	$10,591	88.3	264.9
ESRD	107	4.7	*-15.7%*	74	3.3	*-23.7%*	$61,509	1,177.6	2,158.9
Eating Disorders	22	1.0	*22.2%*	11	0.5	*10.0%*	$12,947	181.8	181.8
HIV/AIDS	39	1.7	*-2.5%*	32	1.4	*-3.0%*	$12,869	179.5	564.1
Hyperlipidemia	976	43.1	*15.6%*	328	14.5	*10.8%*	$3,691	21.5	79.9
Hypertension	2,292	101.2	*-6.3%*	1,104	48.8	*-5.7%*	$8,889	107.8	304.5
Immune Disorders	44	1.9	*7.3%*	23	1.0	*4.5%*	$28,456	204.5	363.6
IBD	70	3.1	*16.7%*	15	0.7	*25.0%*	$5,922	0.0	242.9
Liver Disease	9	0.4	*28.6%*	7	0.3	*16.7%*	$99,669	1,666.7	1,888.9
Morbid Obesity	251	11.1	*-3.5%*	102	4.5	*-13.6%*	$10,054	71.7	163.3
Osteoarthritis	908	40.1	*3.1%*	386	17.0	*-2.0%*	$15,288	70.5	297.4
Peripheral Vascular Disease	115	5.1	*7.5%*	42	1.9	*27.3%*	$19,257	278.3	487.0
Rheumatoid Arthritis	135	6.0	*2.3%*	92	4.1	*-3.2%*	$33,857	74.1	259.3

- *Most prevalent chronic condition is Hypertension, with 2,292 members*
- *Hypertension is also the condition with the most moderate/high risk members (1,104)*
- *Members with mod/high risk Cancer have the highest combined cost: 858 members totaling $16.6M*

Date Range: Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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:** $5,999
- **Admits per 1000:** 43.9
- **ER Visits per 1000:** 210.2

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Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	Apr 2025 - Mar 2026 Eligible	Apr 2025 - Mar 2026 Actual	Apr 2025 - Mar 2026 Rate	*Rate Change*	UMR Norm Rate	UMR Norm *Variance*
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	142.9	805	**5,634.3**	136.5	721	**5,283.5**	*-6.2%*	**5,397.9**	*-2.1%*
Well Child Visit	3 - 6 years	736.2	554	**752.5**	689.8	495	**717.6**	*-4.6%*	**805.6**	*-10.9%*
Adults w/ Well Visit	Adults 18+	19,345	7,062	**36.5%**	18,771	6,880	**36.7%**	*0.1 pts*	**40.3%**	*-3.7 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	5,927	2,599	**43.9%**	5,598	2,497	**44.6%**	*0.8 pts*	**44.9%**	*-0.3 pts*
Cervical Cancer	Females 21 - 64	8,606	2,052	**23.8%**	8,265	1,958	**23.7%**	*-0.2 pts*	**21.7%**	*1.9 pts*
Prostate Cancer	Males 50 - 70	3,683	1,534	**41.7%**	3,474	1,418	**40.8%**	*-0.8 pts*	**41.9%**	*-1.1 pts*
Colorectal Cancer	Members 45 - 75	9,889	1,567	**15.8%**	9,386	1,530	**16.3%**	*0.5 pts*	**15.7%**	*0.6 pts*
Cholesterol	Female 45+ Male 35+	11,986	5,769	**48.1%**	11,535	5,684	**49.3%**	*1.1 pts*	**46.8%**	*2.5 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	607	476	**78.4%**	544	431	**79.2%**	*0.8 pts*		
COPD	Spirometry Test	108	19	**17.6%**	97	22	**22.7%**	*5.1 pts*		
Type 2 Diabetes	A1c Test	1,446	1,241	**85.8%**	1,419	1,236	**87.1%**	*1.3 pts*	**83.5%**	*3.6 pts*
	Eye Exam	-	-	**-**	0	0	**0**	-	**0**	*0*
	Lipid Panel	1,446	1,106	**76.5%**	1,419	1,081	**76.2%**	*-0.3 pts*	**70.7%**	*5.5 pts*
	Urine Protein Test	1,446	891	**61.6%**	1,419	934	**65.8%**	*4.2 pts*	**63.2%**	*2.6 pts*
	Any Diabetes Screen	1,446	1,281	**88.6%**	1,419	1,277	**90.0%**	*1.4 pts*	**87.6%**	*2.4 pts*
Hyperlipidemia	Lipid Profile	844	418	**49.5%**	976	472	**48.4%**	*-1.2 pts*		
Hypertension	Creatinine Test	2,446	470	**19.2%**	2,292	443	**19.3%**	*0.1 pts*		
	Lipid Profile	2,446	552	**22.6%**	2,292	565	**24.7%**	*2.1 pts*		

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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

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14.8

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - 14.6 Q4 Express Scripts – Summary Report
    - 14.7 Q4 CDHP Performance Report
    - **14.8 Q4 LD PPO Performance Report**



Quarterly Plan Performance Review

Low Ded Plan • 2026-4Q

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RPG 5.10 • Run Date: 7/29/2026

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Report Criteria & Contents

Experience Periods*

- **2026 Plan Year (Current)**
  - 2026-4Q.1st four Quarters: Claims Paid 7/1/2025 - 6/30/2026
- **2025 Plan Year**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
  - 2025 Full Year: Claims paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

Group Data

- Data reported is for the Low Ded Plan only:
- Contract = 7670-07-414946 or 7670-11-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,369 groups with approximately 8.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 6/30/2026

* 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: +13.1%
- High-Cost Claimants Paid PMPM trend: +31.2%; Non HCCs trend: +7.3%
- Top Paid Diagnostic Chapters: Health Status & Services (+8.6% Paid PMPM), Musculoskeletal (+20.0%), Neoplasms (Cancer) (+8.0%)

Membership & Demographics

- Total membership is 9.5% higher than prior period
- Employees increased 9.9%, while Dependents were up 9.0%
- 72.9% of members had < $2,500 medical paid, with 14.1% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $30,475, which is 1.8% lower than 2025-4Q
- Paid per ER Visit was $3,388, which is 6.4% higher than 2025-4Q

Network Utilization & Savings

- 97.8% of all Medical spend dollars were to In Network providers
- The average In Network discount was 67.8%, which is 0.7 pts above the 2025 average discount of 67.1%

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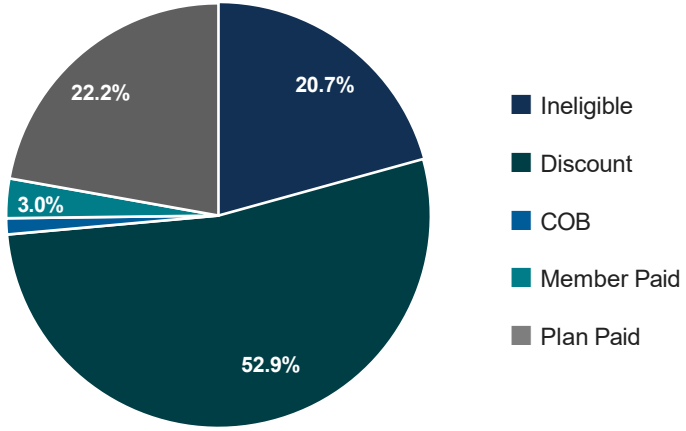
Medical Total Savings Summary

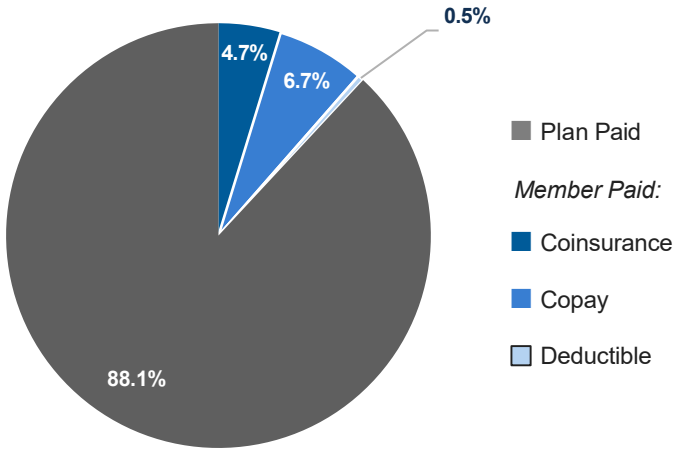
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2026-4Q Total Dollars	2026-4Q PMPM*	2025 PMPM*	*Trend*
Medical Billed	**$652,827,457**	**$2,119**	$1,796	***18.0%***
(-) Ineligible	**$135,085,494**	**$439**	$344	***27.5%***
Medical Covered	**$517,741,962**	**$1,681**	$1,452	***15.8%***
(-) Discount	**$344,873,410**	**$1,120**	$958	***16.8%***
Medical Allowed	**$172,868,553**	**$561**	$494	***13.7%***
(-) COB	**$7,992,622**	**$26**	$20	***27.3%***
(-) Coinsurance	**$7,788,806**	**$25**	$24	***6.8%***
(-) Copay	**$11,054,455**	**$36**	$33	***9.4%***
(-) Deductible	**$758,823**	**$2**	$2	***-1.4%***
Total Member Paid	**$19,602,084**	**$64**	$59	***7.9%***
Total Plan Paid	**$144,771,039**	**$470**	$414	***13.6%***

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.

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Medical & Rx Paid Claims by Age Range

Age	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)						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	$6,890,919	$2,397	$38,602	$13	**$6,929,521**	**$2,410**	$9,301,879	$2,956	$34,970	$11	$9,336,848	**$2,967**	*34.7%*	*23.1%*
1	$932,891	$313	$22,769	$8	**$955,660**	**$320**	$1,147,597	$349	$55,618	$17	$1,203,215	**$366**	*25.9%*	*14.1%*
2 - 4	$1,879,975	$187	$94,174	$9	**$1,974,149**	**$197**	$2,532,539	$243	$152,245	$15	$2,684,785	**$257**	*36.0%*	*30.8%*
5 - 9	$2,464,990	$130	$1,058,729	$56	**$3,523,719**	**$186**	$3,605,208	$180	$513,249	$26	$4,118,458	**$206**	*16.9%*	*10.9%*
10 - 14	$3,347,809	$168	$402,682	$20	**$3,750,491**	**$188**	$4,226,164	$192	$1,260,433	$57	$5,486,596	**$250**	*46.3%*	*32.9%*
15 - 19	$4,913,298	$212	$1,465,329	$63	**$6,378,627**	**$275**	$5,397,877	$213	$1,600,616	$63	$6,998,492	**$276**	*9.7%*	*0.1%*
20 - 24	$4,469,258	$199	$1,655,592	$74	**$6,124,850**	**$273**	$5,815,288	$237	$2,438,402	$99	$8,253,690	**$336**	*34.8%*	*23.1%*
25 - 29	$6,294,307	$324	$2,477,499	$128	**$8,771,806**	**$451**	$7,894,066	$377	$3,191,774	$152	$11,085,841	**$529**	*26.4%*	*17.2%*
30 - 34	$8,171,543	$369	$3,512,469	$159	**$11,684,011**	**$527**	$9,347,716	$404	$4,714,235	$204	$14,061,951	**$608**	*20.4%*	*15.3%*
35 - 39	$10,025,675	$404	$4,059,911	$163	**$14,085,586**	**$567**	$12,091,603	$437	$4,870,126	$176	$16,961,729	**$614**	*20.4%*	*8.2%*
40 - 44	$10,772,695	$445	$4,591,081	$190	**$15,363,777**	**$635**	$13,632,478	$512	$6,550,988	$246	$20,183,466	**$758**	*31.4%*	*19.3%*
45 - 49	$9,308,227	$437	$5,410,526	$254	**$14,718,753**	**$691**	$12,332,134	$503	$6,912,060	$282	$19,244,194	**$785**	*30.7%*	*13.6%*
50 - 54	$12,163,858	$537	$6,396,614	$282	**$18,560,472**	**$819**	$12,541,113	$522	$8,606,440	$358	$21,147,554	**$881**	*13.9%*	*7.5%*
55 - 59	$12,866,132	$619	$6,634,928	$319	**$19,501,060**	**$937**	$16,890,425	$721	$7,955,780	$340	$24,846,204	**$1,061**	*27.4%*	*13.2%*
60 - 64	$14,500,570	$804	$6,235,527	$346	**$20,736,097**	**$1,150**	$19,096,828	$937	$8,062,734	$396	$27,159,562	**$1,333**	*31.0%*	*16.0%*
65+	$7,411,144	$996	$3,046,996	$410	**$10,458,139**	**$1,406**	$8,918,123	$1,050	$4,060,962	$478	$12,979,085	**$1,528**	*24.1%*	*8.7%*
Total	**$116,413,291**	**$414**	**$47,103,426**	**$167**	**$163,516,717**	**$581**	**$144,771,039**	**$470**	**$60,980,632**	**$198**	**$205,751,671**	**$668**	***25.8%***	***14.9%***

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Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	4,363	*182.0%*	12,303	*9.9%*	13,526		
Spouses	1,052	*174.7%*	2,889	*8.8%*	3,144		
Children	2,928	*182.0%*	8,256	*9.0%*	9,000		
Tot. Members	**8,342**	***181.1%***	**23,447**	***9.5%***	**25,669**		
Avg. Family Size	1.9	*-0.3%*	1.9	*-0.4%*	1.9	1.9	*-1.0%*
Financial Summary							
Allowed	$47,025,040	*195.4%*	$138,897,633	*24.5%*	$172,868,553		
Plan Paid	$40,128,710	*190.1%*	$116,413,291	*24.4%*	$144,771,039		
Member Paid (OOP)	$5,616,085	*195.5%*	$16,592,748	*18.1%*	$19,602,084		
Paid PEPY	$9,198	*2.9%*	$9,462	*13.1%*	$10,703	$10,635	*0.6%*
Paid PMPY	$4,810	*3.2%*	$4,965	*13.6%*	$5,640	$5,546	*1.7%*
Paid PEPM	$767	*2.9%*	$789	*13.1%*	$892	$886	*0.6%*
Paid PMPM	$401	*3.2%*	$414	*13.6%*	$470	$462	*1.7%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	88	*36.4%*	120	*49.2%*	179		
HCCs per 1000	10.5	*-51.5%*	5.1	*36.3%*	7.0	7.3	*-5.0%*
Paid per HCC	$228,980	*10.8%*	$253,751	*-3.7%*	$244,393	$229,219	*6.6%*
HCC Paid % of Tot	50.2%	*-24.1 pts*	26.2%	*4.1 pts*	30.2%	31.4%	*-1.2 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$1,015	*2.2%*	$1,038	*17.0%*	$1,214	$1,333	*-9.0%*
Outpatient	$1,416	*0.9%*	$1,428	*16.3%*	$1,660	$1,604	*3.5%*
Physician	$2,297	*5.3%*	$2,418	*8.0%*	$2,611	$2,506	*4.2%*
Ancillary	$82	*-1.5%*	$81	*91.1%*	$155	$102	*52.1%*

- *With $130M paid, the State Active population is 89.5% of total 2026-4Q med spend*
- *On a Paid PMPM basis, State Actives are up 14.1% compared to prior year*
- *Total Low Ded Plan Paid PMPM trend is +13.6%*

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.

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Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2024-4Q	⇒	2025-4Q	⇒	2026-4Q
Average Enrollment										
Employees	4,003	*183.6%*	11,351	*9.5%*	12,432	1	*287.5%*	3	*16.1%*	3
Spouses	937	*176.3%*	2,589	*8.3%*	2,805	1	*137.5%*	2	*26.3%*	2
Children	2,797	*183.0%*	7,914	*8.7%*	8,601	0	-	0	-	0
Tot. Members	**7,736**	***182.5%***	**21,854**	***9.1%***	**23,838**	**1**	***212.5%***	**4**	***20.0%***	**5**
Avg. Family Size	1.9	*-0.4%*	1.9	*-0.4%*	1.9	2.0	*-19.4%*	1.6	*3.3%*	1.7
Financial Summary										
Allowed	$41,071,430	*201.2%*	$123,713,482	*24.6%*	$154,171,871	$14,024	*47.3%*	$20,653	*313.2%*	$85,338
Plan Paid	$35,019,686	*197.2%*	$104,078,363	*24.5%*	$129,561,551	$11,355	*42.2%*	$16,151	*383.0%*	$78,013
Member Paid (OOP)	$5,093,836	*195.5%*	$15,053,276	*17.5%*	$17,684,700	$2,670	*68.7%*	$4,503	*62.7%*	$7,326
Paid PEPY	$8,749	*4.8%*	$9,169	*13.7%*	$10,422	$17,032	*-63.3%*	$6,252	*315.9%*	$26,004
Paid PMPY	$4,527	*5.2%*	$4,762	*14.1%*	$5,435	$8,516	*-54.5%*	$3,876	*302.5%*	$15,603
Paid PEPM	$729	*4.8%*	$764	*13.7%*	$868	$1,419	*-63.3%*	$521	*315.9%*	$2,167
Paid PMPM	$377	*5.2%*	$397	*14.1%*	$453	$710	*-54.5%*	$323	*302.5%*	$1,300
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	70	*50.0%*	105	*48.6%*	156	0	-	0	-	0
HCCs per 1000	9.0	*-46.9%*	4.8	*36.2%*	6.5	0.0	-	0.0	-	0.0
Paid per HCC	$230,519	*11.0%*	$255,813	*-4.1%*	$245,200	$0	-	$0	-	$0
HCC Paid % of Tot	46.1%	*-20.3 pts*	25.8%	*3.7 pts*	29.5%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$981	*2.5%*	$1,005	*14.5%*	$1,151	$0	-	$0	-	$0
Outpatient	$1,300	*2.6%*	$1,334	*18.8%*	$1,584	$988	*5.0%*	$1,037	*352.4%*	$4,692
Physician	$2,163	*8.3%*	$2,342	*8.5%*	$2,541	$7,431	*-61.8%*	$2,839	*282.9%*	$10,873
Ancillary	$82	*-1.1%*	$81	*95.2%*	$158	$98	*-100.0%*	$0	-	$39

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Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2024-4Q	⇒	2025-4Q	⇒	2026-4Q
Average Enrollment										
Employees	348	*165.5%*	925	*15.6%*	1,069	11	*123.5%*	25	*-11.2%*	22
Spouses	109	*163.9%*	288	*14.0%*	328	5	*112.1%*	10	*-13.8%*	9
Children	131	*160.9%*	341	*16.8%*	398	0	*140.0%*	1	*0.0%*	1
Tot. Members	**588**	***164.2%***	**1,554**	***15.5%***	**1,795**	**16**	***120.5%***	**36**	***-11.6%***	**32**
Avg. Family Size	1.7	*-0.5%*	1.7	*0.0%*	1.7	1.5	*-1.3%*	1.5	*-0.5%*	1.5
Financial Summary										
Allowed	$5,707,796	*156.6%*	$14,647,388	*21.3%*	$17,764,207	$231,791	*122.7%*	$516,110	*64.1%*	$847,136
Plan Paid	$4,962,419	*143.0%*	$12,059,589	*21.2%*	$14,612,674	$135,251	*91.6%*	$259,189	*100.2%*	$518,801
Member Paid (OOP)	$497,199	*198.7%*	$1,485,264	*24.5%*	$1,849,350	$22,380	*122.1%*	$49,705	*22.1%*	$60,708
Paid PEPY	$14,247	*-8.5%*	$13,042	*4.8%*	$13,672	$12,296	*-14.3%*	$10,543	*125.4%*	$23,762
Paid PMPY	$8,438	*-8.0%*	$7,763	*4.9%*	$8,140	$8,323	*-13.1%*	$7,233	*126.5%*	$16,383
Paid PEPM	$1,187	*-8.5%*	$1,087	*4.8%*	$1,139	$1,025	*-14.3%*	$879	*125.4%*	$1,980
Paid PMPM	$703	*-8.0%*	$647	*4.9%*	$678	$694	*-13.1%*	$603	*126.5%*	$1,365
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	18	*-11.1%*	16	*37.5%*	22	1	*-100.0%*	0	-	1
HCCs per 1000	30.6	*-66.3%*	10.3	*19.0%*	12.3	61.5	*-100.0%*	0.0	-	31.6
Paid per HCC	$216,572	*3.6%*	$224,337	*3.1%*	$231,402	$109,572	*-100.0%*	$0	-	$366,697
HCC Paid % of Tot	*78.6%*	*-48.8 pts*	*29.8%*	*5.1 pts*	*34.8%*	*81.0%*	*-81.0 pts*	*0.0%*	-	*70.7%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,366	*10.7%*	$1,512	*23.6%*	$1,868	$4,616	*-95.5%*	$210	*5246.3%*	$11,225
Outpatient	$2,945	*-8.0%*	$2,710	*-2.0%*	$2,655	$952	*260.4%*	$3,432	*-34.7%*	$2,240
Physician	$4,046	*-14.4%*	$3,462	*1.3%*	$3,506	$2,509	*37.5%*	$3,451	*-18.0%*	$2,831
Ancillary	$81	*-2.5%*	$79	*40.9%*	$111	$245	*-43.1%*	$139	*-37.3%*	$87

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Financial Summary – Full Year Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024	⇒	2025	⇒	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	4,363	*182.0%*	12,303	*9.9%*	13,526		
Spouses	1,052	*174.7%*	2,889	*8.8%*	3,144		
Children	2,928	*182.0%*	8,256	*9.0%*	9,000		
Tot. Members	**8,342**	***181.1%***	**23,447**	***9.5%***	**25,669**		
Avg. Family Size	1.9	*-0.3%*	1.9	*-0.4%*	1.9	1.9	*-1.0%*
Financial Summary							
Allowed	$47,025,040	*195.4%*	$138,897,633	*24.5%*	$172,868,553		
Plan Paid	$40,128,710	*190.1%*	$116,413,291	*24.4%*	$144,771,039		
Member Paid (OOP)	$5,616,085	*195.5%*	$16,592,748	*18.1%*	$19,602,084		
Paid PEPY	$9,198	*2.9%*	$9,462	*13.1%*	$10,703	$10,635	*0.6%*
Paid PMPY	$4,810	*3.2%*	$4,965	*13.6%*	$5,640	$5,546	*1.7%*
Paid PEPM	$767	*2.9%*	$789	*13.1%*	$892	$886	*0.6%*
Paid PMPM	$401	*3.2%*	$414	*13.6%*	$470	$462	*1.7%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	88	*36.4%*	120	*49.2%*	179		
HCCs per 1000	10.5	*-51.5%*	5.1	*36.3%*	7.0	7.3	*-5.0%*
Paid per HCC	$228,980	*10.8%*	$253,751	*-3.7%*	$244,393	$229,219	*6.6%*
HCC Paid % of Tot	50.2%	*-24.1 pts*	26.2%	*4.1 pts*	30.2%	31.4%	*-1.2 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$1,015	*2.2%*	$1,038	*17.0%*	$1,214	$1,333	*-9.0%*
Outpatient	$1,416	*0.9%*	$1,428	*16.3%*	$1,660	$1,604	*3.5%*
Physician	$2,297	*5.3%*	$2,418	*8.0%*	$2,611	$2,506	*4.2%*
Ancillary	$82	*-1.5%*	$81	*91.1%*	$155	$102	*52.1%*

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 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.

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Financial Summary – Full Year Trend

Active Members

Measure	State Active					Non-State Active				
	2024	⇒	2025	⇒	2026-4Q	2024	⇒	2025	⇒	2026-4Q
Average Enrollment										
Employees	4,003	*183.6%*	11,351	*9.5%*	12,432	1	*287.5%*	3	*16.1%*	3
Spouses	937	*176.3%*	2,589	*8.3%*	2,805	1	*137.5%*	2	*26.3%*	2
Children	2,797	*183.0%*	7,914	*8.7%*	8,601	0	-	0	-	0
Tot. Members	**7,736**	***182.5%***	**21,854**	***9.1%***	**23,838**	**1**	***212.5%***	**4**	***20.0%***	**5**
Avg. Family Size	1.9	*-0.4%*	1.9	*-0.4%*	1.9	2.0	*-19.4%*	1.6	*3.3%*	1.7
Financial Summary										
Allowed	$41,071,430	*201.2%*	$123,713,482	*24.6%*	$154,171,871	$14,024	*47.3%*	$20,653	*313.2%*	$85,338
Plan Paid	$35,019,686	*197.2%*	$104,078,363	*24.5%*	$129,561,551	$11,355	*42.2%*	$16,151	*383.0%*	$78,013
Member Paid (OOP)	$5,093,836	*195.5%*	$15,053,276	*17.5%*	$17,684,700	$2,670	*68.7%*	$4,503	*62.7%*	$7,326
Paid PEPY	$8,749	*4.8%*	$9,169	*13.7%*	$10,422	$17,032	*-63.3%*	$6,252	*315.9%*	$26,004
Paid PMPY	$4,527	*5.2%*	$4,762	*14.1%*	$5,435	$8,516	*-54.5%*	$3,876	*302.5%*	$15,603
Paid PEPM	$729	*4.8%*	$764	*13.7%*	$868	$1,419	*-63.3%*	$521	*315.9%*	$2,167
Paid PMPM	$377	*5.2%*	$397	*14.1%*	$453	$710	*-54.5%*	$323	*302.5%*	$1,300
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	70	*50.0%*	105	*48.6%*	156	0	-	0	-	0
HCCs per 1000	9.0	*-46.9%*	4.8	*36.2%*	6.5	0.0	-	0.0	-	0.0
Paid per HCC	$230,519	*11.0%*	$255,813	*-4.1%*	$245,200	$0	-	$0	-	$0
HCC Paid % of Tot	46.1%	*-20.3 pts*	25.8%	*3.7 pts*	29.5%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$981	*2.5%*	$1,005	*14.5%*	$1,151	$0	-	$0	-	$0
Outpatient	$1,300	*2.6%*	$1,334	*18.8%*	$1,584	$988	*5.0%*	$1,037	*352.4%*	$4,692
Physician	$2,163	*8.3%*	$2,342	*8.5%*	$2,541	$7,431	*-61.8%*	$2,839	*282.9%*	$10,873
Ancillary	$82	*-1.1%*	$81	*95.2%*	$158	$98	*-100.0%*	$0	-	$39

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Financial Summary – Full Year Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024	⇒	2025	⇒	2026-4Q	2024	⇒	2025	⇒	2026-4Q
Average Enrollment										
Employees	348	*165.5%*	925	*15.6%*	1,069	11	*123.5%*	25	*-11.2%*	22
Spouses	109	*163.9%*	288	*14.0%*	328	5	*112.1%*	10	*-13.8%*	9
Children	131	*160.9%*	341	*16.8%*	398	0	*140.0%*	1	*0.0%*	1
Tot. Members	**588**	***164.2%***	**1,554**	***15.5%***	**1,795**	**16**	***120.5%***	**36**	***-11.6%***	**32**
Avg. Family Size	1.7	*-0.5%*	1.7	*0.0%*	1.7	1.5	*-1.3%*	1.5	*-0.5%*	1.5
Financial Summary										
Allowed	$5,707,796	*156.6%*	$14,647,388	*21.3%*	$17,764,207	$231,791	*122.7%*	$516,110	*64.1%*	$847,136
Plan Paid	$4,962,419	*143.0%*	$12,059,589	*21.2%*	$14,612,674	$135,251	*91.6%*	$259,189	*100.2%*	$518,801
Member Paid (OOP)	$497,199	*198.7%*	$1,485,264	*24.5%*	$1,849,350	$22,380	*122.1%*	$49,705	*22.1%*	$60,708
Paid PEPY	$14,247	*-8.5%*	$13,042	*4.8%*	$13,672	$12,296	*-14.3%*	$10,543	*125.4%*	$23,762
Paid PMPY	$8,438	*-8.0%*	$7,763	*4.9%*	$8,140	$8,323	*-13.1%*	$7,233	*126.5%*	$16,383
Paid PEPM	$1,187	*-8.5%*	$1,087	*4.8%*	$1,139	$1,025	*-14.3%*	$879	*125.4%*	$1,980
Paid PMPM	$703	*-8.0%*	$647	*4.9%*	$678	$694	*-13.1%*	$603	*126.5%*	$1,365
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	18	*-11.1%*	16	*37.5%*	22	1	*-100.0%*	0	-	1
HCCs per 1000	30.6	*-66.3%*	10.3	*19.0%*	12.3	61.5	*-100.0%*	0.0	-	31.6
Paid per HCC	$216,572	*3.6%*	$224,337	*3.1%*	$231,402	$109,572	*-100.0%*	$0	-	$366,697
HCC Paid % of Tot	78.6%	*-48.8 pts*	29.8%	*5.1 pts*	34.8%	81.0%	*-81.0 pts*	0.0%	-	70.7%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$1,366	*10.7%*	$1,512	*23.6%*	$1,868	$4,616	*-95.5%*	$210	*5246.3%*	$11,225
Outpatient	$2,945	*-8.0%*	$2,710	*-2.0%*	$2,655	$952	*260.4%*	$3,432	*-34.7%*	$2,240
Physician	$4,046	*-14.4%*	$3,462	*1.3%*	$3,506	$2,509	*37.5%*	$3,451	*-18.0%*	$2,831
Ancillary	$81	*-2.5%*	$79	*40.9%*	$111	$245	*-43.1%*	$139	*-37.3%*	$87

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Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2026-4Q (7/1/2025 - 6/30/2026) Active	Pre-Medicare Retirees	Medicare Retirees	Total	*Trend* *Total*
State Members									
Inpatient	$21,972,265	$2,245,745	$103,687	**$24,321,697**	$27,446,417	$3,230,934	$123,215	**$30,800,566**	*26.6%*
Outpatient	$29,149,638	$4,057,472	$152,122	**$33,359,232**	$37,759,200	$4,464,163	$301,582	**$42,524,945**	*27.5%*
Physician	$51,182,200	$5,094,477	$283,672	**$56,560,348**	$60,579,085	$5,839,395	$454,052	**$66,872,532**	*18.2%*
Ancillary	$1,774,259	$115,583	$6,831	**$1,896,674**	$3,776,850	$183,447	$15,886	**$3,976,183**	*109.6%*
Total	**$104,078,363**	**$11,513,277**	**$546,312**	**$116,137,952**	**$129,561,551**	**$13,717,939**	**$894,735**	**$144,174,225**	***24.1%***
PMPM	**$396.87**	**$684.08**	**$301.46**	**$413.47**	**$452.93**	**$718.55**	**$365.17**	**$468.72**	***13.4%***
Non-State Members									
Inpatient	$0	$0	$7,523	**$7,523**	$0	$351,894	$3,556	**$355,450**	*4624.6%*
Outpatient	$4,321	$16,060	$106,936	**$127,317**	$23,458	$12,136	$58,789	**$94,383**	*-25.9%*
Physician	$11,830	$65,406	$58,266	**$135,502**	$54,363	$22,373	$67,284	**$144,020**	*6.3%*
Ancillary	$0	$993	$4,004	**$4,997**	$193	$44	$2,725	**$2,961**	*-40.7%*
Total	**$16,151**	**$82,460**	**$176,729**	**$275,339**	**$78,013**	**$386,447**	**$132,354**	**$596,814**	***116.8%***
PMPM	**$323.02**	**$992.94**	**$509.37**	**$573.62**	**$1,300.21**	**$10,724.86**	**$384.79**	**$1,356.39**	***136.5%***
All Members									
Inpatient	$21,972,265	$2,245,745	$111,210	**$24,329,221**	$27,446,417	$3,582,828	$126,770	**$31,156,015**	*28.1%*
Outpatient	$29,153,959	$4,073,532	$259,058	**$33,486,549**	$37,782,657	$4,476,299	$360,371	**$42,619,328**	*27.3%*
Physician	$51,194,030	$5,159,883	$341,938	**$56,695,851**	$60,633,448	$5,861,768	$521,336	**$67,016,552**	*18.2%*
Ancillary	$1,774,259	$116,577	$10,835	**$1,901,671**	$3,777,042	$183,491	$18,611	**$3,979,144**	*109.2%*
Total	**$104,094,514**	**$11,595,737**	**$723,040**	**$116,413,291**	**$129,639,564**	**$14,104,386**	**$1,027,088**	**$144,771,039**	***24.4%***
PMPM	**$396.86**	**$685.59**	**$334.87**	**$413.74**	**$453.11**	**$737.40**	**$367.58**	**$469.99**	***13.6%***

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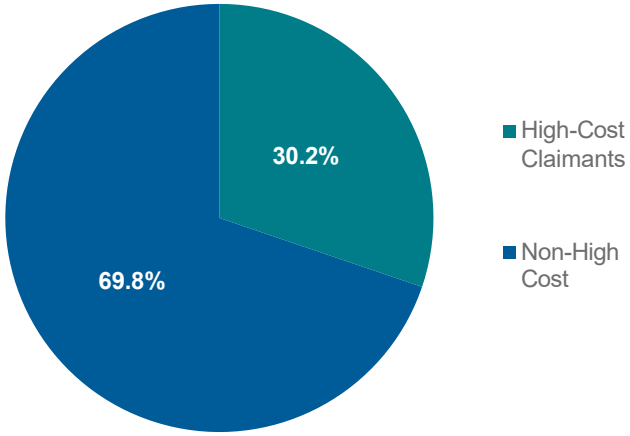
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)					
	*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	4,255	15.3%	$0	0.0%	$0	0.0%	4,260	14.1%	$0	0.0%	$0	0.0%
< $0 - $0	814	2.9%	-$226,897	-0.2%	$30,567	0.2%	1,094	3.6%	-$485,083	-0.3%	$67,078	0.3%
> $0 - $2,500	15,789	56.9%	$11,960,524	10.3%	$4,214,411	25.4%	16,715	55.2%	$13,194,773	9.1%	$4,513,059	23.0%
> $2,500 - $5,000	2,884	10.4%	$10,237,334	8.8%	$2,963,751	17.9%	3,256	10.7%	$11,531,844	8.0%	$3,251,559	16.6%
> $5,000 - $10,000	1,932	7.0%	$13,413,715	11.5%	$3,132,942	18.9%	2,380	7.9%	$16,698,184	11.5%	$3,915,936	20.0%
> $10,000 - $25,000	1,265	4.6%	$19,604,537	16.8%	$3,384,353	20.4%	1,627	5.4%	$25,137,013	17.4%	$4,310,503	22.0%
> $25,000 - $50,000	450	1.6%	$15,245,620	13.1%	$1,558,878	9.4%	540	1.8%	$18,370,106	12.7%	$1,866,353	9.5%
> $50,000 - $100,000	224	0.8%	$15,728,326	13.5%	$820,853	4.9%	239	0.8%	$16,577,866	11.5%	$930,727	4.7%
> $100,000	120	0.4%	$30,450,131	26.2%	$486,993	2.9%	179	0.6%	$43,746,337	30.2%	$746,869	3.8%
Total	**27,733**	**100.0%**	**$116,413,291**	**100.0%**	**$16,592,748**	**100.0%**	**30,290**	**100.0%**	**$144,771,039**	**100.0%**	**$19,602,084**	**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	83	$7,327,810	16.8%
2	Perinatal Originating Conditions	24	$5,238,875	12.0%
3	Health Status & Health Services	169	$4,856,755	11.1%
4	Endocrine, Nutritional & Metabolic	100	$3,442,820	7.9%
5	Circulatory System	104	$3,307,356	7.6%
6	Injury, Poisoning & External Causes	80	$2,773,211	6.3%
7	Nervous System	93	$2,627,095	6.0%
8	Musculoskeletal System	103	$2,566,414	5.9%
9	Blood & Immune Disorders	49	$2,173,305	5.0%
10	Mental, Behavioral & Neurodevelopmental	63	$1,593,920	3.6%
...	*All Others*		*$7,838,776*	*17.9%*
=	**Total**	**179**	**$43,746,337**	**100.0%**

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Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2026-4Q	*Variance*
Inpatient Admissions							
# of Admits	784	*33.9%*	1,050	*3.0%*	1,082		
# of Admit Days	3,683	*37.2%*	5,054	*-0.5%*	5,029		
Paid per Admit	$26,296	*18.1%*	$31,049	*-1.8%*	$30,475	$29,627	*2.9%*
Paid per Admit Day	$5,598	*15.2%*	$6,451	*1.6%*	$6,557	$5,928	*10.6%*
Admits per 1000	94.0	*-52.4%*	44.8	*-5.9%*	42.2	47.3	*-10.9%*
Average LOS	4.7	*2.5%*	4.8	*-3.4%*	4.6	5.0	*-7.0%*
Emergency Room Visits							
# of ER Visits	3,584	*30.4%*	4,672	*24.4%*	5,813		
~ % resulting in Admit	10.9%	*0.5 pts*	11.4%	*-1.5 pts*	9.9%	10.9%	*-1.0 pts*
ER Visits per Patient	1.4	*1.6%*	1.4	*2.6%*	1.5		
ER Visits per 1000	429.6	*-53.6%*	199.3	*13.7%*	226.5	220.9	*2.5%*
Paid per ER Visit	$2,991	*6.5%*	$3,185	*6.4%*	$3,388	$2,466	*37.4%*
Urgent Care Visits							
# of UC Visits	7,444	*25.5%*	9,340	*6.1%*	9,912		
UC Visits per Patient	1.5	*0.9%*	1.5	*-0.3%*	1.5		-
UC Visits per 1000	892.3	*-55.4%*	398.3	*-3.1%*	386.1	247.9	*55.8%*
Paid per UC Visit	$102	*7.5%*	$110	*5.3%*	$116	$119	*-3.2%*
Office Visits							
Off Visits per Patient	5.0	*3.7%*	5.2	*7.9%*	5.6		
Paid per Office Visit	$87	*5.3%*	$91	*4.6%*	$95	$98	*-2.9%*
Office Visits Paid PMPY	$868	*-53.0%*	$407	*14.3%*	$466	$386	*20.7%*
Services							
Radiology Svcs per 1000	8,333.1	*-54.2%*	3,816.2	*14.0%*	4,350.3	3,595.1	*21.0%*
Radiology Paid PMPY	$819	*-51.6%*	$396	*10.3%*	$437		
Lab Services per 1000	22,668.0	*-51.3%*	11,038.9	*11.9%*	12,354.5	9,957.4	*24.1%*
Labs Paid PMPY	$545	*-49.4%*	$275	*14.3%*	$315		

- *Inpatient Admission rate per 1000 decreased 5.9%, and amount paid per Admission is 1.8% lower than prior period*
- *ER utilization increased 13.7%, and amount paid per ER visit is 6.4% higher than prior period*

Admissions and all other **Visits** are counted for utilization if the *initial Paid Date* for the first primary claim (facility claim for non-Office Visits) fell within the time period. For cost purposes, however, all visit costs paid within the time period are included.

Counts **per 1000** and amounts **PMPY** (per member per year) have been annualized.

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Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2024-4Q	⇒	2025-4Q	⇒	2026-4Q
Inpatient Admissions										
# of Admits	721	*37.0%*	988	*1.2%*	1,000	0	-	0	-	0
# of Admit Days	3,261	*43.7%*	4,686	*-2.7%*	4,561	0	-	0	-	0
Paid per Admit	$24,657	*25.2%*	$30,868	*-5.6%*	$29,132	$0	-	$0	-	$0
Paid per Admit Day	$5,452	*19.4%*	$6,508	*-1.9%*	$6,387	$0	-	$0	-	$0
Admits per 1000	93.2	*-51.5%*	45.2	*-7.2%*	42.0	0.0	-	0.0	-	0.0
Average LOS	4.5	*4.9%*	4.7	*-3.8%*	4.6	0.0	-	0.0	-	0.0
Emergency Room Visits										
# of ER Visits	3,298	*32.1%*	4,358	*24.9%*	5,441	1	*100.0%*	2	*0.0%*	2
~ % resulting in Admit	10.7%	*0.5 pts*	11.2%	*-1.5 pts*	9.7%	0.0%	*0.0 pts*	0.0%	*0.0 pts*	0.0%
ER Visits per Patient	1.4	*2.7%*	1.4	*3.0%*	1.5	1.0	*100.0%*	2.0	*-50.0%*	1.0
ER Visits per 1000	426.3	*-53.2%*	199.4	*14.5%*	228.3	750.0	*-36.0%*	480.0	*-16.7%*	400.0
Paid per ER Visit	$2,990	*4.8%*	$3,133	*8.6%*	$3,402	$1,686	*9.9%*	$1,852	*-35.4%*	$1,196
Urgent Care Visits										
# of UC Visits	7,025	*26.1%*	8,861	*5.8%*	9,376	2	*-100.0%*	0	-	0
UC Visits per Patient	1.5	*1.0%*	1.5	*-0.1%*	1.5	1.0	*-100.0%*	0.0	-	0.0
UC Visits per 1000	908.0	*-55.3%*	405.5	*-3.0%*	393.3	1,500.0	*-100.0%*	0.0	-	0.0
Paid per UC Visit	$102	*7.6%*	$110	*5.5%*	$116	$170	*-100.0%*	$0	-	$0
Office Visits										
Off Visits per Patient	4.9	*3.9%*	5.1	*8.1%*	5.5	8.3	*-22.0%*	6.5	*90.8%*	12.4
Paid per Office Visit	$85	*5.8%*	$90	*4.7%*	$95	$156	*-3.2%*	$151	*-19.7%*	$121
Office Visits Paid PMPY	$831	*-52.6%*	$394	*14.6%*	$451	$2,926	*-83.9%*	$471	*219.1%*	$1,504
Services										
Radiology Svcs per 1000	7,756.9	*-53.6%*	3,596.0	*15.1%*	4,140.3	9,000.0	*-62.7%*	3,360.0	*126.2%*	7,600.0
Radiology Paid PMPY	$752	*-50.9%*	$370	*11.3%*	$412	$5,798	*-73.8%*	$1,516	*185.6%*	$4,331
Lab Services per 1000	22,076.6	*-51.1%*	10,799.3	*12.0%*	12,097.4	37,500.0	*-60.3%*	14,880.0	*50.5%*	22,400.0
Labs Paid PMPY	$529	*-49.3%*	$268	*15.3%*	$310	$294	*-54.3%*	$134	*235.2%*	$450

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Utilization Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇒	2025-4Q	⇒	2026-4Q	2024-4Q	⇒	2025-4Q	⇒	2026-4Q
Inpatient Admissions										
# of Admits	62	*-1.6%*	61	*26.2%*	77	1	*0.0%*	1	*400.0%*	5
# of Admit Days	411	*-10.9%*	366	*14.2%*	418	11	*-81.8%*	2	*2400.0%*	50
Paid per Admit	$44,553	*-22.9%*	$34,344	*30.7%*	$44,875	$75,918	*-89.0%*	$8,343	*825.8%*	$77,242
Paid per Admit Day	$6,721	*-14.8%*	$5,724	*44.4%*	$8,266	$6,902	*-39.6%*	$4,172	*85.2%*	$7,724
Admits per 1000	105.4	*-62.8%*	39.3	*9.2%*	42.9	61.5	*-54.7%*	27.9	*465.8%*	157.9
Average LOS	6.6	*-9.5%*	6.0	*-9.5%*	5.4	11.0	*-81.8%*	2.0	*400.0%*	10.0
Emergency Room Visits										
# of ER Visits	272	*12.5%*	306	*15.4%*	353	13	*-53.8%*	6	*183.3%*	17
~ % resulting in Admit	13.6%	*0.4 pts*	14.1%	*-1.6 pts*	12.5%	7.7%	*9.0 pts*	16.7%	*1.0 pts*	17.6%
ER Visits per Patient	1.6	*-12.4%*	1.4	*-3.7%*	1.4	1.3	*15.4%*	1.5	*61.9%*	2.4
ER Visits per 1000	462.5	*-57.4%*	197.0	*-0.2%*	196.6	800.0	*-79.1%*	167.4	*220.6%*	536.8
Paid per ER Visit	$2,977	*32.6%*	$3,949	*-16.5%*	$3,297	$3,597	*-43.7%*	$2,027	*-44.6%*	$1,122
Urgent Care Visits										
# of UC Visits	406	*15.0%*	467	*9.9%*	513	11	*9.1%*	12	*91.7%*	23
UC Visits per Patient	1.5	*0.8%*	1.5	*-6.0%*	1.4	1.6	*-23.6%*	1.2	*91.7%*	2.3
UC Visits per 1000	690.3	*-56.5%*	300.6	*-4.9%*	285.8	676.9	*-50.5%*	334.9	*116.9%*	726.3
Paid per UC Visit	$99	*6.4%*	$105	*2.3%*	$107	$49	*9.0%*	$53	*-38.6%*	$33
Office Visits										
Off Visits per Patient	6.2	*2.2%*	6.4	*3.9%*	6.6	7.7	*22.2%*	9.4	*11.0%*	10.4
Paid per Office Visit	$98	*1.0%*	$99	*4.8%*	$104	$67	*15.6%*	$78	*-27.9%*	$56
Office Visits Paid PMPY	$1,331	*-55.3%*	$594	*10.4%*	$656	$1,433	*-45.9%*	$775	*-21.4%*	$609
Services										
Radiology Svcs per 1000	15,393.0	*-56.1%*	6,763.2	*3.8%*	7,019.1	27,076.9	*-61.6%*	10,409.3	*1.9%*	10,610.5
Radiology Paid PMPY	$1,671	*-54.5%*	$760	*0.3%*	$762	$1,409	*-54.1%*	$647	*-9.0%*	$589
Lab Services per 1000	29,549.8	*-51.8%*	14,247.4	*10.0%*	15,674.8	53,907.7	*-67.4%*	17,553.5	*-8.4%*	16,073.7
Labs Paid PMPY	$748	*-49.5%*	$377	*3.0%*	$389	$372	*-64.7%*	$131	*51.5%*	$199

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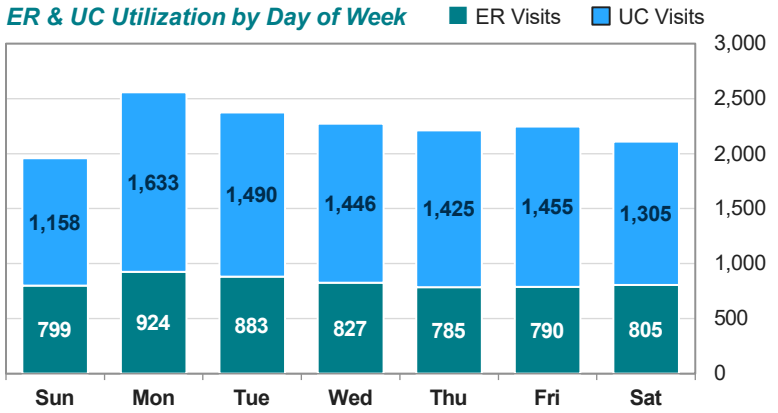
On Demand Care Summary

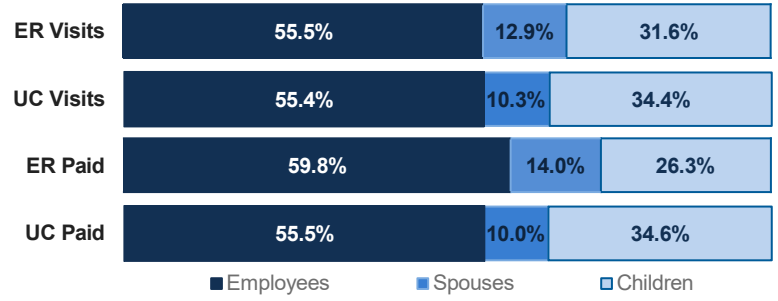
Emergency Room & Urgent Care

Measure	2025-4Q	2026-4Q	Change	UMR Norm	Variance
Emergency Room					
# of Visits	4,672	5,813	*24.4%*		
# of Patients	3,269	3,964	*21.3%*		
Total Plan Paid	$14,878,349	$19,697,253	*32.4%*		
Total Mem Paid	$2,828,036	$3,541,522	*25.2%*		
Visits per 1000	199.3	226.5	*13.7%*	220.9	*2.5%*
Paid per Visit	$3,185	$3,388	*6.4%*	$2,466	*37.4%*
Paid PMPM	$53	$64	*20.9%*	$45	*40.9%*
% ER Patients w/ Office Visit*	92.6%	94.6%	*1.9 pts*		
% Potentially Avoidable**	15.6%	15.8%	*0.1 pts*	82.3%	*-66.5 pts*
Urgent Care					
# of Visits	9,340	9,912	*6.1%*		
# of Patients	6,084	6,478	*6.5%*		
Total Plan Paid	$1,024,954	$1,145,047	*11.7%*		
Total Mem Paid	$675,892	$732,927	*8.4%*		
Visits per 1000	398.3	386.1	*-3.1%*	247.9	*55.8%*
Paid per Visit	$110	$116	*5.3%*	$119	*-3.2%*
Paid PMPM	$4	$4	*2.0%*	$2	*50.8%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	**Total**	ER	UC	Total
Employee	3,229	5,487	**8,716**	$11,771,302	$635,361	**$12,406,663**
Spouse	748	1,020	**1,768**	$2,754,470	$114,019	**$2,868,489**
Child	1,836	3,405	**5,241**	$5,171,481	$395,667	**$5,567,149**
Total	**5,813**	**9,912**	**15,725**	**$19,697,253**	**$1,145,047**	**$20,842,301**

* 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.

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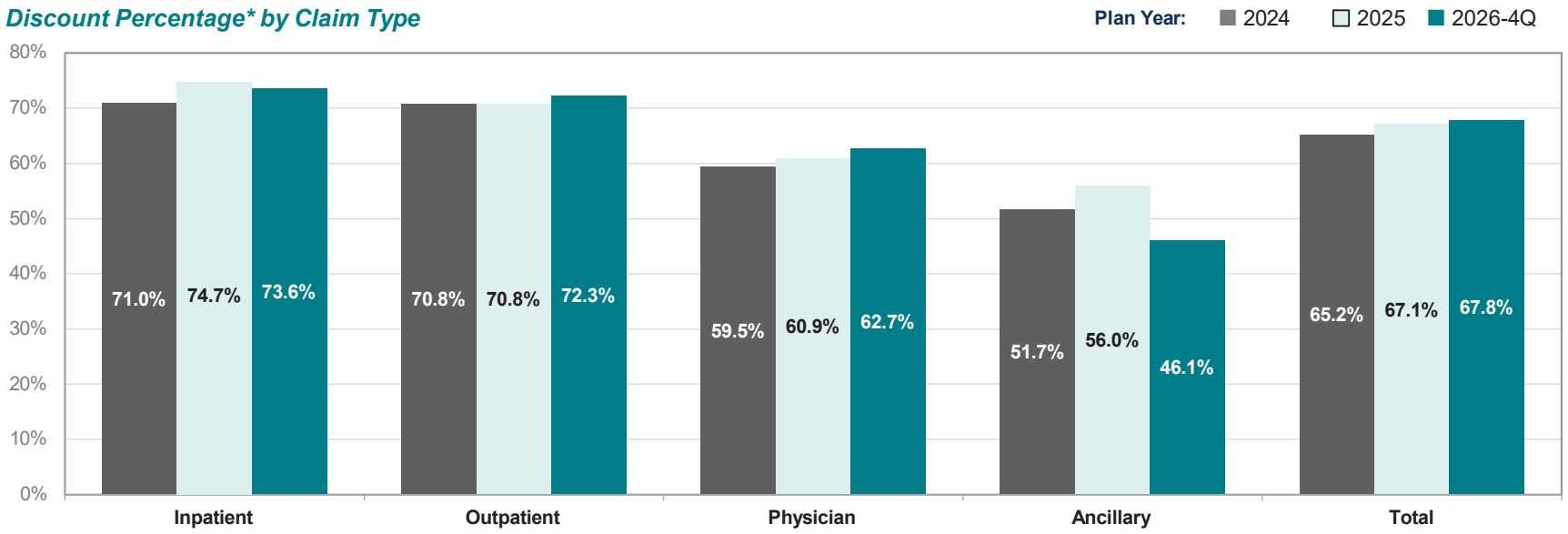
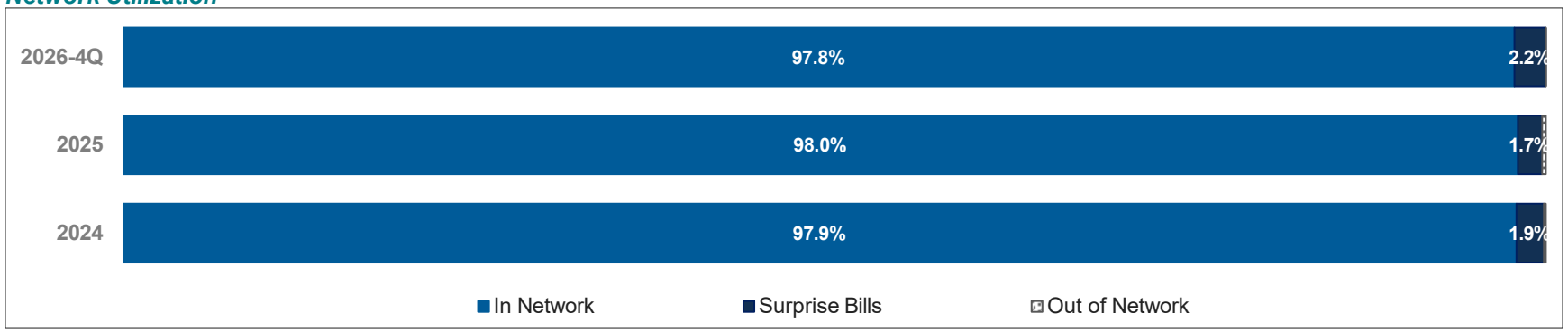
Network Summary

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.

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Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2025 (Full Year)		2026-4Q		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	17,663	$15,611,505	$9,568,657	$2,860,480	$3,182,368	$6,065,192	$9,546,313
Musculoskeletal System	6,392	$9,971,815	7,440	$13,100,875	$8,690,570	$3,433,427	$976,878	$5,306,533	$7,794,343
Neoplasms	3,006	$10,454,135	3,262	$12,366,184	$9,365,545	$2,012,583	$988,056	$4,826,222	$7,539,963
Mental, Behavioral & Neurodevelopmental	5,403	$9,148,979	6,433	$11,672,951	$5,564,033	$898,598	$5,210,321	$5,025,576	$6,647,375
Circulatory System	3,700	$9,265,567	4,131	$10,588,077	$7,402,412	$2,605,813	$579,852	$6,253,815	$4,334,262
Injury, Poisoning & External Causes	3,374	$8,521,617	3,944	$9,966,908	$6,496,839	$865,988	$2,604,081	$5,258,455	$4,708,453
Symptoms, Signs & Findings, NEC	10,316	$7,524,028	11,377	$9,375,996	$6,051,808	$1,481,109	$1,843,078	$3,262,495	$6,113,501
Digestive System	3,369	$6,835,609	3,770	$8,614,370	$5,605,984	$1,821,322	$1,187,064	$3,992,220	$4,622,150
Endocrine, Nutritional & Metabolic	6,742	$5,668,698	7,867	$7,843,761	$6,485,484	$907,767	$450,510	$3,842,683	$4,001,078
Nervous System	3,485	$5,995,432	4,180	$7,541,056	$5,818,816	$1,007,513	$714,727	$2,188,002	$5,353,054
Genitourinary System	5,020	$5,876,996	5,777	$6,963,249	$4,861,493	$1,355,447	$746,308	$1,851,305	$5,111,944
Perinatal Originating Conditions	312	$4,049,899	383	$6,576,703	$5,520	$85	$6,571,098	$5,617,689	$959,015
Respiratory System	6,826	$5,610,487	7,291	$6,348,698	$3,613,450	$642,786	$2,092,462	$2,623,318	$3,725,380
Pregnancy, Childbirth & the Puerperium	643	$5,490,502	738	$6,283,050	$4,185,490	$1,431,177	$666,384	$7,417	$6,275,634
Blood & Immune Disorders	1,041	$2,739,481	1,252	$2,780,387	$1,923,063	$151,012	$706,312	$2,235,021	$545,366
Infectious & Parasitic Diseases	1,937	$1,811,338	1,779	$2,680,073	$1,689,809	$363,873	$626,391	$1,405,471	$1,274,602
Eye and Adnexa	5,230	$1,509,643	5,681	$1,767,219	$1,098,448	$269,310	$399,461	$788,677	$978,542
Skin & Subcutaneous Tissue	5,109	$1,235,100	5,881	$1,691,721	$995,373	$264,653	$431,695	$608,392	$1,083,329
Congenital Malformations & Abnormalities	435	$581,437	464	$1,660,779	$226,811	$256,828	$1,177,140	$840,509	$820,270
Ear and Mastoid Process	2,008	$974,018	2,241	$1,335,501	$590,273	$74,369	$670,859	$491,438	$844,064
External Causes of Morbidity	11	$22,660	17	$1,975	$383	$508	$1,084	$623	$1,352
Total	**23,085**	**$116,413,291**	**25,343**	**$144,771,039**	**$90,240,263**	**$22,704,647**	**$31,826,128**	**$62,491,052**	**$82,279,986**

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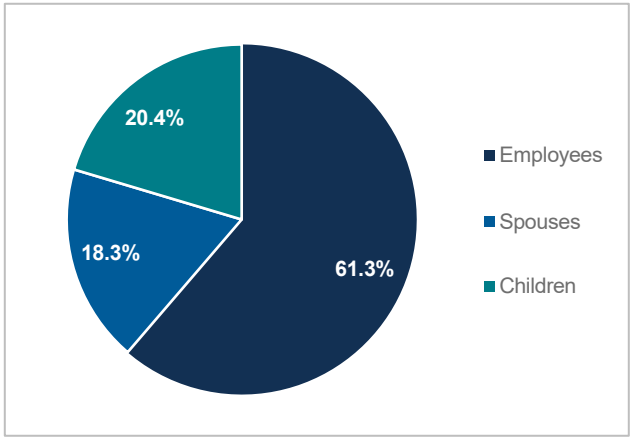
#1 Top Dx Chapter

Health Status & Health Services

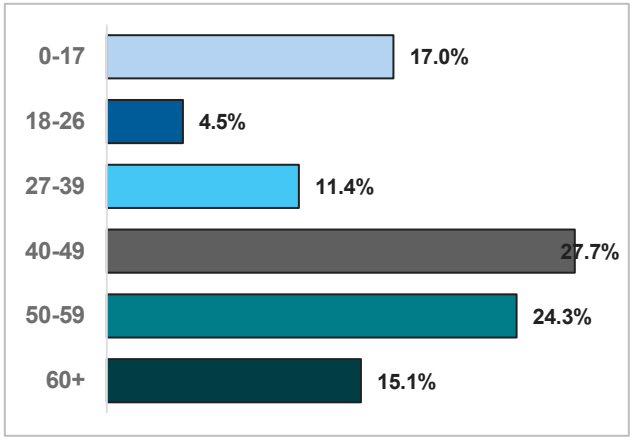
Breakout by Diagnostic Grouping & Demographics

#	Health Status & Services Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Encounter for antineoplastic therapies	80	517	$4,610,759	29.5%
2	Medical examination/evaluation	13,333	24,333	$3,264,103	20.9%
3	Neoplasm-related encounters	4,760	8,911	$2,717,501	17.4%
4	Exposure, enc, screen or contact w infectious dz	6,360	9,696	$2,029,745	13.0%
5	Contraceptive & procreative management	1,007	1,878	$774,996	5.0%
6	Other aftercare encounter	658	1,279	$375,438	2.4%
7	Implant, device or graft related encounter	481	1,374	$322,647	2.1%
8	Encount for obs & exam for conds ruled out	2,786	3,925	$273,349	1.8%
9	Organ transplant status	27	333	$198,701	1.3%
10	Other specified status	1,019	2,186	$193,646	1.2%
11	Family history of disease	258	331	$173,417	1.1%
12	Encounter for administrative purposes	63	109	$125,175	0.8%
13	Personal history of other disease	414	598	$98,900	0.6%
14	Personal history of malignant neoplasm	120	192	$92,018	0.6%
15	Encounter for prophylactic or oth procedures	89	112	$84,381	0.5%
16	Other specified encounters & counseling	428	982	$76,583	0.5%
17	Enc for prophylactic measures (ex immuniz)	174	257	$74,425	0.5%
18	Genetic susceptibility to disease	26	58	$34,990	0.2%
19	Acquired absence of limb or organ	62	141	$33,079	0.2%
20	Encounter for mental health conditions	1,876	2,377	$16,197	0.1%
...	*All Others*	*485*	*712*	*$41,451*	*0.3%*
=	**Total**	**17,663**	**60,427**	**$15,611,505**	**100.0%**

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



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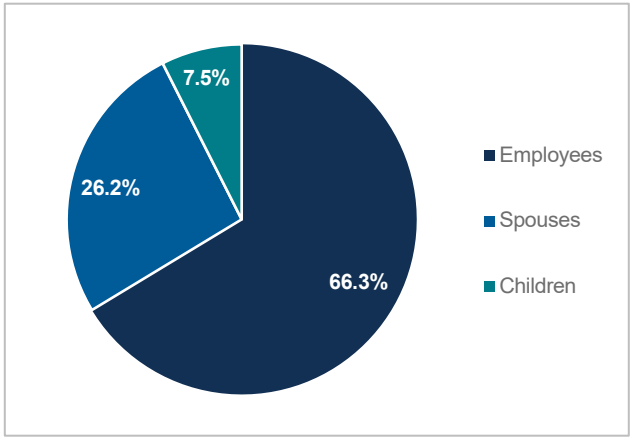
#2 Top Dx Chapter

Musculoskeletal System

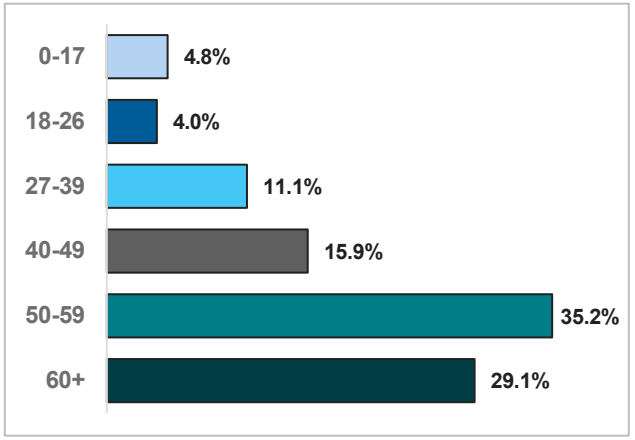
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	2,171	10,102	$3,876,728	29.6%
2	Osteoarthritis & osteoporosis	1,054	3,124	$2,438,809	18.6%
3	Other musculoskeletal pain	4,376	15,792	$1,769,849	13.5%
4	Tendon, tissue, muscle disorders	1,747	4,902	$1,570,519	12.0%
5	Scoliosis & oth deformities	676	1,495	$882,199	6.7%
6	Joint disorders & fractures	687	1,697	$835,533	6.4%
7	Other MSK	134	561	$703,938	5.4%
8	Low back pain	1,089	3,505	$432,996	3.3%
9	Rheumatoid arthritis & related disease	190	899	$370,035	2.8%
10	Lupus	160	643	$139,800	1.1%
11	Gout & crystal arthropathies	129	222	$45,327	0.3%
12	Biomechanical lesions	533	2,630	$35,141	0.3%
=	**Total**	**7,440**	**47,605**	**$13,100,875**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



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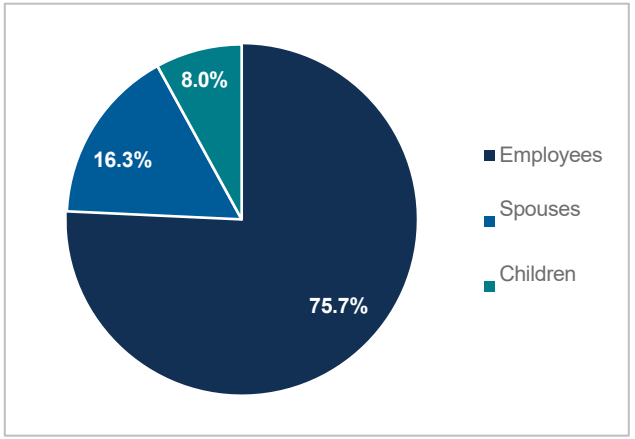
#3 Top Dx Chapter

Neoplasms (Cancer)

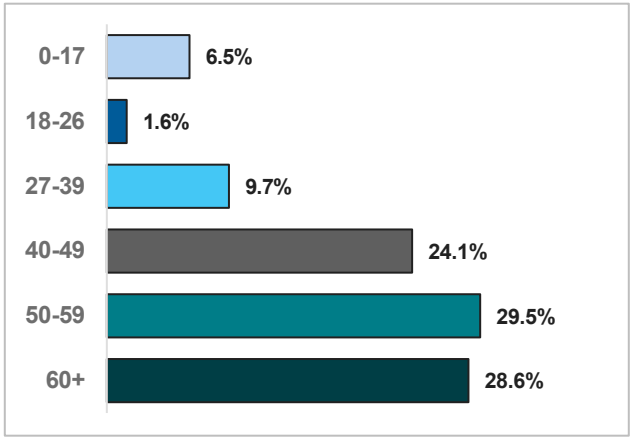
Breakout by Diagnostic Grouping & Demographics

#	Neoplasms (Cancer) Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Breast cancer	179	2,464	$2,707,203	21.9%
2	Benign neoplasms	2,268	3,774	$1,755,437	14.2%
3	Other cancer	68	417	$1,052,696	8.5%
4	Neoplasms of unspec nature	1,270	1,972	$867,308	7.0%
5	Other gastrointestinal cancers	23	409	$818,351	6.6%
6	Leukemia	34	515	$737,582	6.0%
7	Multiple myeloma	7	183	$725,298	5.9%
8	Colorectal cancer	38	631	$595,748	4.8%
9	Secondary malignancies	47	258	$578,896	4.7%
10	Lymphoma	38	510	$517,517	4.2%
11	Head & neck cancers	22	214	$446,243	3.6%
12	Skin cancer	223	687	$441,310	3.6%
13	Prostate cancer	69	627	$414,210	3.3%
14	Pancreatic cancer	10	203	$213,717	1.7%
15	Thyroid cancer	69	350	$108,591	0.9%
16	Respiratory cancers	12	238	$77,805	0.6%
17	Oral cancer	7	54	$76,472	0.6%
18	Kidney Cancer	17	53	$61,440	0.5%
19	Ovarian cancer	12	159	$54,149	0.4%
20	Endometrial cancer	15	65	$39,997	0.3%
...	*All Others*	*44*	*173*	*$76,213*	*0.6%*
=	**Total**	**3,262**	**15,016**	**$12,366,184**	**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 $7,328,260 – see Health Status for more details

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Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2024 (Full Year)		2025 (Full Year)		2026-4Q		2026-4Q 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	1,401	$2,742,261	$54,535	$53,831	$2,624,065	$9,829
Depressive disorders	1,312	$1,765,217	1,657	$2,195,970	1,961	$2,529,005	$267,849	$41,704	$2,218,588	$864
Anxiety & related Disorders	1,659	$914,955	2,234	$1,366,176	2,688	$1,874,535	$64,121	$99,813	$1,710,601	$0
Trauma & stressor disorders	1,151	$777,003	1,462	$1,169,043	1,839	$1,467,186	$9,506	$19,439	$1,438,241	$0
Other mental health	359	$444,148	475	$484,670	553	$807,883	$138,129	$59,342	$610,333	$80
Alcohol-related disorders	100	$479,637	129	$614,122	151	$724,413	$438,966	$131,096	$152,925	$1,426
Bipolar & related Disorders	220	$270,639	285	$252,131	316	$501,558	$189,399	$25,601	$286,558	$0
Schizophrenia spectrum disorders	29	$162,208	40	$204,689	42	$234,350	$154,629	$27,119	$52,601	$0
Suicidal ideation, attempt or self-harm	61	$408,763	59	$212,799	61	$229,655	$46,138	$139,573	$43,944	$0
Eating disorders	53	$266,949	67	$215,695	70	$227,841	$20,549	$0	$207,292	$0
Obsessive compulsive disorders	82	$67,055	113	$292,390	155	$204,605	$16,682	$0	$187,923	$0
Other substance use	96	$10,587	94	$16,449	129	$57,552	$27,141	$5,751	$24,659	$0
Cannabis-related disorders	19	$5,535	26	$42,633	35	$36,287	$0	$24,442	$11,845	$0
Stimulant disorders	11	$15,213	10	$7,200	14	$22,213	$12,677	$0	$9,536	$0
Opiod disorders	23	$40,867	30	$70,004	36	$13,607	-$5,138	$558	$18,187	$0
Total	**4,161**	**$6,596,135**	**5,403**	**$9,148,979**	**6,433**	**$11,672,951**	**$1,435,184**	**$628,271**	**$9,597,298**	**$12,199**

UMR

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Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	80	3.2	*29.0%*	53	2.1	*29.3%*	$8,134	200.0	362.5
Asthma	867	34.4	*8.5%*	340	13.5	*6.6%*	$6,992	66.9	309.1
Atrial Fibrillation	182	7.2	*15.2%*	124	4.9	*12.7%*	$30,950	236.3	483.5
Blood Disorders	1,172	46.5	*24.9%*	502	19.9	*21.8%*	$13,658	116.9	262.8
CAD	306	12.1	*20.0%*	150	6.0	*26.1%*	$23,102	183.0	359.5
COPD	60	2.4	*-11.8%*	31	1.2	*-3.1%*	$36,552	266.7	516.7
Cancer	1,662	66.0	*14.0%*	794	31.5	*14.2%*	$15,699	84.2	157.6
Chronic Pain	174	6.9	*31.8%*	73	2.9	*37.7%*	$33,194	390.8	580.5
CHF	60	2.4	*3.4%*	35	1.4	*0.0%*	$22,502	333.3	416.7
Demyelinating Diseases	74	2.9	*7.2%*	50	2.0	*-2.0%*	$35,206	81.1	486.5
Depression	1,855	73.6	*19.4%*	1,388	55.1	*22.2%*	$9,089	105.7	281.9
Diabetes	1,650	65.5	*14.7%*	1,170	46.4	*17.1%*	$8,083	58.8	253.9
ESRD	72	2.9	*16.1%*	47	1.9	*9.3%*	$49,049	750.0	1,500.0
Eating Disorders	68	2.7	*11.5%*	40	1.6	*-9.1%*	$11,443	58.8	308.8
HIV/AIDS	45	1.8	*15.4%*	40	1.6	*48.1%*	$6,886	22.2	155.6
Hyperlipidemia	1,016	40.3	*27.5%*	318	12.6	*20.9%*	$2,869	9.8	50.2
Hypertension	2,149	85.3	*11.2%*	1,036	41.1	*8.7%*	$7,356	73.1	240.6
Immune Disorders	86	3.4	*19.4%*	39	1.5	*25.8%*	$35,560	162.8	267.4
IBD	131	5.2	*52.3%*	36	1.4	*50.0%*	$3,095	7.6	99.2
Liver Disease	2	0.1	*-50.0%*	2	0.1	*-33.3%*	$82,327	1,500.0	1,500.0
Morbid Obesity	410	16.3	*11.7%*	205	8.1	*11.4%*	$8,171	85.4	190.2
Osteoarthritis	845	33.5	*26.7%*	345	13.7	*18.6%*	$8,520	32.0	130.2
Peripheral Vascular Disease	87	3.5	*1.2%*	24	1.0	*0.0%*	$7,010	80.5	218.4
Rheumatoid Arthritis	163	6.5	*19.0%*	123	4.9	*20.6%*	$11,705	73.6	343.6

- *Most prevalent chronic condition is Hypertension, with 2,149 members*
- *Depression is the condition with the most moderate/high risk members (1,388)*
- *Members with mod/high risk Depression also have the highest combined cost, totaling $12.6M*

Date Range: Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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:** $6,255
- **Admits per 1000:** 42.9
- **ER Visits per 1000:** 214.6

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Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	Apr 2025 - Mar 2026 Eligible	Apr 2025 - Mar 2026 Actual	Apr 2025 - Mar 2026 Rate	*Rate Change*	UMR Norm Rate	UMR Norm *Variance*
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	284.8	1,591	**5,585.5**	328.2	1,880	**5,727.6**	*2.5%*	**5,397.9**	*6.1%*
Well Child Visit	3 - 6 years	1,121.0	917	**818.0**	1,240.1	1,015	**818.5**	*0.1%*	**805.6**	*1.6%*
Adults w/ Well Visit	Adults 18+	17,002	7,523	**44.2%**	19,116	8,572	**44.8%**	*0.6 pts*	**40.3%**	*4.5 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	5,174	2,521	**48.7%**	5,862	2,892	**49.3%**	*0.6 pts*	**44.9%**	*4.4 pts*
Cervical Cancer	Females 21 - 64	8,965	2,631	**29.3%**	10,079	2,722	**27.0%**	*-2.3 pts*	**21.7%**	*5.3 pts*
Prostate Cancer	Males 50 - 70	2,306	1,066	**46.2%**	2,590	1,242	**48.0%**	*1.7 pts*	**41.9%**	*6.0 pts*
Colorectal Cancer	Members 45 - 75	7,186	1,388	**19.3%**	8,144	1,503	**18.5%**	*-0.9 pts*	**15.7%**	*2.8 pts*
Cholesterol	Female 45+ Male 35+	8,859	5,180	**58.5%**	10,014	5,989	**59.8%**	*1.3 pts*	**46.8%**	*13.0 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	799	648	**81.1%**	867	652	**75.2%**	*-5.9 pts*		
COPD	Spirometry Test	68	11	**16.2%**	60	7	**11.7%**	*-4.5 pts*		
Type 2 Diabetes	A1c Test	1,316	1,217	**92.5%**	1,516	1,398	**92.2%**	*-0.3 pts*	**83.5%**	*8.7 pts*
	Eye Exam	-	-	**-**	0	0	**0**	-	**0**	*0*
	Lipid Panel	1,316	1,083	**82.3%**	1,516	1,261	**83.2%**	*0.9 pts*	**70.7%**	*12.5 pts*
	Urine Protein Test	1,316	929	**70.6%**	1,516	1,052	**69.4%**	*-1.2 pts*	**63.2%**	*6.2 pts*
	Any Diabetes Screen	1,316	1,249	**94.9%**	1,516	1,430	**94.3%**	*-0.6 pts*	**87.6%**	*6.7 pts*
Hyperlipidemia	Lipid Profile	797	381	**47.8%**	1,016	498	**49.0%**	*1.2 pts*		
Hypertension	Creatinine Test	1,933	377	**19.5%**	2,149	405	**18.8%**	*-0.7 pts*		
	Lipid Profile	1,933	475	**24.6%**	2,149	529	**24.6%**	*0.0 pts*		

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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

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14.9

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - 14.6 Q4 Express Scripts – Summary Report
    - 14.7 Q4 CDHP Performance Report
    - 14.8 Q4 LD PPO Performance Report
    - **14.9 Q4 EPO Performance Report**



Quarterly Plan Performance Review

EPO Plan • 2026-4Q

UMR
A UnitedHealthcare Company

RPG 5.10 • Run Date: 7/29/2026

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Report Criteria & Contents

Experience Periods*

- **2026 Plan Year (Current)**
  - 2026-4Q.1st four Quarters: Claims Paid 7/1/2025 - 6/30/2026
- **2025 Plan Year**
  - 2025-4Q.1st four Quarters: Claims Paid 7/1/2024 - 6/30/2025
  - 2025 Full Year: Claims paid 7/1/2024 - 6/30/2025
- **2024 Plan Year**
  - 2024-4Q.1st four Quarters: Claims Paid 7/1/2023 - 6/30/2024
  - 2024 Full Year: Claims paid 7/1/2023 - 6/30/2024

Group Data

- Data reported is for the EPO Plan only:
- Contract = 7670-00-414946 or 7670-09-414946
- Except where indicated, Report is for Medical data only excluding claim expenses

Normative Comparison Data

- Norm Groups: UMR Book of Business in InfoPort℠
- Composition: 5,369 groups with approximately 8.9 million members
- Norm Period matches Current Year: Claims Paid 7/1/2025 - 6/30/2026

* 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: -6.1%
- High-Cost Claimants Paid PMPM trend: -16.9%; Non HCCs trend: +3.0%
- Top Paid Diagnostic Chapters: Circulatory System (+32.6% Paid PMPM), Musculoskeletal (+3.0%), Health Status & Services (+7.2%)

Membership & Demographics

- Total membership is 14.2% lower than prior period
- Employees decreased 12.8%, while Dependents were down 15.9%
- 63.2% of members had < $2,500 medical paid, with 8.2% having no claims paid at all during the reporting period

Utilization Key Indicators

- Paid per IP Admit was $43,822, which is 15.9% higher than 2025-4Q
- Paid per ER Visit was $3,464, which is 2.1% higher than 2025-4Q

Network Utilization & Savings

- 96.2% of all Medical spend dollars were to In Network providers
- The average In Network discount was 62.9%, which is 7.3 pts above the 2025 average discount of 55.7%

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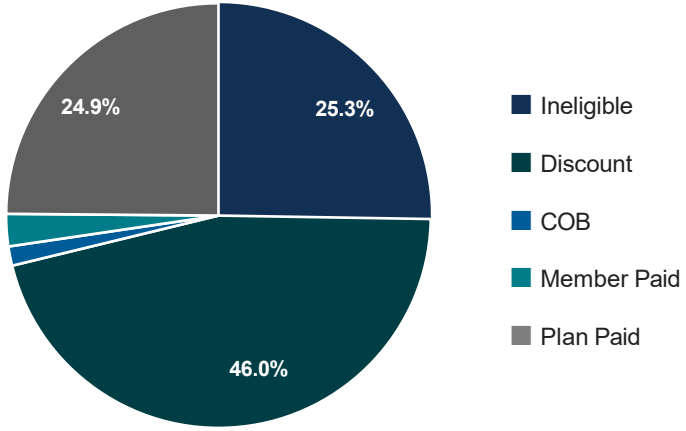
Medical Total Savings Summary

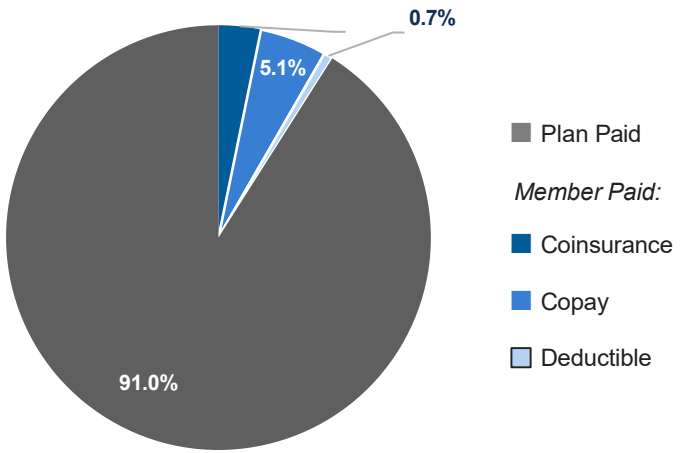
Dollar Chain: Billed to Paid Dollars

Dollar Amount	2026-4Q Total Dollars	2026-4Q PMPM*	2025 PMPM*	*Trend*
Medical Billed	**$148,879,383**	**$2,797**	$2,435	***14.9%***
(-) Ineligible	**$37,582,181**	**$706**	$628	***12.4%***
Medical Covered	**$111,297,202**	**$2,091**	$1,807	***15.7%***
(-) Discount	**$68,366,926**	**$1,285**	$981	***30.9%***
Medical Allowed	**$42,930,276**	**$807**	$826	***-2.3%***
(-) COB	**$2,177,083**	**$41**	$32	***26.9%***
(-) Coinsurance	**$1,308,040**	**$25**	$23	***8.5%***
(-) Copay	**$2,074,358**	**$39**	$36	***8.2%***
(-) Deductible	**$278,545**	**$5**	$5	***2.3%***
Total Member Paid	**$3,660,944**	**$69**	$64	***7.9%***
Total Plan Paid	**$36,997,864**	**$695**	$728	***-4.5%***

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.

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Medical & Rx Paid Claims by Age Range

Age	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)						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	$3,482,910	$9,139	$1,530	$4	**$3,484,440**	**$9,143**	$3,251,765	$9,049	$6,540	$18	$3,258,305	**$9,067**	*-6.5%*	*-0.8%*
1	$262,186	$580	$3,283	$7	**$265,469**	**$587**	$80,320	$248	$532	$2	$80,852	**$250**	*-69.5%*	*-57.4%*
2 - 4	$222,846	$132	$13,323	$8	**$236,169**	**$140**	$365,251	$257	$18,266	$13	$383,517	**$270**	*62.4%*	*92.7%*
5 - 9	$614,866	$165	$58,465	$16	**$673,331**	**$181**	$732,898	$247	$53,978	$18	$786,876	**$265**	*16.9%*	*47.0%*
10 - 14	$975,930	$218	$155,934	$35	**$1,131,864**	**$253**	$933,753	$253	$96,687	$26	$1,030,440	**$279**	*-9.0%*	*10.3%*
15 - 19	$1,642,999	$314	$641,876	$123	**$2,284,875**	**$436**	$1,576,299	$346	$252,536	$55	$1,828,835	**$401**	*-20.0%*	*-8.0%*
20 - 24	$1,291,273	$247	$522,167	$100	**$1,813,440**	**$347**	$1,729,134	$388	$723,174	$162	$2,452,308	**$550**	*35.2%*	*58.5%*
25 - 29	$567,203	$309	$285,001	$155	**$852,204**	**$464**	$519,289	$335	$209,132	$135	$728,421	**$470**	*-14.5%*	*1.2%*
30 - 34	$1,290,590	$535	$675,745	$280	**$1,966,335**	**$816**	$1,409,080	$672	$634,819	$303	$2,043,899	**$975**	*3.9%*	*19.6%*
35 - 39	$1,872,927	$528	$545,746	$154	**$2,418,673**	**$682**	$1,874,774	$675	$360,184	$130	$2,234,958	**$805**	*-7.6%*	*18.0%*
40 - 44	$2,095,410	$488	$1,927,250	$449	**$4,022,659**	**$938**	$1,823,127	$519	$1,659,819	$472	$3,482,946	**$991**	*-13.4%*	*5.6%*
45 - 49	$6,258,133	$1,417	$1,465,014	$332	**$7,723,147**	**$1,749**	$2,372,755	$602	$1,454,380	$369	$3,827,135	**$971**	*-50.4%*	*-44.5%*
50 - 54	$4,051,960	$684	$2,126,508	$359	**$6,178,468**	**$1,043**	$2,856,723	$599	$1,750,294	$367	$4,607,018	**$966**	*-25.4%*	*-7.4%*
55 - 59	$6,477,200	$938	$3,221,683	$466	**$9,698,882**	**$1,404**	$5,431,873	$857	$3,204,098	$506	$8,635,971	**$1,363**	*-11.0%*	*-2.9%*
60 - 64	$8,314,397	$1,162	$3,597,700	$503	**$11,912,098**	**$1,665**	$7,935,950	$1,304	$3,384,406	$556	$11,320,356	**$1,860**	*-5.0%*	*11.7%*
65+	$5,735,874	$1,312	$2,593,144	$593	**$8,329,018**	**$1,905**	$4,104,872	$937	$3,265,269	$746	$7,370,141	**$1,683**	*-11.5%*	*-11.7%*
Total	**$45,156,705**	**$728**	**$17,834,368**	**$287**	$62,991,072	$1,015	**$36,997,864**	**$695**	**$17,074,113**	**$321**	**$54,071,977**	$1,016	***-14.2%***	***0.0%***

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Financial Summary – YTD Trend

Total Plan & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	1,266	*121.4%*	2,804	*-12.8%*	2,446		
Spouses	248	*117.0%*	539	*-15.6%*	455		
Children	837	*118.3%*	1,827	*-16.0%*	1,534		
Tot. Members	**2,351**	***119.9%***	**5,170**	***-14.2%***	**4,435**		
Avg. Family Size	1.9	*-0.7%*	1.8	*-1.6%*	1.8	1.9	*-5.4%*
Financial Summary							
Allowed	$23,794,146	*115.3%*	$51,230,661	*-16.2%*	$42,930,276		
Plan Paid	$21,264,587	*112.4%*	$45,156,705	*-18.1%*	$36,997,864		
Member Paid (OOP)	$1,619,919	*144.2%*	$3,956,451	*-7.5%*	$3,660,944		
Paid PEPY	$16,792	*-4.1%*	$16,103	*-6.1%*	$15,127	$10,635	*42.2%*
Paid PMPY	$9,043	*-3.4%*	$8,734	*-4.5%*	$8,342	$5,546	*50.4%*
Paid PEPM	$1,399	*-4.1%*	$1,342	*-6.1%*	$1,261	$886	*42.2%*
Paid PMPM	$754	*-3.4%*	$728	*-4.5%*	$695	$462	*50.4%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	62	*-4.8%*	59	*-20.3%*	47		
HCCs per 1000	26.4	*-56.7%*	11.4	*-7.1%*	10.6	7.3	*44.4%*
Paid per HCC	$268,731	*7.9%*	$289,942	*-10.5%*	$259,607	$229,219	*13.3%*
HCC Paid % of Tot	78.4%	*-40.5 pts*	37.9%	*-4.9 pts*	33.0%	31.4%	*1.6 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$3,372	*-17.3%*	$2,789	*-26.8%*	$2,041	$1,333	*53.1%*
Outpatient	$2,218	*10.7%*	$2,455	*0.5%*	$2,468	$1,604	*53.8%*
Physician	$3,357	*1.2%*	$3,396	*9.5%*	$3,720	$2,506	*48.4%*
Ancillary	$95	*-1.3%*	$94	*19.7%*	$113	$102	*10.6%*

- *With $29.7M paid, the State Active population is 80.2% of total 2026-4Q med spend*
- *On a Paid PMPM basis, State Actives are down 8.4% compared to prior year*
- *Total EPO Plan Paid PMPM trend is -4.5%*

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.

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Financial Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Average Enrollment										
Employees	1,045	*119.1%*	2,291	*-14.4%*	1,962	1	*80.0%*	2	*38.9%*	2
Spouses	211	*116.3%*	457	*-17.3%*	378	0	-	0	-	0
Children	777	*117.9%*	1,694	*-16.5%*	1,414	0	-	0	-	0
Tot. Members	**2,034**	***118.4%***	**4,442**	***-15.5%***	**3,754**	**1**	***80.0%***	**2**	***38.9%***	**2**
Avg. Family Size	1.9	*-0.4%*	1.9	*-1.3%*	1.9	1.0	*0.0%*	1.0	*0.0%*	1.0
Financial Summary										
Allowed	$20,352,857	*106.4%*	$42,008,318	*-21.9%*	$32,814,972	$1,603	*250.4%*	$5,618	*-6.5%*	$5,256
Plan Paid	$18,846,945	*103.3%*	$38,309,548	*-22.6%*	$29,660,623	$1,265	*244.1%*	$4,354	*4.3%*	$4,541
Member Paid (OOP)	$1,346,491	*138.0%*	$3,203,983	*-10.3%*	$2,872,879	$338	*274.0%*	$1,264	*-43.5%*	$715
Paid PEPY	$18,031	*-7.2%*	$16,724	*-9.6%*	$15,120	$1,518	*91.2%*	$2,903	*-24.9%*	$2,180
Paid PMPY	$9,265	*-6.9%*	$8,625	*-8.4%*	$7,901	$1,518	*91.2%*	$2,903	*-24.9%*	$2,180
Paid PEPM	$1,503	*-7.2%*	$1,394	*-9.6%*	$1,260	$127	*91.2%*	$242	*-24.9%*	$182
Paid PMPM	$772	*-6.9%*	$719	*-8.4%*	$658	$127	*91.2%*	$242	*-24.9%*	$182
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	54	*-11.1%*	48	*-25.0%*	36	0	-	0	-	0
HCCs per 1000	26.5	*-59.3%*	10.8	*-11.3%*	9.6	0.0	-	0.0	-	0.0
Paid per HCC	$278,222	*10.8%*	$308,200	*-16.6%*	$257,038	$0	-	$0	-	$0
HCC Paid % of Tot	79.7%	*-41.1 pts*	38.6%	*-7.4 pts*	31.2%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$3,774	*-23.2%*	$2,899	*-34.9%*	$1,888	$0	-	$0	-	$0
Outpatient	$2,062	*12.4%*	$2,317	*3.4%*	$2,396	$0	-	$0	-	$0
Physician	$3,342	*-0.7%*	$3,318	*6.0%*	$3,516	$1,229	*104.6%*	$2,516	*-25.2%*	$1,882
Ancillary	$87	*4.1%*	$90	*12.3%*	$101	$289	*33.9%*	$387	*-23.2%*	$297

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Financial Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Average Enrollment										
Employees	201	*133.0%*	468	*-6.2%*	439	19	*127.2%*	44	*-2.7%*	43
Spouses	33	*122.9%*	74	*-5.8%*	70	4	*104.4%*	8	*-10.9%*	7
Children	55	*127.5%*	124	*-9.0%*	113	5	*81.8%*	8	*-11.0%*	7
Tot. Members	**289**	***130.8%***	**667**	***-6.7%***	**622**	**28**	***116.6%***	**60**	***-4.9%***	**57**
Avg. Family Size	1.4	*-0.9%*	1.4	*-0.5%*	1.4	1.4	*-4.7%*	1.4	*-2.3%*	1.3
Financial Summary										
Allowed	$3,115,537	*179.4%*	$8,705,026	*-2.2%*	$8,509,892	$324,150	*57.9%*	$511,699	*212.7%*	$1,600,156
Plan Paid	$2,220,423	*196.7%*	$6,587,906	*-1.6%*	$6,480,548	$195,955	*30.1%*	$254,897	*234.3%*	$852,153
Member Paid (OOP)	$243,460	*183.3%*	$689,806	*1.1%*	$697,628	$29,630	*107.2%*	$61,398	*46.1%*	$89,721
Paid PEPY	$11,053	*27.3%*	$14,073	*4.8%*	$14,754	$10,136	*-42.7%*	$5,804	*243.4%*	$19,933
Paid PMPY	$7,688	*28.5%*	$9,882	*5.4%*	$10,414	$7,083	*-39.9%*	$4,254	*251.4%*	$14,950
Paid PEPM	$921	*27.3%*	$1,173	*4.8%*	$1,230	$845	*-42.7%*	$484	*243.4%*	$1,661
Paid PMPM	$641	*28.5%*	$823	*5.4%*	$868	$590	*-39.9%*	$355	*251.4%*	$1,246
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	7	*57.1%*	11	*-9.1%*	10	1	*-100.0%*	0	-	1
HCCs per 1000	24.2	*-31.9%*	16.5	*-2.6%*	16.1	36.1	*-100.0%*	0.0	-	17.5
Paid per HCC	$201,561	*2.5%*	$206,510	*12.9%*	$233,228	$132,680	*-100.0%*	$0	-	$604,761
HCC Paid % of Tot	*63.5%*	*-29.1 pts*	*34.5%*	*1.5 pts*	*36.0%*	*67.7%*	*-67.7 pts*	*0.0%*	-	*71.0%*
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$734	*201.8%*	$2,216	*3.6%*	$2,296	$1,449	*-23.2%*	$1,113	*743.2%*	$9,382
Outpatient	$3,137	*10.2%*	$3,459	*-16.8%*	$2,877	$4,165	*-62.6%*	$1,556	*81.9%*	$2,830
Physician	$3,678	*10.8%*	$4,077	*24.0%*	$5,056	$1,175	*36.4%*	$1,603	*66.3%*	$2,665
Ancillary	$138	*-5.6%*	$130	*42.2%*	$185	$293	*-105.9%*	-$17	*-518.6%*	$73

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Financial Summary – Full Year Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024	⇨	2025	⇨	2026-4Q	2026-4Q	*Variance*
Average Enrollment							
Employees	1,266	*121.4%*	2,804	*-12.8%*	2,446		
Spouses	248	*117.0%*	539	*-15.6%*	455		
Children	837	*118.3%*	1,827	*-16.0%*	1,534		
Tot. Members	**2,351**	***119.9%***	**5,170**	***-14.2%***	**4,435**		
Avg. Family Size	1.9	*-0.7%*	1.8	*-1.6%*	1.8	1.9	*-5.4%*
Financial Summary							
Allowed	$23,794,146	*115.3%*	$51,230,661	*-16.2%*	$42,930,276		
Plan Paid	$21,264,587	*112.4%*	$45,156,705	*-18.1%*	$36,997,864		
Member Paid (OOP)	$1,619,919	*144.2%*	$3,956,451	*-7.5%*	$3,660,944		
Paid PEPY	$16,792	*-4.1%*	$16,103	*-6.1%*	$15,127	$10,635	*42.2%*
Paid PMPY	$9,043	*-3.4%*	$8,734	*-4.5%*	$8,342	$5,546	*50.4%*
Paid PEPM	$1,399	*-4.1%*	$1,342	*-6.1%*	$1,261	$886	*42.2%*
Paid PMPM	$754	*-3.4%*	$728	*-4.5%*	$695	$462	*50.4%*
High-Cost Claimants (Med Paid $100,000+)							
# of HCCs	62	*-4.8%*	59	*-20.3%*	47		
HCCs per 1000	26.4	*-56.7%*	11.4	*-7.1%*	10.6	7.3	*44.4%*
Paid per HCC	$268,731	*7.9%*	$289,942	*-10.5%*	$259,607	$229,219	*13.3%*
HCC Paid % of Tot	78.4%	*-40.5 pts*	37.9%	*-4.9 pts*	33.0%	31.4%	*1.6 pts*
Cost Distribution by Claim Type (Paid PMPY)							
Inpatient	$3,372	*-17.3%*	$2,789	*-26.8%*	$2,041	$1,333	*53.1%*
Outpatient	$2,218	*10.7%*	$2,455	*0.5%*	$2,468	$1,604	*53.8%*
Physician	$3,357	*1.2%*	$3,396	*9.5%*	$3,720	$2,506	*48.4%*
Ancillary	$95	*-1.3%*	$94	*19.7%*	$113	$102	*10.6%*

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.

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Financial Summary – Full Year Trend

Active Members

Measure	State Active					Non-State Active				
	2024	⇨	2025	⇨	2026-4Q	2024	⇨	2025	⇨	2026-4Q
Average Enrollment										
Employees	1,045	*119.1%*	2,291	*-14.4%*	1,962	1	*80.0%*	2	*38.9%*	2
Spouses	211	*116.3%*	457	*-17.3%*	378	0	-	0	-	0
Children	777	*117.9%*	1,694	*-16.5%*	1,414	0	-	0	-	0
Tot. Members	**2,034**	***118.4%***	**4,442**	***-15.5%***	**3,754**	**1**	***80.0%***	**2**	***38.9%***	**2**
Avg. Family Size	1.9	*-0.4%*	1.9	*-1.3%*	1.9	1.0	*0.0%*	1.0	*0.0%*	1.0
Financial Summary										
Allowed	$20,352,857	*106.4%*	$42,008,318	*-21.9%*	$32,814,972	$1,603	*250.4%*	$5,618	*-6.5%*	$5,256
Plan Paid	$18,846,945	*103.3%*	$38,309,548	*-22.6%*	$29,660,623	$1,265	*244.1%*	$4,354	*4.3%*	$4,541
Member Paid (OOP)	$1,346,491	*138.0%*	$3,203,983	*-10.3%*	$2,872,879	$338	*274.0%*	$1,264	*-43.5%*	$715
Paid PEPY	$18,031	*-7.2%*	$16,724	*-9.6%*	$15,120	$1,518	*91.2%*	$2,903	*-24.9%*	$2,180
Paid PMPY	$9,265	*-6.9%*	$8,625	*-8.4%*	$7,901	$1,518	*91.2%*	$2,903	*-24.9%*	$2,180
Paid PEPM	$1,503	*-7.2%*	$1,394	*-9.6%*	$1,260	$127	*91.2%*	$242	*-24.9%*	$182
Paid PMPM	$772	*-6.9%*	$719	*-8.4%*	$658	$127	*91.2%*	$242	*-24.9%*	$182
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	54	*-11.1%*	48	*-25.0%*	36	0	-	0	-	0
HCCs per 1000	26.5	*-59.3%*	10.8	*-11.3%*	9.6	0.0	-	0.0	-	0.0
Paid per HCC	$278,222	*10.8%*	$308,200	*-16.6%*	$257,038	$0	-	$0	-	$0
HCC Paid % of Tot	79.7%	*-41.1 pts*	38.6%	*-7.4 pts*	31.2%	0.0%	-	0.0%	-	0.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$3,774	*-23.2%*	$2,899	*-34.9%*	$1,888	$0	-	$0	-	$0
Outpatient	$2,062	*12.4%*	$2,317	*3.4%*	$2,396	$0	-	$0	-	$0
Physician	$3,342	*-0.7%*	$3,318	*6.0%*	$3,516	$1,229	*104.6%*	$2,516	*-25.2%*	$1,882
Ancillary	$87	*4.1%*	$90	*12.3%*	$101	$289	*33.9%*	$387	*-23.2%*	$297

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Financial Summary – Full Year Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024	⇨	2025	⇨	2026-4Q	2024	⇨	2025	⇨	2026-4Q
Average Enrollment										
Employees	201	*133.0%*	468	*-6.2%*	439	19	*127.2%*	44	*-2.7%*	43
Spouses	33	*122.9%*	74	*-5.8%*	70	4	*104.4%*	8	*-10.9%*	7
Children	55	*127.5%*	124	*-9.0%*	113	5	*81.8%*	8	*-11.0%*	7
Tot. Members	**289**	***130.8%***	**667**	***-6.7%***	**622**	**28**	***116.6%***	**60**	***-4.9%***	**57**
Avg. Family Size	1.4	*-0.9%*	1.4	*-0.5%*	1.4	1.4	*-4.7%*	1.4	*-2.3%*	1.3
Financial Summary										
Allowed	$3,115,537	*179.4%*	$8,705,026	*-2.2%*	$8,509,892	$324,150	*57.9%*	$511,699	*212.7%*	$1,600,156
Plan Paid	$2,220,423	*196.7%*	$6,587,906	*-1.6%*	$6,480,548	$195,955	*30.1%*	$254,897	*234.3%*	$852,153
Member Paid (OOP)	$243,460	*183.3%*	$689,806	*1.1%*	$697,628	$29,630	*107.2%*	$61,398	*46.1%*	$89,721
Paid PEPY	$11,053	*27.3%*	$14,073	*4.8%*	$14,754	$10,136	*-42.7%*	$5,804	*243.4%*	$19,933
Paid PMPY	$7,688	*28.5%*	$9,882	*5.4%*	$10,414	$7,083	*-39.9%*	$4,254	*251.4%*	$14,950
Paid PEPM	$921	*27.3%*	$1,173	*4.8%*	$1,230	$845	*-42.7%*	$484	*243.4%*	$1,661
Paid PMPM	$641	*28.5%*	$823	*5.4%*	$868	$590	*-39.9%*	$355	*251.4%*	$1,246
High-Cost Claimants (Med Paid $100,000+)										
# of HCCs	7	*57.1%*	11	*-9.1%*	10	1	*-100.0%*	0	-	1
HCCs per 1000	24.2	*-31.9%*	16.5	*-2.6%*	16.1	36.1	*-100.0%*	0.0	-	17.5
Paid per HCC	$201,561	*2.5%*	$206,510	*12.9%*	$233,228	$132,680	*-100.0%*	$0	-	$604,761
HCC Paid % of Tot	63.5%	*-29.1 pts*	34.5%	*1.5 pts*	36.0%	67.7%	*-67.7 pts*	0.0%	-	71.0%
Cost Distribution by Claim Type (Paid PMPY)										
Inpatient	$734	*201.8%*	$2,216	*3.6%*	$2,296	$1,449	*-23.2%*	$1,113	*743.2%*	$9,382
Outpatient	$3,137	*10.2%*	$3,459	*-16.8%*	$2,877	$4,165	*-62.6%*	$1,556	*81.9%*	$2,830
Physician	$3,678	*10.8%*	$4,077	*24.0%*	$5,056	$1,175	*36.4%*	$1,603	*66.3%*	$2,665
Ancillary	$138	*-5.6%*	$130	*42.2%*	$185	$293	*-105.9%*	-$17	*-518.6%*	$73

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Medical Paid Claims by Claim Type

Breakout of State vs. Non-State by Member Status

Claim Type	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2026-4Q (7/1/2025 - 6/30/2026) Active	Pre-Medicare Retirees	Medicare Retirees	Total	*Trend* *Total*
State Members									
Inpatient	$12,877,660	$1,199,662	$277,347	**$14,354,669**	$7,087,485	$893,349	$535,209	**$8,516,043**	*-40.7%*
Outpatient	$10,292,163	$2,141,444	$164,429	**$12,598,036**	$8,995,224	$1,604,559	$185,836	**$10,785,619**	*-14.4%*
Physician	$14,739,517	$2,455,428	$262,748	**$17,457,693**	$13,198,041	$2,704,839	$441,513	**$16,344,393**	*-6.4%*
Ancillary	$400,208	$65,942	$20,906	**$487,055**	$379,873	$103,469	$11,773	**$495,115**	*1.7%*
Total	**$38,309,548**	**$5,862,477**	**$725,429**	**$44,897,454**	**$29,660,623**	**$5,306,217**	**$1,174,331**	**$36,141,170**	***-19.5%***
PMPM	**$718.72**	**$882.14**	**$535.67**	**$732.39**	**$658.43**	**$875.41**	**$835.03**	**$688.20**	***-6.0%***
Non-State Members									
Inpatient	$0	$60,333	$6,337	**$66,670**	$0	$443,749	$91,028	**$534,776**	*702.1%*
Outpatient	$0	$4,108	$89,129	**$93,237**	$0	$104,890	$56,420	**$161,309**	*73.0%*
Physician	$3,773	$19,203	$76,830	**$99,806**	$3,921	$81,524	$70,389	**$155,835**	*56.1%*
Ancillary	$581	$0	-$1,043	**-$462**	$620	$100	$4,054	**$4,773**	*-1132.8%*
Total	**$4,354**	**$83,643**	**$171,253**	**$259,251**	**$4,541**	**$630,263**	**$221,890**	**$856,694**	***230.4%***
PMPM	**$241.90**	**$1,394.05**	**$259.87**	**$351.76**	**$181.64**	**$10,504.38**	**$355.59**	**$1,208.31**	***243.5%***
All Members									
Inpatient	$12,877,660	$1,259,995	$283,684	**$14,421,339**	$7,087,485	$1,337,098	$626,236	**$9,050,819**	*-37.2%*
Outpatient	$10,292,163	$2,145,552	$253,558	**$12,691,274**	$8,995,224	$1,709,449	$242,255	**$10,946,929**	*-13.7%*
Physician	$14,743,290	$2,474,631	$339,578	**$17,557,499**	$13,201,962	$2,786,363	$511,902	**$16,500,228**	*-6.0%*
Ancillary	$400,788	$65,942	$19,863	**$486,593**	$380,492	$103,569	$15,827	**$499,888**	*2.7%*
Total	**$38,313,903**	**$5,946,120**	**$896,682**	**$45,156,705**	**$29,665,164**	**$5,936,479**	**$1,396,221**	**$36,997,864**	***-18.1%***
PMPM	**$718.56**	**$886.72**	**$445.39**	**$727.87**	**$658.17**	**$969.79**	**$687.68**	**$695.13**	***-4.5%***

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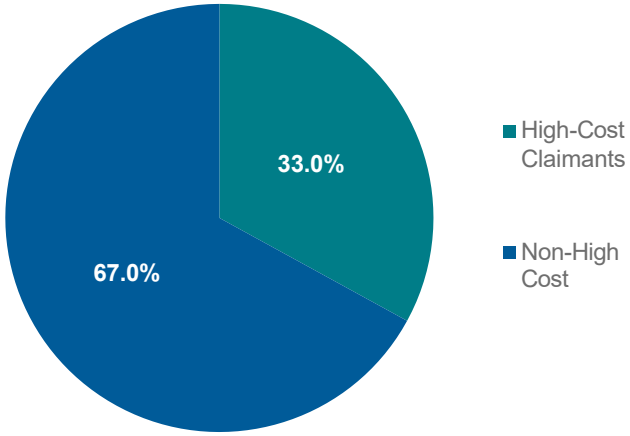
Medical Cost Distribution

Distribution by Member Cost

Member Total Paid Range	2025-4Q (7/1/2024 - 6/30/2025)						2026-4Q (7/1/2025 - 6/30/2026)					
	*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	510	8.6%	$0	0.0%	$0	0.0%	425	8.2%	$0	0.0%	$0	0.0%
< $0 - $0	189	3.2%	-$95,218	-0.2%	$6,017	0.2%	207	4.0%	-$218,141	-0.6%	$3,687	0.1%
> $0 - $2,500	3,153	53.4%	$2,654,130	5.9%	$745,717	18.8%	2,648	51.0%	$2,275,508	6.2%	$624,070	17.0%
> $2,500 - $5,000	745	12.6%	$2,657,120	5.9%	$612,651	15.5%	698	13.4%	$2,550,266	6.9%	$578,828	15.8%
> $5,000 - $10,000	556	9.4%	$3,841,377	8.5%	$762,798	19.3%	545	10.5%	$3,809,064	10.3%	$745,980	20.4%
> $10,000 - $25,000	411	7.0%	$6,416,535	14.2%	$823,391	20.8%	414	8.0%	$6,684,713	18.1%	$892,602	24.4%
> $25,000 - $50,000	197	3.3%	$6,759,361	15.0%	$523,866	13.2%	137	2.6%	$4,819,972	13.0%	$386,070	10.5%
> $50,000 - $100,000	84	1.4%	$5,816,835	12.9%	$269,061	6.8%	69	1.3%	$4,874,968	13.2%	$239,605	6.5%
> $100,000	59	1.0%	$17,106,564	37.9%	$212,950	5.4%	47	0.9%	$12,201,515	33.0%	$190,101	5.2%
Total	**5,904**	**100.0%**	**$45,156,705**	**100.0%**	**$3,956,451**	**100.0%**	**5,190**	**100.0%**	**$36,997,864**	**100.0%**	**$3,660,944**	**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	Circulatory System	31	$3,161,873	25.9%
2	Neoplasms	20	$2,034,111	16.7%
3	Injury, Poisoning & External Causes	24	$1,638,899	13.4%
4	Health Status & Health Services	40	$1,128,024	9.2%
5	Musculoskeletal System	27	$781,461	6.4%
6	Perinatal Originating Conditions	4	$599,621	4.9%
7	Respiratory System	22	$429,402	3.5%
8	Digestive System	18	$403,103	3.3%
9	Endocrine, Nutritional & Metabolic	25	$372,867	3.1%
10	Mental, Behavioral & Neurodevelopmental	13	$305,571	2.5%
...	*All Others*		*$1,346,583*	*11.0%*
=	**Total**	**47**	**$12,201,515**	**100.0%**

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Utilization Summary – YTD Trend

Plan Totals & Norm

Measure	Total Plan					UMR Norm	
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2026-4Q	*Variance*
Inpatient Admissions							
# of Admits	352	*-8.8%*	321	*-30.2%*	224		
# of Admit Days	1,948	*0.6%*	1,959	*-38.7%*	1,201		
Paid per Admit	$42,917	*-11.9%*	$37,811	*15.9%*	$43,822	$29,627	*47.9%*
Paid per Admit Day	$7,755	*-20.1%*	$6,196	*31.9%*	$8,173	$5,928	*37.9%*
Admits per 1000	149.7	*-58.5%*	62.1	*-18.7%*	50.5	47.3	*6.7%*
Average LOS	5.5	*10.3%*	6.1	*-12.1%*	5.4	5.0	*7.3%*
Emergency Room Visits							
# of ER Visits	1,387	*-13.2%*	1,204	*-5.5%*	1,138		
~ % resulting in Admit	14.7%	*1.4 pts*	16.1%	*-4.4 pts*	11.7%	10.9%	*0.8 pts*
ER Visits per Patient	1.5	*-4.5%*	1.4	*2.0%*	1.5		
ER Visits per 1000	589.8	*-60.5%*	232.9	*10.2%*	256.6	220.9	*16.2%*
Paid per ER Visit	$3,016	*12.4%*	$3,391	*2.1%*	$3,464	$2,466	*40.5%*
Urgent Care Visits							
# of UC Visits	2,749	*-2.1%*	2,692	*-22.7%*	2,081		
UC Visits per Patient	1.7	*3.9%*	1.7	*-4.7%*	1.6		-
UC Visits per 1000	1,169.1	*-55.5%*	520.7	*-9.9%*	469.2	247.9	*89.3%*
Paid per UC Visit	$129	*4.4%*	$134	*4.8%*	$141	$119	*18.1%*
Office Visits							
Off Visits per Patient	5.9	*3.9%*	6.1	*1.7%*	6.2		
Paid per Office Visit	$114	*3.9%*	$118	*7.6%*	$127	$98	*29.2%*
Office Visits Paid PMPY	$1,488	*-56.0%*	$654	*11.7%*	$730	$386	*89.2%*
Services							
Radiology Svcs per 1000	8,194.1	*-53.5%*	3,811.7	*-0.5%*	3,793.4	3,595.1	*5.5%*
Radiology Paid PMPY	$1,376	*-55.1%*	$618	*-2.4%*	$603		
Lab Services per 1000	26,054.9	*-56.2%*	11,417.2	*8.6%*	12,395.4	9,957.4	*24.5%*
Labs Paid PMPY	$567	*-48.8%*	$290	*-8.6%*	$265		

- *Inpatient Admission rate per 1000 decreased significantly (–18.7%), but amount paid per Admission is significantly (+15.9%) higher than prior period*
- *ER utilization increased 10.2%, and amount paid per ER visit is 2.1% 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.

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Utilization Summary – YTD Trend

Active Members

Measure	State Active					Non-State Active				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Inpatient Admissions										
# of Admits	301	*-17.3%*	249	*-32.5%*	168	0	-	0	-	0
# of Admit Days	1,708	*-9.3%*	1,550	*-41.0%*	915	0	-	0	-	0
Paid per Admit	$46,084	*-10.8%*	$41,100	*12.3%*	$46,169	$0	-	$0	-	$0
Paid per Admit Day	$8,121	*-18.7%*	$6,602	*28.4%*	$8,477	$0	-	$0	-	$0
Admits per 1000	148.0	*-62.1%*	56.1	*-20.2%*	44.8	0.0	-	0.0	-	0.0
Average LOS	5.7	*9.7%*	6.2	*-12.5%*	5.4	0.0	-	0.0	-	0.0
Emergency Room Visits										
# of ER Visits	1,189	*-17.3%*	983	*-7.7%*	907	0	-	1	*-100.0%*	0
~ % resulting in Admit	13.7%	*-0.7 pts*	13.0%	*-2.3 pts*	10.7%	0.0%	-	0.0%	*0.0 pts*	0.0%
ER Visits per Patient	1.5	*-4.1%*	1.4	*3.7%*	1.5	0.0	-	1.0	*-100.0%*	0.0
ER Visits per 1000	584.5	*-62.1%*	221.3	*9.2%*	241.6	0.0	-	666.7	*-100.0%*	0.0
Paid per ER Visit	$3,055	*14.6%*	$3,502	*4.6%*	$3,663	$0	-	$369	*-100.0%*	$0
Urgent Care Visits										
# of UC Visits	2,478	*-3.7%*	2,386	*-22.3%*	1,854	0	-	0	-	0
UC Visits per Patient	1.7	*3.3%*	1.7	*-3.6%*	1.7	0.0	-	0.0	-	0.0
UC Visits per 1000	1,218.2	*-55.9%*	537.2	*-8.1%*	493.9	0.0	-	0.0	-	0.0
Paid per UC Visit	$131	*3.8%*	$136	*5.0%*	$143	$0	-	$0	-	$0
Office Visits										
Off Visits per Patient	5.6	*3.1%*	5.8	*2.2%*	5.9	11.0	*-27.3%*	8.0	*-31.3%*	5.5
Paid per Office Visit	$117	*4.6%*	$123	*7.5%*	$132	$129	*15.6%*	$149	*51.8%*	$227
Office Visits Paid PMPY	$1,463	*-56.3%*	$639	*12.6%*	$720	$1,704	*-53.3%*	$796	*50.3%*	$1,196
Services										
Radiology Svcs per 1000	7,803.8	*-55.1%*	3,503.3	*1.7%*	3,561.3	4,800.0	*-44.4%*	2,666.7	*-28.0%*	1,920.0
Radiology Paid PMPY	$1,338	*-55.4%*	$597	*-3.5%*	$576	$386	*-35.0%*	$251	*-22.6%*	$194
Lab Services per 1000	25,033.4	*-56.6%*	10,872.9	*8.1%*	11,751.1	33,600.0	*-60.3%*	13,333.3	*-31.6%*	9,120.0
Labs Paid PMPY	$561	*-49.2%*	$285	*-8.0%*	$262	$735	*-42.8%*	$421	*-39.5%*	$254

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Utilization Summary – YTD Trend

Retired Members

Measure	State Retirees					Non-State Retirees				
	2024-4Q	⇨	2025-4Q	⇨	2026-4Q	2024-4Q	⇨	2025-4Q	⇨	2026-4Q
Inpatient Admissions										
# of Admits	43	*58.1%*	68	*-26.5%*	50	8	*-50.0%*	4	*50.0%*	6
# of Admit Days	221	*78.3%*	394	*-35.8%*	253	19	*-21.1%*	15	*120.0%*	33
Paid per Admit	$24,353	*9.9%*	$26,753	*15.2%*	$30,832	$23,557	*-10.7%*	$21,041	*310.3%*	$86,330
Paid per Admit Day	$4,738	*-2.6%*	$4,617	*32.0%*	$6,093	$9,919	*-43.4%*	$5,611	*179.7%*	$15,696
Admits per 1000	148.9	*-31.5%*	102.0	*-21.2%*	80.3	289.2	*-76.9%*	66.8	*57.7%*	105.3
Average LOS	5.1	*12.7%*	5.8	*-12.7%*	5.1	2.4	*57.9%*	3.8	*46.7%*	5.5
Emergency Room Visits										
# of ER Visits	185	*8.1%*	200	*2.5%*	205	13	*53.8%*	20	*30.0%*	26
~ % resulting in Admit	18.4%	*12.6 pts*	31.0%	*-15.4 pts*	15.6%	53.8%	*-33.8 pts*	20.0%	*-4.6 pts*	15.4%
ER Visits per Patient	1.8	*-11.3%*	1.6	*-7.6%*	1.4	1.3	*9.9%*	1.4	*13.8%*	1.6
ER Visits per 1000	640.5	*-53.2%*	300.0	*9.8%*	329.4	469.9	*-29.0%*	333.8	*36.7%*	456.1
Paid per ER Visit	$2,812	*10.2%*	$3,098	*-7.8%*	$2,857	$2,329	*-55.9%*	$1,028	*24.9%*	$1,284
Urgent Care Visits										
# of UC Visits	245	*17.6%*	288	*-28.5%*	206	26	*-30.8%*	18	*16.7%*	21
UC Visits per Patient	1.5	*8.0%*	1.7	*-12.2%*	1.5	1.6	*10.8%*	1.8	*-31.4%*	1.2
UC Visits per 1000	848.2	*-49.1%*	432.0	*-23.4%*	331.0	939.8	*-68.0%*	300.4	*22.6%*	368.4
Paid per UC Visit	$114	*11.6%*	$127	*5.0%*	$134	$50	*-28.3%*	$36	*9.1%*	$39
Office Visits										
Off Visits per Patient	7.2	*7.8%*	7.8	*-6.5%*	7.3	7.2	*7.4%*	7.8	*21.8%*	9.4
Paid per Office Visit	$101	*1.6%*	$102	*10.0%*	$113	$47	*7.9%*	$50	*8.5%*	$55
Office Visits Paid PMPY	$1,729	*-55.1%*	$776	*5.1%*	$816	$781	*-53.2%*	$366	*29.1%*	$472
Services										
Radiology Svcs per 1000	10,871.3	*-47.5%*	5,712.0	*-14.6%*	4,877.0	9,036.1	*-38.5%*	5,557.7	*31.6%*	7,315.8
Radiology Paid PMPY	$1,754	*-55.5%*	$781	*-1.2%*	$772	$298	*24.9%*	$373	*44.7%*	$539
Lab Services per 1000	33,406.7	*-53.9%*	15,388.5	*4.1%*	16,024.1	24,180.7	*-68.9%*	7,527.1	*103.7%*	15,333.3
Labs Paid PMPY	$623	*-45.8%*	$338	*-11.9%*	$297	$440	*-66.7%*	$146	*-29.2%*	$104

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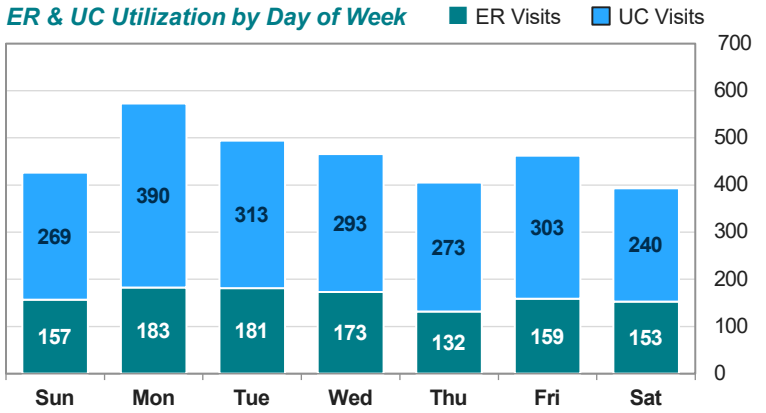
On Demand Care Summary

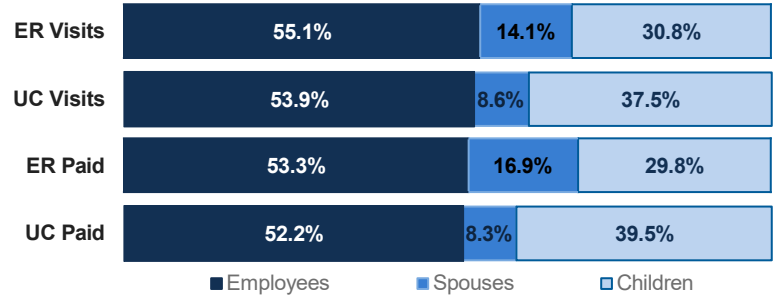
Emergency Room & Urgent Care

Measure	2025-4Q	2026-4Q	Change	UMR Norm	Variance
Emergency Room					
# of Visits	1,204	1,138	*-5.5%*		
# of Patients	841	779	*-7.4%*		
Total Plan Paid	$4,082,842	$3,941,773	*-3.5%*		
Total Mem Paid	$570,269	$561,452	*-1.5%*		
Visits per 1000	232.9	256.6	*10.2%*	220.9	*16.2%*
Paid per Visit	$3,391	$3,464	*2.1%*	$2,466	*40.5%*
Paid PMPM	$66	$74	*12.5%*	$45	*63.2%*
% ER Patients w/ Office Visit*	95.7%	96.4%	*0.7 pts*		
% Potentially Avoidable**	12.8%	13.4%	*0.6 pts*	82.3%	*-68.9 pts*
Urgent Care					
# of Visits	2,692	2,081	*-22.7%*		
# of Patients	1,560	1,266	*-18.8%*		
Total Plan Paid	$361,901	$293,276	*-19.0%*		
Total Mem Paid	$121,454	$96,142	*-20.8%*		
Visits per 1000	520.7	469.2	*-9.9%*	247.9	*89.3%*
Paid per Visit	$134	$141	*4.8%*	$119	*18.1%*
Paid PMPM	$6	$6	*-5.5%*	$2	*123.6%*

ER & UC Utilization by Day of Week



ER & UC Utilization & Cost by Relationship



	# of Visits			Total Paid		
	ER	UC	**Total**	ER	UC	Total
Employee	627	1,121	**1,748**	$2,100,526	$153,141	**$2,253,667**
Spouse	161	179	**340**	$666,986	$24,402	**$691,389**
Child	350	781	**1,131**	$1,174,261	$115,733	**$1,289,993**
Total	**1,138**	**2,081**	**3,219**	**$3,941,773**	**$293,276**	**$4,235,049**

* 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.

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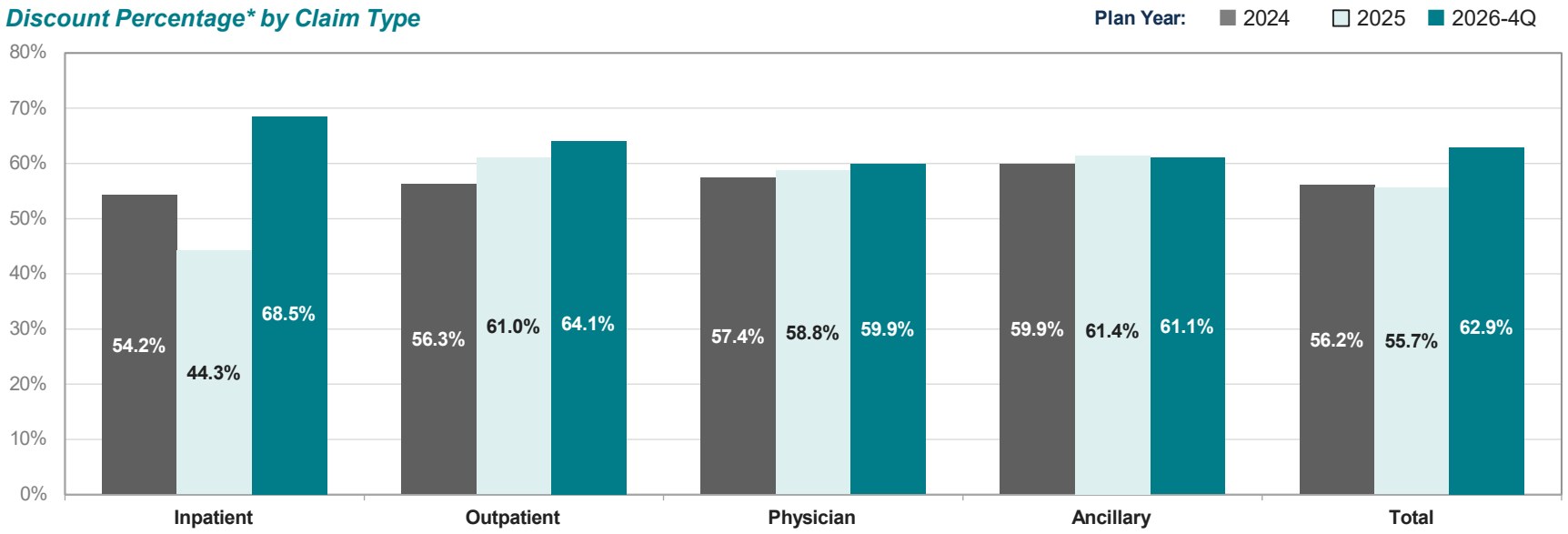
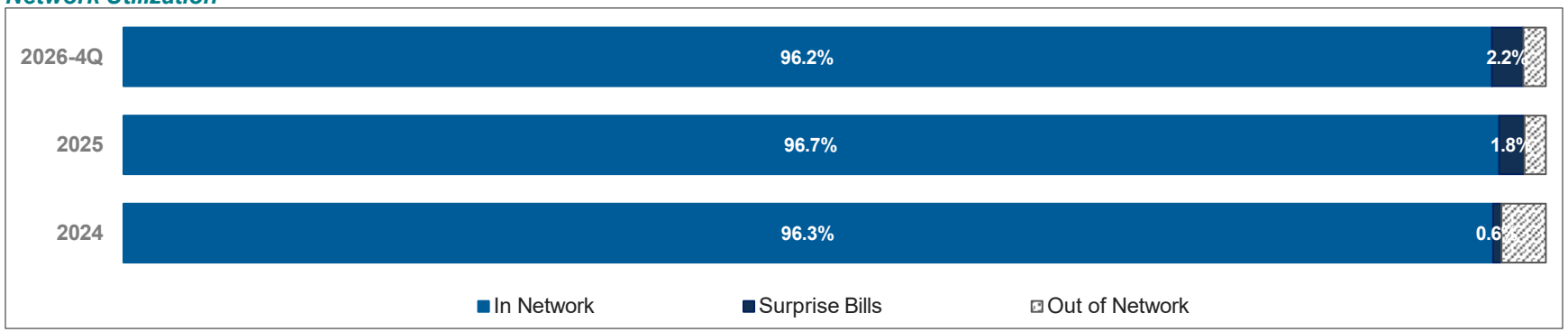
Network Summary

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.

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Clinical Classification Summary

Breakout by Diagnostic Chapter

Diagnostic Chapter	2025 (Full Year)		2026-4Q		CYTD Paid by Relationship			CYTD Paid by Sex	
	Patients	Total Paid	Patients	Total Paid	Employee	Spouse	Child	Male	Female
Circulatory System	1,057	$4,561,417	931	$5,188,621	$2,214,042	$848,856	$2,125,723	$3,698,453	$1,490,168
Musculoskeletal System	1,916	$5,111,750	1,689	$4,518,606	$3,318,133	$930,488	$269,985	$1,785,802	$2,732,805
Health Status & Health Services	3,709	$3,578,036	3,223	$3,291,946	$2,148,394	$595,026	$548,526	$1,291,833	$2,000,113
Injury, Poisoning & External Causes	954	$3,217,301	851	$3,242,468	$1,954,753	$424,098	$863,617	$1,902,292	$1,340,176
Neoplasms	948	$5,069,259	790	$3,180,063	$2,373,065	$632,012	$174,985	$847,172	$2,332,891
Mental, Behavioral & Neurodevelopmental	1,305	$2,232,030	1,175	$2,337,994	$959,807	$181,770	$1,196,416	$854,799	$1,483,194
Symptoms, Signs & Findings, NEC	2,460	$2,751,576	2,111	$2,073,887	$1,270,272	$349,036	$454,579	$738,131	$1,335,757
Digestive System	839	$3,833,453	720	$2,037,726	$1,549,518	$257,025	$231,183	$894,237	$1,143,489
Nervous System	1,081	$1,684,188	990	$1,872,456	$1,174,747	$295,781	$401,928	$669,511	$1,202,945
Respiratory System	1,683	$1,989,295	1,365	$1,713,210	$842,676	$171,795	$698,738	$1,070,875	$642,335
Genitourinary System	1,125	$2,141,134	998	$1,675,274	$1,166,883	$301,624	$206,767	$548,293	$1,126,981
Endocrine, Nutritional & Metabolic	1,718	$1,519,332	1,547	$1,600,643	$1,190,483	$268,766	$141,394	$840,511	$760,132
Pregnancy, Childbirth & the Puerperium	100	$1,125,245	101	$1,174,362	$853,061	$148,444	$172,857	$7	$1,174,355
Perinatal Originating Conditions	60	$3,326,874	50	$746,311	$524	$0	$745,786	$553,104	$193,206
Eye and Adnexa	1,537	$443,366	1,376	$625,082	$405,312	$61,077	$158,693	$269,194	$355,887
Infectious & Parasitic Diseases	496	$868,889	344	$583,666	$375,110	$171,895	$36,661	$194,431	$389,236
Skin & Subcutaneous Tissue	1,389	$471,294	1,279	$492,626	$347,805	$48,233	$96,588	$232,310	$260,316
Ear and Mastoid Process	513	$468,197	440	$253,415	$128,915	$37,706	$86,793	$112,185	$141,230
Congenital Malformations & Abnormalities	97	$259,127	93	$199,281	$66,167	$543	$132,571	$129,774	$69,507
Blood & Immune Disorders	216	$504,817	204	$190,227	$141,528	$13,610	$35,089	$42,629	$147,598
External Causes of Morbidity	1	$124	1	$0	$0	$0	$0	$0	$0
Total	**5,279**	**$45,156,705**	**4,622**	**$36,997,864**	**$22,481,196**	**$5,737,787**	**$8,778,881**	**$16,675,543**	**$20,322,321**

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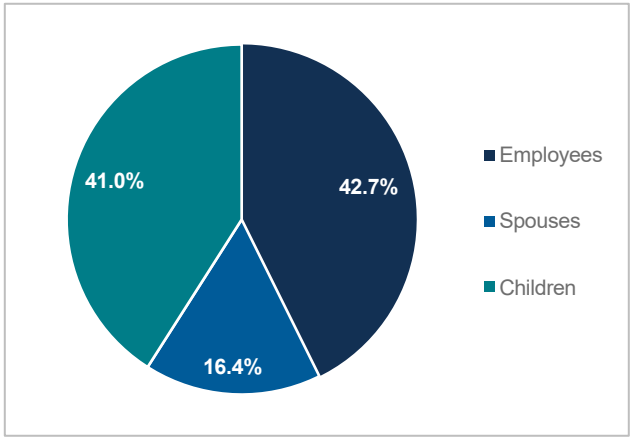
#1 Top Dx Chapter

Circulatory System

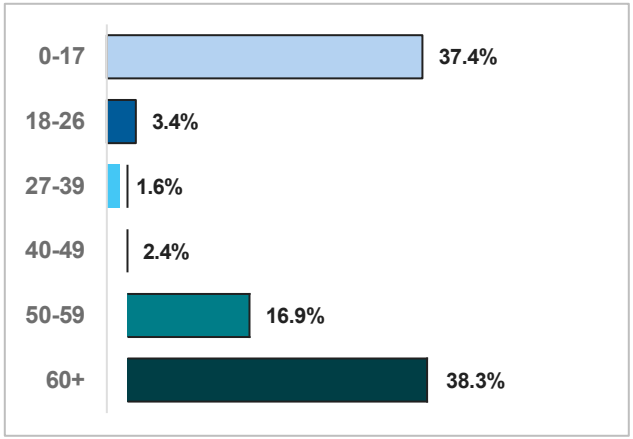
Breakout by Diagnostic Grouping & Demographics

#	Circulatory System Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Coronary atherosclerosis & oth heart disease	149	423	$2,165,300	41.7%
2	Cardiac dysrhythmias	186	642	$855,935	16.5%
3	Myocardial infarction	11	93	$334,790	6.5%
4	Hypertension	501	1,056	$303,860	5.9%
5	Nonspecific chest pain	192	434	$280,375	5.4%
6	Acute pulmonary embolism, DVT	35	162	$276,938	5.3%
7	Heart failure	32	73	$242,327	4.7%
8	Other circulatory	62	122	$228,198	4.4%
9	Nonrheumatic & unspecified valve disorders	55	156	$224,082	4.3%
10	Vascular disease	73	226	$173,710	3.3%
11	Cerebrovascular disease	37	126	$95,235	1.8%
12	Myocarditis & cardiomyopathy	9	31	$7,872	0.2%
=	**Total**	**931**	**3,951**	**$5,188,621**	**100.0%**

Circulatory System Paid by Relationship



Circulatory System Paid by Age Range



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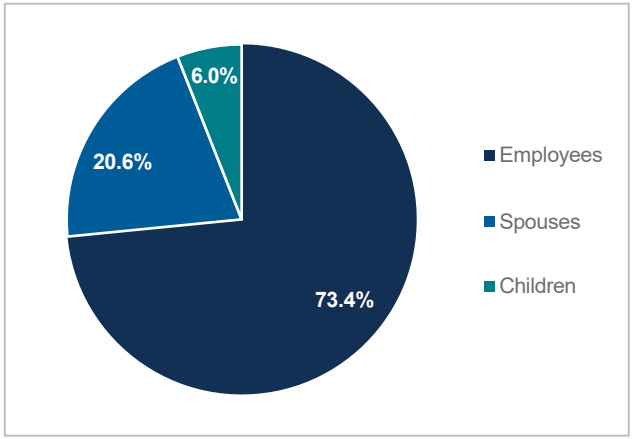
#2 Top Dx Chapter

Musculoskeletal System

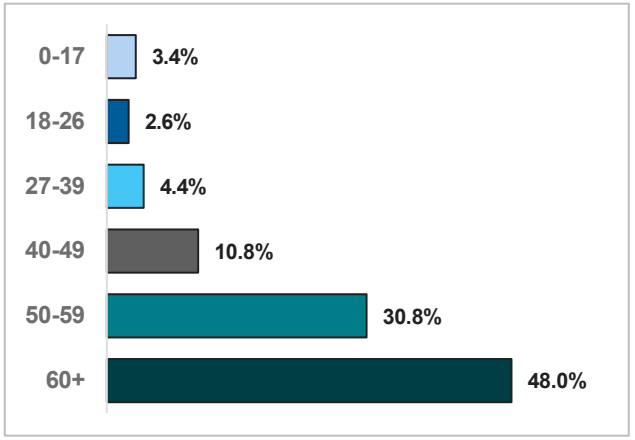
Breakout by Diagnostic Grouping & Demographics

#	Musculoskeletal Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Spondylopathies & arthropathy	529	2,919	$1,565,378	34.6%
2	Osteoarthritis & osteoporosis	337	1,046	$853,866	18.9%
3	Other musculoskeletal pain	1,082	3,939	$582,282	12.9%
4	Tendon, tissue, muscle disorders	422	1,167	$543,775	12.0%
5	Joint disorders & fractures	154	450	$372,938	8.3%
6	Scoliosis & oth deformities	164	338	$202,827	4.5%
7	Low back pain	231	854	$137,849	3.1%
8	Other MSK	27	151	$111,538	2.5%
9	Rheumatoid arthritis & related disease	50	235	$80,944	1.8%
10	Lupus	39	159	$51,915	1.1%
11	Gout & crystal arthropathies	42	77	$8,795	0.2%
12	Biomechanical lesions	129	759	$6,501	0.1%
=	**Total**	**1,689**	**12,484**	**$4,518,606**	**100.0%**

Musculoskeletal Paid by Relationship



Musculoskeletal Paid by Age Range



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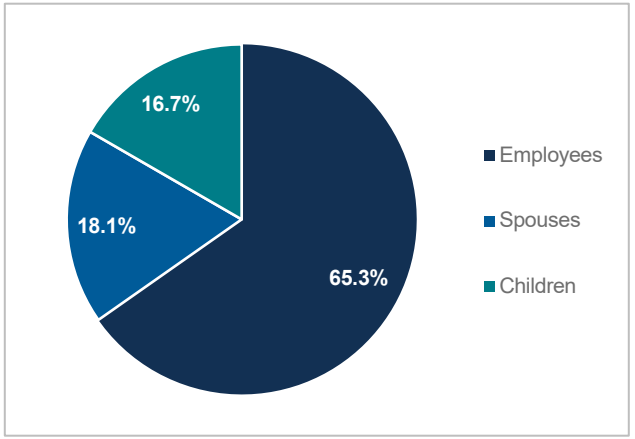
#3 Top Dx Chapter

Health Status & Health Services

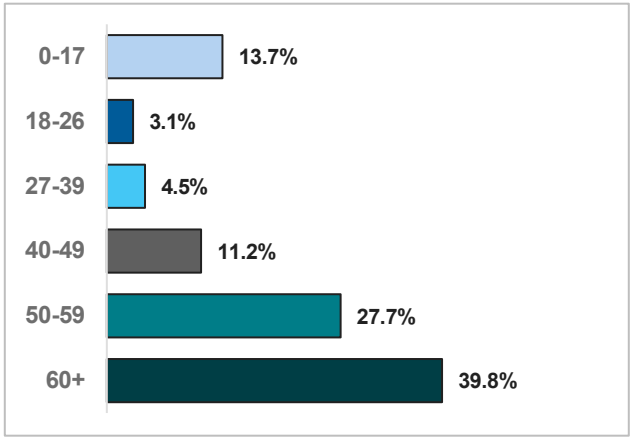
Breakout by Diagnostic Grouping & Demographics

#	Health Status & Services Dx Grouping	Patients	Claims	Total Paid	% Paid
1	Encounter for antineoplastic therapies	16	66	$1,014,714	30.8%
2	Neoplasm-related encounters	1,002	2,157	$674,219	20.5%
3	Medical examination/evaluation	2,370	4,053	$621,235	18.9%
4	Exposure, enc, screen or contact w infectious dz	1,303	1,800	$364,794	11.1%
5	Implant, device or graft related encounter	165	565	$135,069	4.1%
6	Other aftercare encounter	143	257	$133,963	4.1%
7	Contraceptive & procreative management	128	223	$121,453	3.7%
8	Encount for obs & exam for conds ruled out	363	531	$70,136	2.1%
9	Encounter for administrative purposes	13	28	$41,057	1.2%
10	Other specified status	262	586	$33,466	1.0%
11	Personal history of other disease	65	86	$19,514	0.6%
12	Family history of disease	51	58	$13,118	0.4%
13	Enc for prophylactic measures (ex immuniz)	25	50	$11,842	0.4%
14	Other specified encounters & counseling	57	105	$7,954	0.2%
15	Encounter for prophylactic or oth procedures	12	12	$6,136	0.2%
16	Personal history of malignant neoplasm	31	45	$5,816	0.2%
17	Genetic susceptibility to disease	7	9	$5,203	0.2%
18	Organ transplant status	10	70	$3,410	0.1%
19	Personal history of nicotine dependence	11	12	$2,672	0.1%
20	Acquired absence of limb or organ	14	25	$2,228	0.1%
...	*All Others*	*167*	*211*	*$3,946*	*0.1%*
=	**Total**	**3,223**	**11,151**	**$3,291,946**	**100.0%**

Health Status & Services Paid by Relationship



Health Status & Services Paid by Age Range



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Condition Focus

Mental & Behavioral Trend

Prevalence & Cost by Diagnostic Grouping

Mental & Behavioral Diagnostic Grouping	2024 (Full Year)		2025 (Full Year)		2026-4Q		2026-4Q 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	358	$581,347	$144,112	$6,711	$430,525	$0
Neurodevelopmental disorders	253	$292,459	260	$259,148	245	$465,372	$0	$1,335	$460,841	$3,196
Anxiety & related Disorders	512	$337,685	490	$381,768	468	$398,968	$0	$12,672	$386,296	$0
Trauma & stressor disorders	338	$370,626	332	$297,354	319	$322,416	$0	$5,273	$317,143	$0
Eating disorders	15	$51,171	13	$88,845	10	$130,946	$114,000	$0	$16,946	$0
Other mental health	141	$117,944	133	$99,065	111	$122,936	$6,022	$69,165	$47,749	$0
Bipolar & related Disorders	79	$92,390	66	$83,919	55	$96,214	$41,367	$0	$54,847	$0
Alcohol-related disorders	45	$307,936	30	$150,432	30	$78,301	$25,864	$35,235	$17,202	$0
Suicidal ideation, attempt or self-harm	23	$42,788	24	$141,882	15	$65,108	$0	$60,499	$4,609	$0
Obsessive compulsive disorders	22	$60,775	20	$9,774	37	$24,984	$0	$0	$24,984	$0
Cannabis-related disorders	5	$3,870	10	$2,953	7	$24,886	$15,984	$7,199	$1,703	$0
Schizophrenia spectrum disorders	16	$33,159	13	$68,703	10	$16,148	$5,520	-$591	$11,219	$0
Other substance use	40	$10,408	37	$7,180	32	$4,736	$0	$199	$4,537	$0
Opiod disorders	13	$38,318	8	$13,737	5	$4,277	$592	$3,198	$486	$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**	**1,175**	**$2,337,994**	**$353,461**	**$200,894**	**$1,780,443**	**$3,196**

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Condition Focus

Chronic Conditions

Prevalence & Severity of 24 Chronic Conditions

Chronic Condition	With Condition			Moderate/High Risk Condition					
	# of Mems	Mems per 1000	*Change vs LY*	# of Mems	Mems per 1000	*Change vs LY*	Allowed PMPY	Admits per 1000	ER Visits per 1000
Affective Psychosis	8	1.7	*-11.1%*	2	0.4	*-50.0%*	$2,688	125.0	0.0
Asthma	210	45.3	*-10.3%*	85	18.4	*-22.7%*	$5,292	66.7	242.9
Atrial Fibrillation	75	16.2	*13.6%*	56	12.1	*24.4%*	$31,315	226.7	506.7
Blood Disorders	211	45.6	*6.6%*	86	18.6	*-12.2%*	$21,713	123.2	346.0
CAD	90	19.4	*0.0%*	43	9.3	*-14.0%*	$14,901	155.6	355.6
COPD	28	6.0	*-30.0%*	19	4.1	*-24.0%*	$27,459	357.1	714.3
Cancer	440	95.0	*-19.7%*	231	49.9	*-14.4%*	$18,401	77.3	186.4
Chronic Pain	38	8.2	*-2.6%*	27	5.8	*80.0%*	$126,538	710.5	1,026.3
CHF	19	4.1	*-29.6%*	7	1.5	*-58.8%*	$25,888	157.9	473.7
Demyelinating Diseases	21	4.5	*10.5%*	15	3.2	*0.0%*	$17,268	47.6	333.3
Depression	358	77.3	*-12.3%*	264	57.0	*-13.4%*	$11,145	97.8	340.8
Diabetes	473	102.1	*-7.1%*	356	76.9	*-6.1%*	$13,664	78.2	255.8
ESRD	20	4.3	*25.0%*	14	3.0	*75.0%*	$185,896	650.0	1,350.0
Eating Disorders	9	1.9	*-40.0%*	8	1.7	*-20.0%*	$30,887	666.7	1,000.0
HIV/AIDS	4	0.9	*-20.0%*	3	0.6	*-40.0%*	$2,724	0.0	0.0
Hyperlipidemia	201	43.4	*0.5%*	72	15.5	*4.3%*	$4,240	14.9	89.6
Hypertension	502	108.4	*-11.5%*	239	51.6	*-0.8%*	$16,758	135.5	274.9
Immune Disorders	23	5.0	*9.5%*	9	1.9	*-10.0%*	$29,859	130.4	521.7
IBD	27	5.8	*22.7%*	9	1.9	*80.0%*	$3,078	0.0	0.0
Liver Disease	0	0.0	*-100.0%*	0	0.0	*-100.0%*	$0	0.0	0.0
Morbid Obesity	83	17.9	*-16.2%*	43	9.3	*-18.9%*	$8,320	120.5	192.8
Osteoarthritis	278	60.0	*-0.4%*	120	25.9	*-4.0%*	$9,875	46.8	147.5
Peripheral Vascular Disease	22	4.8	*-4.3%*	9	1.9	*50.0%*	$23,949	181.8	590.9
Rheumatoid Arthritis	48	10.4	*-14.3%*	40	8.6	*-13.0%*	$11,132	104.2	395.8

- *Most prevalent chronic condition is Hypertension, with 502 members*
- *Diabetes is the condition with the most moderate/high risk members (356)*
- *Members with mod/high risk Diabetes also have the highest combined cost, totaling $4.86M*

Date Range: Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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:** $9,153
- **Admits per 1000:** 48.2
- **ER Visits per 1000:** 234.1

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Prevention, Wellness, & Maintenance

Preventive & Condition-specific Screening Rate Trends

Preventive Service	Population	Apr 2024 - Mar 2025 Eligible	Apr 2024 - Mar 2025 Actual	Apr 2024 - Mar 2025 Rate	Apr 2025 - Mar 2026 Eligible	Apr 2025 - Mar 2026 Actual	Apr 2025 - Mar 2026 Rate	*Rate Change*	UMR Norm Rate	UMR Norm *Variance*
Well Visits	*Rate for Well Baby & Well Child is Visits per 1,000. Rate for adults is the percentage who had a well visit.*									
Well Baby Visit	0 - 15 months	42.8	237	**5,538.1**	36.1	217	**6,017.2**	*8.7%*	**5,397.9**	*11.5%*
Well Child Visit	3 - 6 years	217.0	179	**824.9**	192.7	165	**856.1**	*3.8%*	**805.6**	*6.3%*
Adults w/ Well Visit	Adults 18+	4,129	1,798	**43.5%**	3,631	1,621	**44.6%**	*1.1 pts*	**40.3%**	*4.3 pts*
Screenings	*Rate for all screenings is the percentage of eligible population who had the screening during the period.*									
Mammogram	Females 40 - 69	1,488	795	**53.4%**	1,303	636	**48.8%**	*-4.6 pts*	**44.9%**	*3.9 pts*
Cervical Cancer	Females 21 - 64	1,966	463	**23.6%**	1,682	404	**24.0%**	*0.5 pts*	**21.7%**	*2.3 pts*
Prostate Cancer	Males 50 - 70	883	438	**49.6%**	805	386	**47.9%**	*-1.7 pts*	**41.9%**	*6.0 pts*
Colorectal Cancer	Members 45 - 75	2,408	433	**18.0%**	2,160	374	**17.3%**	*-0.7 pts*	**15.7%**	*1.6 pts*
Cholesterol	Female 45+ Male 35+	2,717	1,557	**57.3%**	2,429	1,398	**57.5%**	*0.3 pts*	**46.8%**	*10.8 pts*
Condition-specific	**Screening**									
Asthma	Office Visit for Asthma	234	189	**80.8%**	210	171	**81.4%**	*0.7 pts*		
COPD	Spirometry Test	40	5	**12.5%**	28	4	**14.3%**	*1.8 pts*		
Type 2 Diabetes	A1c Test	467	415	**88.9%**	438	403	**92.0%**	*3.1 pts*	**83.5%**	*8.5 pts*
	Eye Exam	-	-	**-**	0	0	**0**	-	**0**	*0*
	Lipid Panel	467	349	**74.7%**	438	328	**74.9%**	*0.2 pts*	**70.7%**	*4.2 pts*
	Urine Protein Test	467	307	**65.7%**	438	278	**63.5%**	*-2.3 pts*	**63.2%**	*0.3 pts*
	Any Diabetes Screen	467	426	**91.2%**	438	412	**94.1%**	*2.8 pts*	**87.6%**	*6.5 pts*
Hyperlipidemia	Lipid Profile	200	99	**49.5%**	201	113	**56.2%**	*6.7 pts*		
Hypertension	Creatinine Test	567	117	**20.6%**	502	135	**26.9%**	*6.3 pts*		
	Lipid Profile	567	153	**27.0%**	502	143	**28.5%**	*1.5 pts*		

Date Range: Reporting periods are service-based with 3 months of runout: Current period is Service Dates 4/1/2025 - 3/31/2026, Paid through 6/30/2026

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

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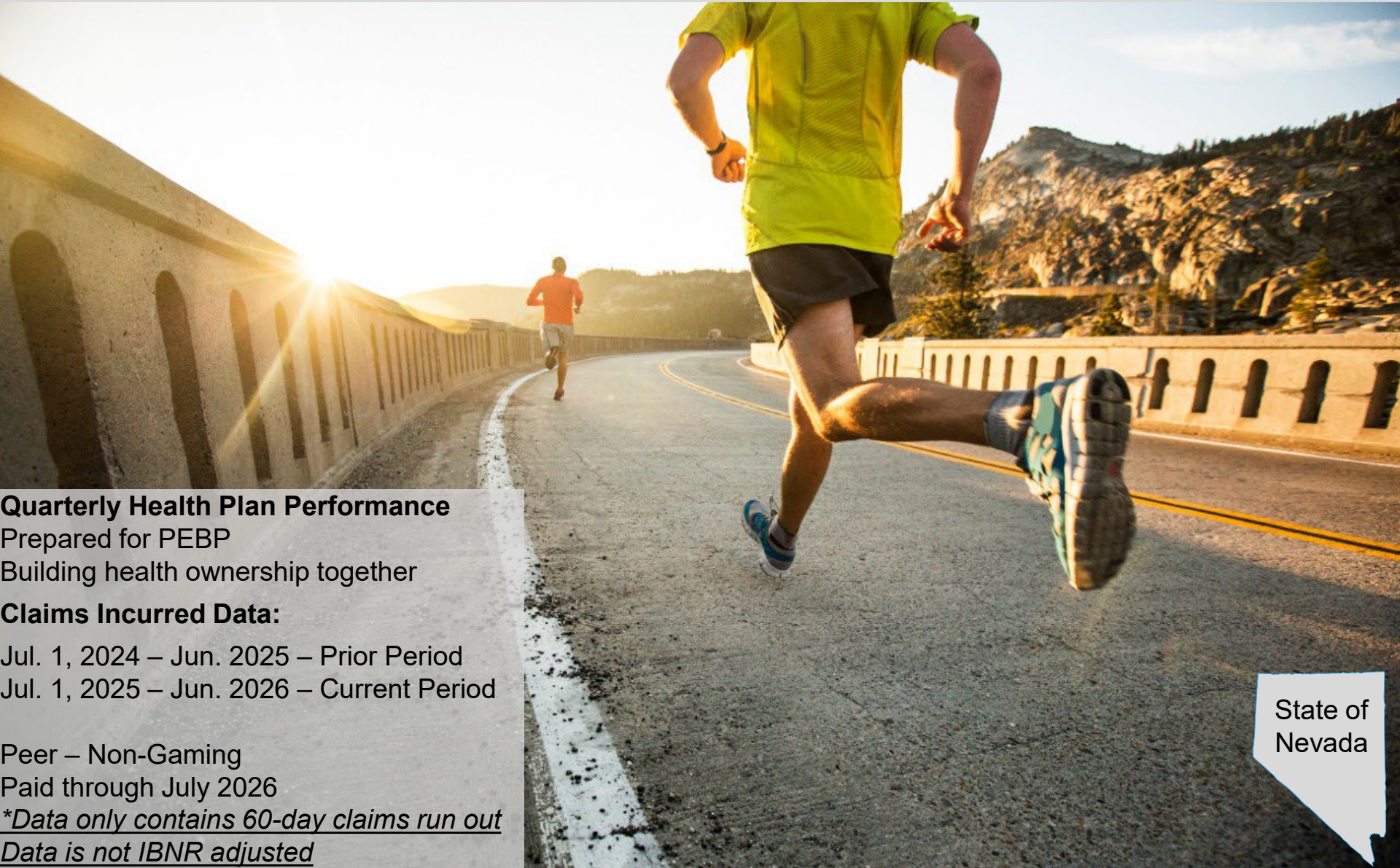
14.10

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)
    - 14.1 Q4 UMR – Obesity and Diabetes Care Management
    - 14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q4 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q4 Express Scripts – Utilization Report
    - 14.6 Q4 Express Scripts – Summary Report
    - 14.7 Q4 CDHP Performance Report
    - 14.8 Q4 LD PPO Performance Report
    - 14.9 Q4 EPO Performance Report
    - **14.10 Q4 HPN Performance Report**

Power Of Partnership.



Quarterly Health Plan Performance
Prepared for PEBP
Building health ownership together

Claims Incurred Data:

Jul. 1, 2024 – Jun. 2025 – Prior Period
Jul. 1, 2025 – Jun. 2026 – Current Period

Peer – Non-Gaming
Paid through July 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

UnitedHealthcare

Population

- -4.9% decrease for employees from prior period
- -4.9% decrease for members from prior period

Medical Paid PMPM

- 17.6% increase in medical paid PMPM from prior period
- Non-Catastrophic spend remained relatively flat from prior period
- 36.5% increase in Catastrophic spend

High-Cost Claimants

- 91 HCC in Q4 2025, up 30%
- 37.2% of medical spend comes from HCC

Emergency Room

- ER Visits Per 1,000 members increased 6.1%
- Avg. paid per ER Visit increased 10.1%

Urgent Care

- Urgent Care visits per 1,000 decreased slightly -2.5%
- Avg. paid per Urgent care visit increased 8%

Rx Drivers

- Rx Net Paid PMPM increased 20.1%
- Specialty Spend decreased 10.7%
- Specialty Rx driving 36.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 18.5% on PMPM basis

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Executive Summary Utilization & Spend

UnitedHealthcare

Claims Paid by Age Group														
	July - June 2025 Q4						July - June 2026 Q4						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$628,889	$1,421	$1,029	$2	$629,917	$1,423	$1,394,206	$2,854	$15,648	$32	$1,409,854	$2,886	123.8%	102.8%
01	$107,880	$225	$1,014	$2	$108,894	$227	$132,589	$357	$10,275	$28	$142,865	$385	58.6%	69.2%
02-04	$971,530	$501	$7,446	$4	$978,976	$505	$605,618	$355	$4,270	$3	$609,888	$358	-29.1%	-29.2%
05-09	$708,182	$189	$57,359	$15	$765,541	$205	$792,822	$223	$30,047	$8	$822,869	$231	17.8%	13.1%
10-14	$956,030	$183	$123,496	$24	$1,079,526	$206	$781,605	$158	$67,193	$14	$848,798	$172	-13.6%	-16.9%
15-19	$1,241,880	$201	$193,688	$31	$1,435,568	$233	$1,006,218	$177	$236,257	$42	$1,242,476	$218	-12.2%	-6.2%
20-24	$1,172,710	$203	$185,527	$32	$1,358,237	$235	$1,235,115	$215	$224,719	$39	$1,459,834	$255	6.0%	8.2%
25-29	$1,028,854	$309	$242,470	$73	$1,271,324	$382	$991,398	$324	$349,250	$114	$1,340,647	$438	4.8%	14.6%
30-34	$1,083,825	$302	$519,796	$145	$1,603,621	$447	$1,402,561	$414	$523,000	$155	$1,925,561	$569	37.1%	27.2%
35-39	$1,644,111	$365	$967,693	$215	$2,611,804	$580	$3,058,906	$752	$1,112,199	$274	$4,171,105	$1,026	105.9%	76.7%
40-44	$1,766,943	$351	$874,979	$174	$2,641,922	$525	$1,824,179	$358	$1,152,945	$227	$2,977,124	$585	2.0%	11.3%
45-49	$2,577,834	$417	$1,891,791	$306	$4,469,625	$723	$2,704,607	$472	$1,550,709	$271	$4,255,316	$743	13.3%	2.8%
50-54	$2,739,212	$365	$2,500,674	$333	$5,239,885	$697	$4,424,303	$622	$3,125,759	$439	$7,550,062	$1,061	70.5%	52.1%
55-59	$2,660,877	$363	$2,710,377	$369	$5,371,255	$732	$3,099,634	$430	$3,238,459	$450	$6,338,093	$880	18.6%	20.2%
60-64	$3,577,656	$510	$2,214,614	$315	$5,792,270	$825	$3,100,631	$477	$2,547,253	$392	$5,647,884	$869	-6.4%	5.3%
65+	$4,139,092	$802	$1,995,085	$386	$6,134,177	$1,188	$3,637,772	$703	$2,356,305	$455	$5,994,076	$1,159	-12.3%	-2.5%
Total	$27,005,505	$368	$14,487,037	$197	$41,492,542	$565	$30,192,164	$432	$16,544,288	$237	$46,736,452	$669	12.6%	18.5%

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Financial Summary

Financial and Demographic (*July 2025 thru June 2026 Q4*)												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲	Thru 4Q23	Thru 4Q24	Thru 4Q25	▲
Avg. # Employees	3,555	3,524	3,353	-4.9%	3,130	3,108	2,972	-4.4%	425	416	381	-8.5%
Avg. # Members	6,242	6,118	5,818	-4.9%	5,664	5,550	5,296	-4.6%	578	569	522	-8.3%
Ratio	1.8	1.7	1.7	-0.1%	1.8	1.8	1.8	-0.2%	1.4	1.4	1.4	0.2%
Financial												
Medical Paid	$26,128,051	$27,005,505	$30,192,164	11.8%	$22,180,278	$23,708,863	$26,773,388	12.9%	$3,947,773	$3,296,642	$3,418,776	3.7%
Member Paid	$2,078,832	$2,494,165	$2,568,504	3.0%	$1,435,185	$1,670,976	$1,749,220	4.7%	$643,647	$823,189	$819,283	-0.5%
Net Paid PEPY	$7,350	$7,663	$9,005	17.5%	$7,087	$7,628	$9,008	18.1%	$9,287	$7,926	$8,979	13.3%
Net Paid PMPY	$4,186	$4,414	$5,190	17.6%	$3,916	$4,272	$5,055	18.3%	$6,833	$5,795	$6,551	13.1%
Net Paid PEPM	$613	$639	$750	17.5%	$591	$636	$751	18.1%	$774	$661	$748	13.3%
Net Paid PMPM	$349	$368	$432	17.6%	$326	$356	$421	18.3%	$569	$483	$546	13.1%
High Cost Claimants												
# of HCC's > $50k	71	70	91	30.0%	54	56	74	32.1%	17	14	17	21.4%
Avg. paid per claimant	$117,170	$119,000	$124,903	5.0%	$114,543	$125,073	$129,844	3.8%	$125,512	$94,707	$103,395	9.2%
HCC % of Spend	31.2%	30.5%	37.2%	22.1%	27.5%	29.4%	35.7%	21.4%	51.2%	37.8%	48.5%	28.2%
Spend by Location (PMPY)												
Inpatient	$1,144	$1,311	$1,572	19.9%	$1,041	$1,237	$1,488	20.3%	$2,149	$2,030	$2,425	19.5%
Outpatient	$1,029	$1,012	$1,276	26.1%	$862	$939	$1,204	28.2%	$2,196	$1,252	$1,554	24.2%
Professional	$1,335	$1,409	$1,645	16.7%	$1,099	$1,180	$1,443	22.3%	$1,772	$1,790	$1,897	6.0%
Total	$3,507	$3,731	$4,492	20.4%	$3,002	$3,356	$4,135	23.2%	$6,117	$5,072	$5,877	15.9%

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Paid Claims by Claim Type

UnitedHealthcare®

Net Paid Claims - Total Total Participants									
	July - June 2025 Q4				July - June 2026 Q4				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$5,585,518	$243,070	$2,189,908	$8,018,495	$7,404,280	$62,576	$1,676,719	$9,143,575	14.0%
OutPatient	$16,567,821	$482,361	$1,950,201	$19,000,383	$18,782,455	$347,016	$1,972,548	$21,102,019	11.1%
Total - Medical	$22,153,339	$725,431	$4,140,108	$27,018,878	$26,186,735	$409,593	$3,649,267	$30,245,594	11.9%

Net Paid Claims - Total Total Participants									
	July - Sept. 2024 Q1				July - Sept. 2025 Q1				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$332	$468	$2,671	$368	$412	$365	$705	$433	17.7%

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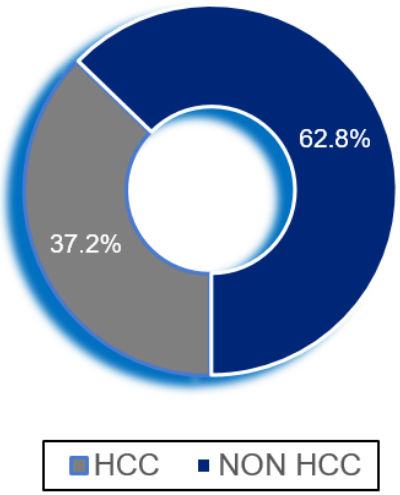
Cost Distribution – Medical Claims > $50K

July - June 4Q24							July - June 4Q25					
# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid
10	0.2%	$1,677,710	6.2%	$898,853	53.6%	> $100k	5	0.1%	$3,103,814	10.3%	$1,893,344	61.0%
25	0.4%	$2,075,325	7.7%	$1,008,381	48.6%	$50k- $100k	38	0.7%	$2,759,626	9.1%	$2,096,110	76.0%
68	1.1%	$2,696,136	10.0%	$1,701,054	63.1%	$25k - $50k	87	1.5%	$3,256,804	10.8%	$2,479,379	76.1%
240	3.9%	$5,249,094	19.4%	$3,300,733	62.9%	$10k - $25k	229	4.1%	$5,001,254	16.6%	$3,769,496	75.4%
379	6.2%	$3,448,392	12.8%	$2,210,958	64.1%	$5k - $10k	478	8.5%	$4,307,128	14.3%	$2,694,094	62.5%

% Paid Attributed to Catastrophic Cases



HCC > $50k - CCSR Chapter Conditions - Thru 4Q25			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Neoplasms	9	$2,606,935	8.5%
Diseases of the circulatory system	16	$2,153,541	7.1%
Injury, poisoning and certain other consequences of external causes	9	$934,667	3.1%
Diseases of the nervous system	11	$897,369	2.9%
Diseases of the musculoskeletal system and connective tissue	9	$864,794	2.8%

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Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	July - June 4Q24	July - June 4Q25	▲	July - June 4Q24	July - June 4Q25	▲	July - June 4Q24	July - June 4Q25	▲
Inpatient									
# of Admits	411	180	-56.2%	354	150	-57.6%	57	30	-47.4%
# of Bedays	2,665	1,039	-61.0%	2,144	729	-66.0%	521	310	-40.5%
Avg. Paid per Admit	$21,017	$22,476	6.9%	$21,041	$22,276	5.9%	$20,869	$23,475	12.5%
Avg. Paid per Day	$3,241	$3,894	20.1%	$3,474	$4,584	31.9%	$2,283	$2,272	-0.5%
Admits Per K	67.2	30.9	-53.9%	63.8	28.3	-55.6%	100.2	57.5	-42.6%
Days Per K	435.6	178.6	-59.0%	386.3	137.7	-64.4%	915.8	594.1	-35.1%
ALOS	6.5	5.8	-11.0%	6.1	4.9	-19.8%	5.5	5.9	7.3%
Admits from ER	198	99	-50.0%	169	84	-50.3%	29	15	-48.3%
Physician Office Visits									
Per Member Per Year	0.6	0.5	-4.0%	0.6	0.5	-3.2%	0.6	0.6	-11.0%
Paid Per Visit	$162	$179	10.9%	$167	$187	12.0%	$117	$106	-10.1%
Net Paid PMPM	$8	$8	6.4%	$8	$8	8.4%	$6	$5	-20.0%
Emergency Room									
# of Visits	803	810	0.9%	729	715	-1.9%	74	95	28.4%
Visits Per K	131.2	139.2	6.1%	131.4	135.0	2.8%	130.1	182.1	40.0%
Avg Paid Per Visit	$2,887	$3,179	10.1%	$2,905	$3,252	11.9%	$2,709	$2,628	-3.0%
Urgent Care									
# of Visits	880	774	-12.0%	794	708	-10.8%	86	66	-23.3%
Visits Per K	143.8	133.0	-7.5%	143.1	133.7	-6.6%	151.2	126.5	-16.3%
Avg Paid Per Visit	$124	$129	4.6%	$93	$90	-2.9%	$93	$76	-18.4%

**Not Representative of all utilization*

Data based on medical spend only

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Diagnosis Grouper Summary – Top 25

UnitedHealthcare

Top 25 CCSR Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Leukemia - acute myeloid leukemia (AML)	$1,404,035	5.7%	$1,404,035	$0	$0	$0	$1,404,035	$0
Spondylopathies/spondyloarthropathy (including infective)	$892,695	3.6%	$816,610	$75,074	$1,011	$280,114	$612,580	$0
Neurodevelopmental disorders	$873,685	3.5%	$34,265	$2,130	$837,290	$577,506	$296,179	$0
Pulmonary heart disease	$677,536	2.7%	$999	$9,653	$666,885	$666,901	$10,635	$0
Septicemia	$567,789	2.3%	$494,227	$73,045	$517	$157,761	$410,028	$0
Sleep wake disorders	$491,834	2.0%	$423,209	$49,647	$18,977	$246,751	$245,083	$0
Encounter for antineoplastic therapies	$475,199	1.9%	$475,199	$0	$0	$24,189	$451,010	$0
Liveborn	$462,529	1.9%	$0	$0	$462,529	$430,269	$32,260	$0
Osteoarthritis	$420,296	1.7%	$360,212	$59,903	$182	$56,215	$364,082	$0
Diabetes mellitus with complication	$406,379	1.6%	$273,470	$101,003	$31,906	$266,347	$140,032	$0
Abdominal pain and other digestive/abdomen signs and symptoms	$400,914	1.6%	$264,204	$87,815	$48,894	$97,240	$303,674	$0
Breast cancer - all other types	$337,141	1.4%	$181,133	$156,008	$0	$4,973	$332,168	$0
Other specified and unspecified liver disease	$326,587	1.3%	$10,964	$315,354	$268	$317,527	$9,060	$0
Chronic kidney disease	$325,162	1.3%	$313,740	$11,402	$21	$320,314	$4,848	$0
Depressive disorders	$318,683	1.3%	$177,843	$30,035	$110,805	$107,470	$211,213	$0
Cardiac dysrhythmias	$317,024	1.3%	$305,358	$11,666	$0	$142,159	$174,866	$0
Neoplasm-related encounters	$297,602	1.2%	$262,650	$33,100	$1,852	$105,159	$192,443	$0
Nonspecific chest pain	$294,237	1.2%	$177,869	$44,031	$72,337	$115,213	$179,024	$0
Hearing loss	$286,397	1.2%	$212,218	$24,154	$50,025	$104,227	$182,170	$0
Sprains and strains, initial encounter	$285,330	1.1%	$222,520	$15,161	$47,650	$91,065	$194,266	$0
Nonrheumatic and unspecified valve disorders	$276,951	1.1%	$276,612	$340	$0	$103,512	$173,440	$0
Headache; including migraine	$273,061	1.1%	$167,259	$92,943	$12,859	$15,255	$257,806	$0
Complication of other surgical or medical care, injury, initial encounter	$269,229	1.1%	$205,535	$60,040	$3,654	$102,617	$166,612	$0
Benign neoplasms	$266,496	1.1%	$236,308	$25,027	$5,161	$40,405	$226,090	$0
Urinary tract infections	$260,594	1.1%	$132,678	$99,605	$28,311	$41,686	$218,908	$0

**Not Representative of all utilization*

Data based on medical spend only

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Mental Health Drilldown

UnitedHealthcare

Top 10 Mental Health				
CCSR Category Description	July - June 4Q24		July - June 4Q25	
	Patients	Total Paid	Patients	Total Paid
Neurodevelopmental disorders	238	$658,790	211	$873,685
Depressive disorders	368	$322,964	396	$318,683
Anxiety and fear-related disorders	477	$221,521	440	$196,167
Trauma- and stressor-related disorders	270	$141,655	261	$170,483
Bipolar and related disorders	90	$82,080	79	$73,111
Alcohol-related disorders	25	$84,398	17	$57,892
Suicidal ideation/attempt/intentional self-harm	14	$47,188	13	$73,944
Schizophrenia spectrum and other psychotic disorders	11	$24,311	14	$20,225
Other specified and unspecified mood disorders	28	$16,944	19	$15,432
Stimulant-related disorders	3	$7,927	2	$19,394

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Respiratory Disorders

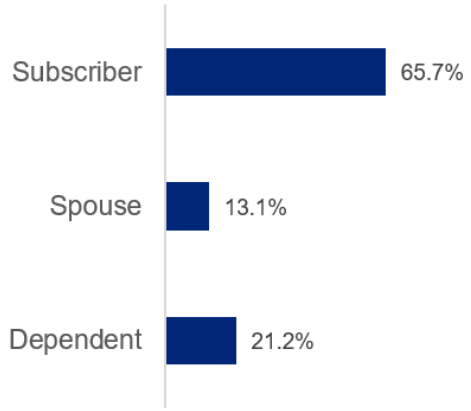
UnitedHealthcare

Top 10 Respiratory Disorders				
CCSR Category Description	Patients	Claims	Total Paid	% Paid
Asthma	220	470	$224,903	17.8%
Other specified and unspecified upper respiratory disease	316	1,131	$184,244	14.5%
Respiratory failure; insufficiency; arrest	31	207	$181,609	14.3%
Pneumonia (except that caused by tuberculosis)	41	120	$142,492	11.2%
Other specified upper respiratory infections	650	917	$135,046	10.7%
Sinusitis	292	429	$100,295	7.9%
Acute and chronic tonsillitis	58	110	$75,460	6.0%
Pleurisy, pleural effusion and pulmonary collapse	27	97	$63,546	5.0%
Pneumothorax	6	35	$56,058	4.4%
Acute bronchitis	246	322	$39,303	3.1%

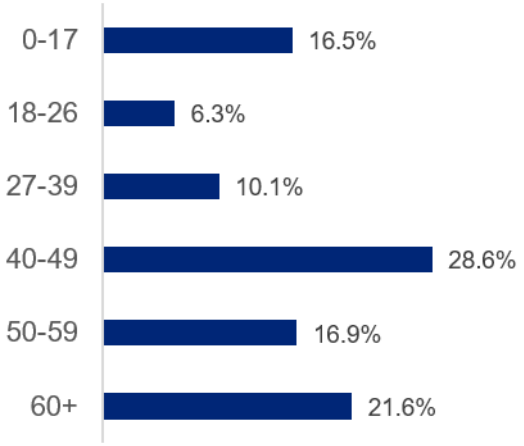
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range



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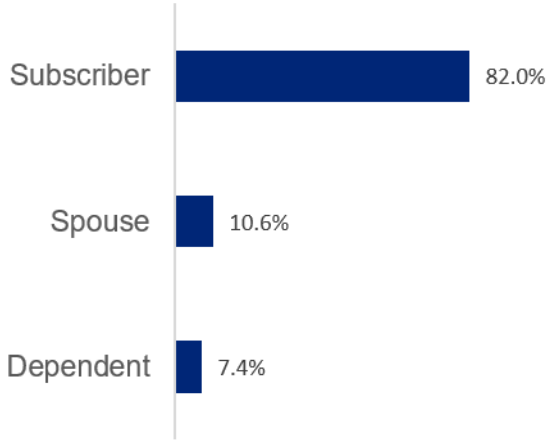
Infections

Top 10 Infectious and Parasitic Diseases				
CCSR Description	Patients	Claims	Total Paid	% Paid
Septicemia	30	83	$567,789	72.8%
COVID-19	88	220	$86,531	11.1%
Viral infection	174	254	$72,755	9.3%
HIV infection	28	172	$30,486	3.9%
Foodborne intoxications	5	6	$14,242	1.8%
Hepatitis	7	40	$2,285	0.3%
Fungal infections	91	129	$2,138	0.3%
Sexually transmitted infections (excluding HIV and hepatitis)	29	39	$2,124	0.3%
Bacterial infections	19	23	$1,064	0.1%
Parasitic, other specified and unspecified infections	6	9	$476	0.1%

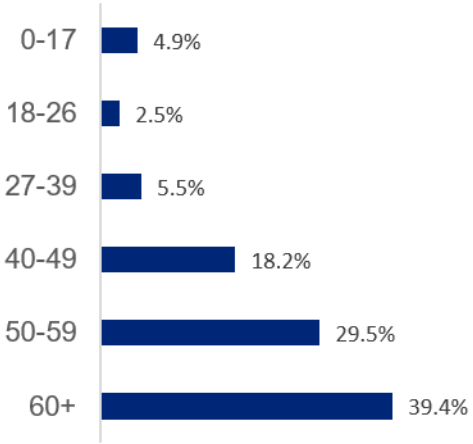
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range



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Pregnancy Related Disorders

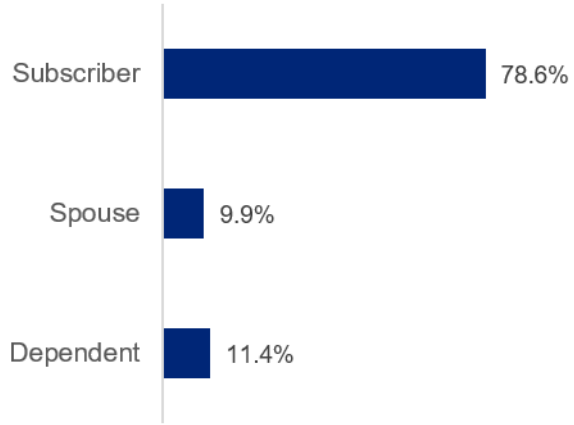
UnitedHealthcare

Top 10 Complications of Pregnancy				
CCSR Description	Patients	Claims	Total Paid	% Paid
Other specified complications in pregnancy	45	204	$137,167	17.8%
Complications specified during childbirth	21	31	$134,889	17.5%
Hypertension and hypertensive-related conditions	15	94	$112,463	14.6%
Malposition, disproportion or other labor complications	16	33	$95,904	12.4%
Uncomplicated pregnancy, delivery or puerperium	65	272	$76,465	9.9%
Diabetes or abnormal glucose tolerance complicating pregnancy	16	90	$64,711	8.4%
Previous C-section	7	14	$50,417	6.5%
Early or threatened labor	14	25	$44,563	5.8%
Early, first or unspecified trimester hemorrhage	13	28	$32,646	4.2%
Maternal care related to fetal conditions	23	44	$22,623	2.9%

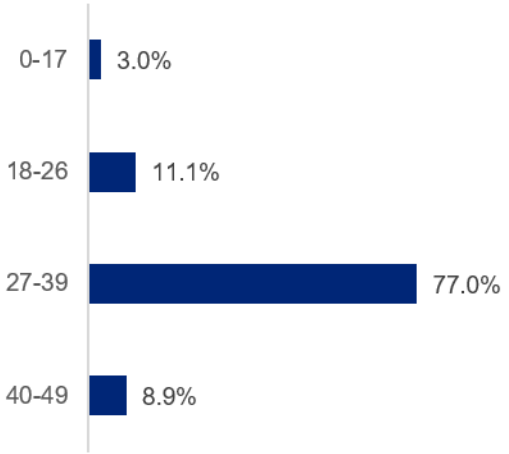
**Not Representative of all utilization*

Data based on medical spend only

Spend by Relationship



Spend by Age Range



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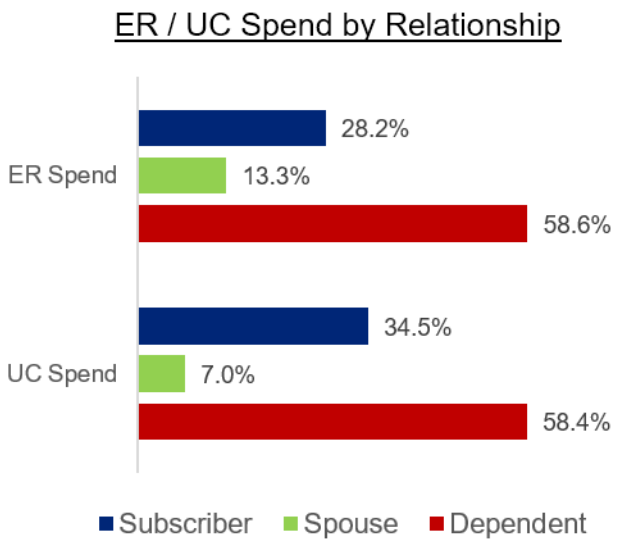
Emergency Room and Urgent Care

	July - June 4Q24		July - June 4Q25		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	803	3,927	810	3,641		
Visits Per Member	0.13	0.48	0.14	0.54	0.08	0.14
Visits Per K	131.2	641.8	139.2	625.8	104.3	586.2
Avg. Paid Per Visit	$2,887	$112	$3,179	$121	$2,856	$118

**Not Representative of all utilization*

Data based on medical spend only

Emergency Room and Urgent Care Visits by Relationships - 4Q25				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	238	40.9	994	170.9
Spouse	97	16.7	343	59.0
Dependent	475	81.6	2,304	396.0
Total	810	139.2	3,641	625.8



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Clinical Conditions by Medical Spend

(CCSR Chapter Conditions)

UnitedHealthcare®

Top 15 Common Condition	Members Per K	PMPM
Neoplasms	126.2	$44.65
Diseases of the circulatory system	221.0	$42.96
Diseases of the musculoskeletal system and connective tissue	295.3	$28.27
Mental, behavioral and neurodevelopmental disorders	193.2	$26.84
Injury, poisoning and certain other consequences of external causes	155.0	$26.27
Factors influencing health status and contact with health services	686.9	$22.30
Diseases of the digestive system	157.4	$22.15
Diseases of the nervous system	176.7	$21.93
Diseases of the genitourinary system	215.5	$21.38
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere	447.6	$18.93
Diseases of the respiratory system	270.4	$18.14
Endocrine, nutritional and metabolic diseases	339.6	$16.02
Pregnancy, childbirth and the puerperium	16.2	$12.88
Certain infectious and parasitic diseases	77.7	$11.17
Certain conditions originating in the perinatal period	8.3	$7.29
**Not Representative of all utilization*	*Data based on medical spend only*	

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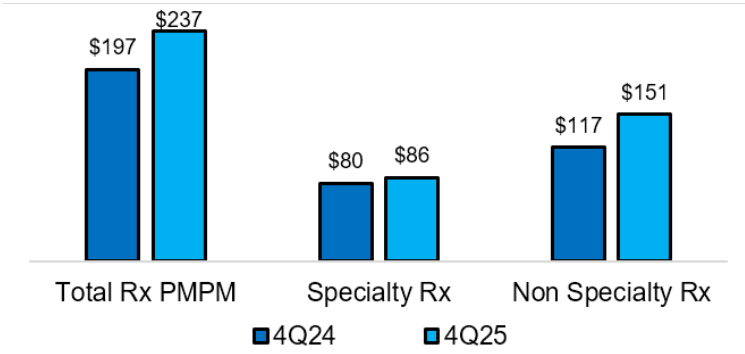
Pharmacy Drivers

	July -June 4Q24	July - June 4Q25	Δ
Enrolled Members	6,118	5,818	-4.9%
Average Prescriptions PMPY	17.3	17.9	3.3%
Formulary Rate	89.1%	89.4%	0.3%
Generic Use Rate	86.0%	85.1%	-1.0%
Generic Substitution Rate	98.8%	98.8%	0.0%
Avg Net Paid per Prescription	$137	$159	16.2%
Net Paid PMPM	$197	$237	20.1%

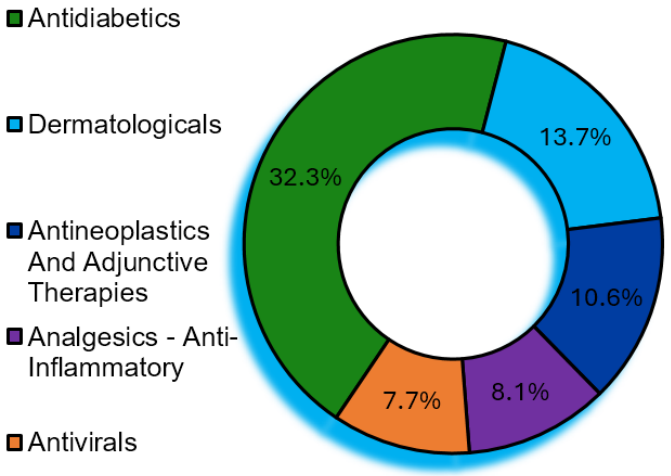
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of 20.1%, (**$40 PMPM**) from prior period
- Avg. paid per Script increased 16.2% (**$22 PMPM**) year over year
- Specialty Rx spend driving **36.3%** of Rx Spend
- Specialty Rx spend decreased **-10.6%** from the prior period
- Rx Drivers
  - **Mounjaro** (Antidiabetic) Spend up **97.2%**
  - **Jardiance** (Antidiabetic) Spend up **25.9%**
  - **Skyrizi Pen** (Dermatologicals) Spend up **108.7%**

Top 5 Therapeutic Classes by Spend



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14.11

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)

14.1 Q4 UMR – Obesity and Diabetes Care Management
14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
14.4 Q4 UnitedHealthcare – Basic Life Insurance
14.5 Q4 Express Scripts – Utilization Report
14.6 Q4 Express Scripts – Summary Report
14.7 Q4 CDHP Performance Report
14.8 Q4 LD PPO Performance Report
14.9 Q4 EPO Performance Report
14.10 Q4 HPN Performance Report
14.11 Q4 Dental Performance Report



Quarterly Plan Performance Review

Dental • 2026-4Q

Claims Paid 7/1/2025 - 6/30/2026

UMR
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RPG 5.10 • Run Date: 7/29/2026

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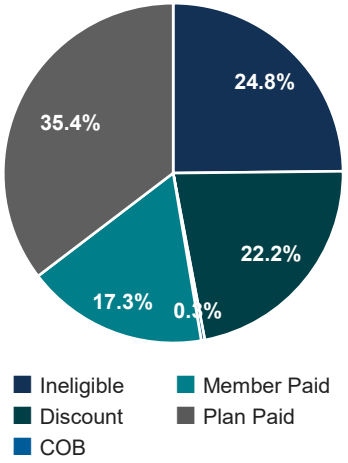
Dental Total Savings Summary

Breakouts & Network Performance

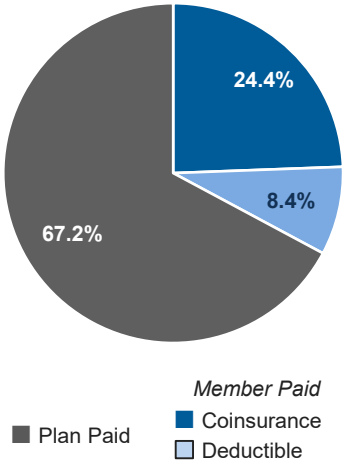
Dental Dollar Chain: Billed to Paid Dollars

Dollar Amount	Total Dollars	PMPM
Dental Billed	$83,546,926	$101.87
(-) Ineligible	$21,143,000	$25.78
Dental Covered	$62,403,926	$76.09
(-) Discount	$18,888,195	$23.03
Dental Allowed	$43,515,731	$53.06
(-) COB	$290,866	$0.35
(-) Coinsurance	$10,942,250	$13.34
(-) Deductible	$3,771,250	$4.60
Total Member Paid	$14,713,500	$17.94
Total Plan Paid	$30,111,251	$36.71

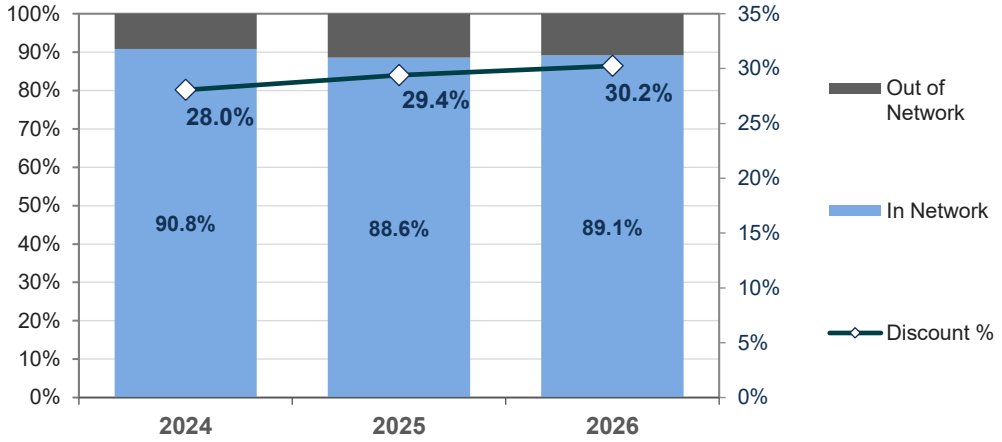
Breakout of Billed Dollars



Breakout of Paid Dollars



Dental Network Performance



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Dental Claims Breakouts

Age Range, Member Cost, and Dental Category

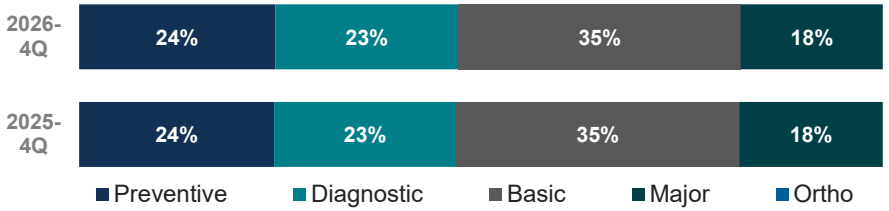
Dental Paid Claims by Age Range

Age	2025-4Q		2026-4Q		*Change*	
	Total Paid	Paid PMPM	Total Paid	Paid PMPM	*Total*	*PMPM*
< 01	$9,093	$1.90	$12,238	$2.47	*34.6%*	*30.1%*
01	$51,362	$10.09	$59,990	$10.92	*16.8%*	*8.2%*
02 - 04	$454,129	$23.53	$447,536	$24.31	*-1.5%*	*3.3%*
05 - 09	$1,325,075	$34.15	$1,396,763	$36.30	*5.4%*	*6.3%*
10 - 14	$1,447,535	$31.75	$1,559,339	$33.97	*7.7%*	*7.0%*
15 - 19	$1,903,140	$35.97	$2,108,062	$39.56	*10.8%*	*10.0%*
20 - 24	$1,208,259	$21.34	$1,267,141	$22.25	*4.9%*	*4.2%*
25 - 29	$1,026,138	$25.18	$1,097,886	$26.30	*7.0%*	*4.5%*
30 - 34	$1,246,859	$26.65	$1,322,407	$28.70	*6.1%*	*7.7%*
35 - 39	$1,618,466	$30.55	$1,611,181	$29.44	*-0.5%*	*-3.6%*
40 - 44	$1,736,362	$30.86	$1,856,472	$32.26	*6.9%*	*4.5%*
45 - 49	$1,747,128	$33.28	$1,912,602	$34.89	*9.5%*	*4.8%*
50 - 54	$2,114,876	$35.63	$2,113,442	$37.03	*-0.1%*	*3.9%*
55 - 59	$2,274,126	$37.77	$2,382,469	$38.91	*4.8%*	*3.0%*
60 - 64	$2,672,565	$43.13	$2,700,354	$44.64	*1.0%*	*3.5%*
65+	$8,064,181	$49.66	$8,263,372	$50.71	*2.5%*	*2.1%*
Total	**$28,899,293**	**$35.40**	**$30,111,251**	**$36.71**	***4.2%***	***3.7%***

Dental Cost Distribution

Member Total Paid Range	Unique Members	Members % of Tot	Total Paid	Tot Paid % of Tot	Total OOP (Mem Paid)	OOP % of Tot
No Claims	27,139	36.1%	$0	0.0%	$0	0.0%
< $0 - $0	1,184	1.6%	-$17,921	-0.1%	$103,335	0.7%
> $0 - $250	12,232	16.3%	$1,951,409	6.5%	$826,830	5.6%
> $250 - $500	16,168	21.5%	$5,894,270	19.6%	$1,568,594	10.7%
> $500 - $750	6,132	8.2%	$3,719,407	12.4%	$1,372,357	9.3%
> $750 - $1000	3,309	4.4%	$2,864,419	9.5%	$1,492,988	10.1%
> $1000	9,016	12.0%	$15,699,666	52.1%	$9,349,397	63.5%
Total	**75,180**	**100.0%**	**$30,111,251**	**100.0%**	$14,713,500	100.0%

Paid Breakout by Dental Category



Dental Category	2025-4Q		2026-4Q		*Change*
	Patients	Total Paid	Patients	Total Paid	*Total Paid*
Preventive	36,983	$7,009,776	37,128	$7,347,132	*4.8%*
Diagnostic	43,549	$6,546,983	44,103	$6,865,823	*4.9%*
Basic	22,141	$10,180,735	22,222	$10,574,542	*3.9%*
Major	7,410	$5,161,799	7,428	$5,323,755	*3.1%*
Orthodontia	2	$0	4	$0	-
Total Dental	**47,223**	**$28,899,293**	**47,519**	**$30,111,251**	***4.2%***

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Dental Paid by Member Status

Breakout of State vs. Non-State by Member Status

Program	2025-4Q (7/1/2024 - 6/30/2025) Active	Pre-Medicare Retirees	Medicare Retirees	Total	2026-4Q (7/1/2025 - 6/30/2026) Active	Pre-Medicare Retirees	Medicare Retirees	Total	Trend Total
State Members									
Dental	$19,499,955	$2,276,076	$613,322	**$22,389,353**	$20,532,283	$2,249,736	$644,552	**$23,426,571**	*4.6%*
Dental Exchange			$4,265,064	**$4,265,064**			$4,492,673	**$4,492,673**	*5.3%*
Total	**$19,499,955**	**$2,276,076**	**$4,878,385**	**$26,654,417**	**$20,532,283**	**$2,249,736**	**$5,137,225**	**$27,919,243**	***4.7%***
PMPM	**$31.67**	**$40.51**	**$50.65**	**$34.69**	**$33.07**	**$41.14**	**$52.13**	**$36.06**	***3.9%***
Non-State Members									
Dental	$5,138	$58,220	$215,758	**$279,116**	$5,467	$44,268	$213,195	**$262,930**	*-5.8%*
Dental Exchange			$1,965,760	**$1,965,760**			$1,929,078	**$1,929,078**	*-1.9%*
Total	**$5,138**	**$58,220**	**$2,181,518**	**$2,244,876**	**$5,467**	**$44,268**	**$2,142,273**	**$2,192,008**	***-2.4%***
PMPM	**$31.18**	**$44.52**	**$46.86**	**$46.74**	**$27.90**	**$49.99**	**$47.71**	**$47.67**	***2.0%***
All Members									
Dental	$19,505,093	$2,334,296	$829,080	**$22,668,469**	$20,537,749	$2,294,004	$857,748	**$23,689,501**	*4.5%*
Dental Exchange			$6,230,824	**$6,230,824**			$6,421,750	**$6,421,750**	*3.1%*
Total	**$19,505,093**	**$2,334,296**	**$7,059,904**	**$28,899,293**	**$20,537,749**	**$2,294,004**	**$7,279,498**	**$30,111,251**	***4.2%***
PMPM	**$31.67**	**$40.60**	**$49.41**	**$35.40**	**$33.06**	**$41.28**	**$50.75**	**$36.71**	***3.7%***

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14.12

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14.6 Q4 Express Scripts – Summary Report
14.7 Q4 CDHP Performance Report
14.8 Q4 LD PPO Performance Report
14.9 Q4 EPO Performance Report
14.10 Q4 HPN Performance Report
14.11 Q4 Dental Performance Report
14.12 Q4 WTW's Individual Marketplace (Via Benefits) Enrollment & Performance Report

Public Employees' Benefits Programs

Quarterly Update – 4th Quarter Fiscal Year 2026

WTW's Individual Marketplace (Via Benefits)

August 7, 2026



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Executive Summary

Quarterly Update – 4th Quarter Fiscal Year 2026

Plan Enrollment

- As of FY Q4, 19,748 plan applications have been processed for PEBP retirees through Via Benefits, selecting 971 plans across 104 carriers.
- Medicare Supplement (MS) plans made up 82% of enrollments, led by AARP (5,538) and Anthem BCBS NV (1,410). Average MS premium: $151 per month.
- Medicare Advantage (MA) enrollment remained at 18%, with top selections from Humana (411) and Hometown Health Plan (373). Average MA premium: $53 per month.

Customer Satisfaction

- Enrollment Calls: 4.8/5.0 from 33 surveys.
- Service Calls: 4.4/5.0 from 285 surveys.
- Combined Q3 satisfaction: 4.5/5.0.

Health Reimbursement Arrangement

- 12,432 HRA accounts were active at the end of Q4 2026.
- 112,647 claims were processed, with 92.3% auto-reimbursed (103,947 claims).
- Total reimbursements: $8.5M across 44,967 payments, averaging $190.56 per payment.

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Summary of Retiree Decisions and Costs

Quarterly Update – 4th Quarter Fiscal Year 2026

Retiree Plan Selection Through 6/30/2026	Q4	Previous Qtr.
Total applications through Individual Marketplace	19,748	19,725
Number of carriers**	104	105
Number of plans**	971	978

Plan Type Selection Through 6/30/2026	Q4	Previous Qtr.
Medicare Advantage (MA, MAPD)	2,053	2,056
Medicare Supplement (MS)	9,519	9,513

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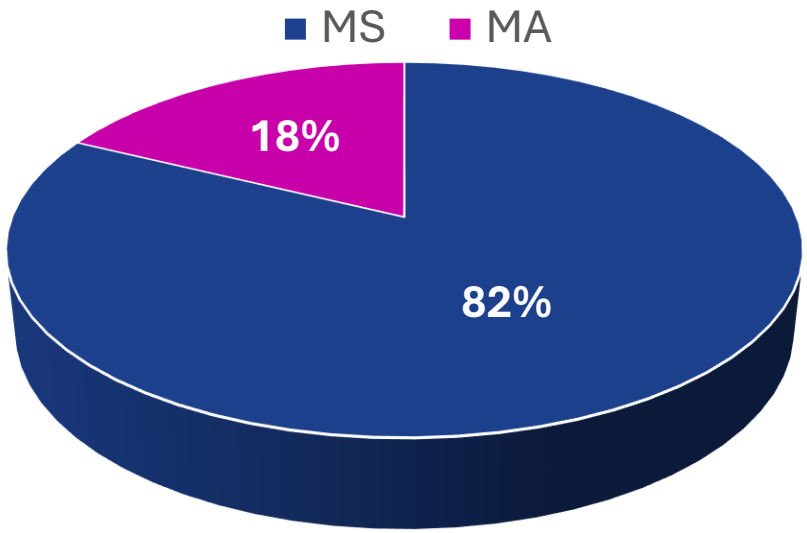
Summary of Retiree Decisions and Costs - Continue

Quarterly Update – 4th 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)	9,519	$151
Medicare Advantage (MA,MAPD)	2,053	$3 / $5
Part D drug coverage	5,543	$25
Dental coverage	893	$39
Vision coverage	1,740	$15

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Summary of Retiree Carrier Choice

Quarterly Update – 4th Quarter Fiscal Year 2026

Top Medicare Supplement Plans

Carrier	Total
AARP	5,538
Anthem BCBS of NV	1,410
Humana	592
Anthem BCBS	339
Cigna Health	307

Medicare Supplement Carrier Choice

Carrier	Percentage
AARP	58%
Anthem BCBS of NV	15%
Humana	6%
Anthem BCBS	4%
Cigna Health	3%
All Others	14%

Cost Data For MS Plans

Data	Cost
Minimum	$22
Average	$151
Median	$1,135
Maximum	$2,249

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Summary of Retiree Carrier Choice - Slide 2

Quarterly Update – 4th Quarter Fiscal Year 2026

Top Medicare Advantage Plans

Carrier	Total
Humana	411
Hometown Health Plan	373
Aetna	371
AARP from UHC	305
AllWell	92

Medicare Advantage Carrier Choice

Carrier	Percentage
Humana	20%
Hometown Health Plan	18%
Aetna	18%
AARP from UHC	15%
AllWell	4%
All Others	14%

Cost Data For MA Plans

Data	Cost
Minimum	$0
Average	$53
Median	$124
Maximum	$248

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Summary of Retiree Carrier Choice – Slide 3

Quarterly Update – 4th Quarter Fiscal Year 2026

Top Part D Plans

Carrier	Total
WellCare	2,624
Humana	1,527
AARP Part D from United Healthcare	479
Aetna Medicare Rx	285
CIGNA	247

Part D (RX) Carrier Choice

Carrier	Percentage
WellCare	47%
Humana	28%
AARP Part D from United Healthcare	9%
Aetna Medicare Rx	5%
CIGNA	4%
All Others	7%

Cost Data For Part D Plans

Data	Cost
Minimum	$0
Average	$29
Median	$240
Maximum	$480

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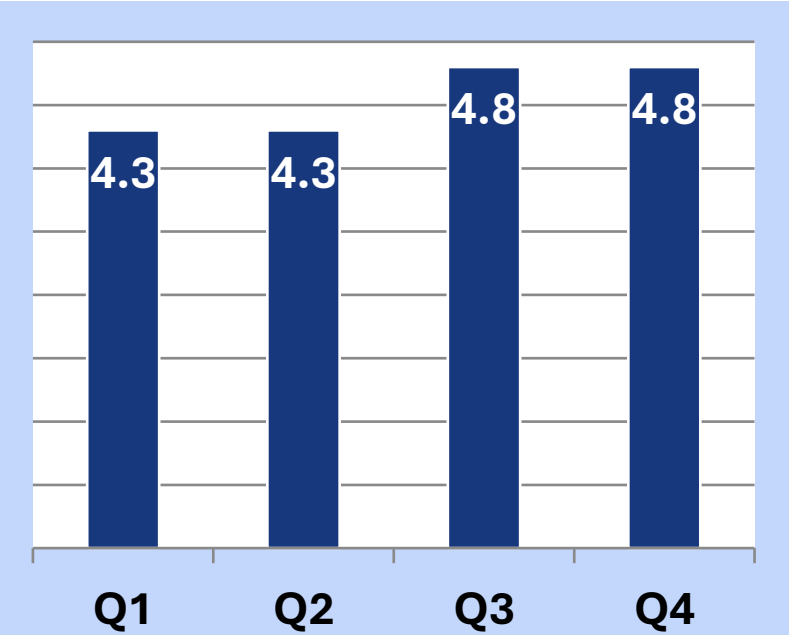
Customer Service – Voice of the Customer (VoC)

Quarterly Update – 4th 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.

Q4 Enrollment Satisfaction

CSAT score	Count	%
5	27	82%
4	5	15%
3	1	4%
2	0	0%
1	0	0%
	33	**100%**



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

Quarterly Update – 4th Quarter Fiscal Year 2026

Q4 Service Satisfaction

CSAT score	Count	%
5	198	70%
4	44	15%
3	20	7%
2	16	5%
1	8	3%
	285	**100%**



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

Quarterly Update – 4th Quarter Fiscal Year 2026

Q4 Enrollment and Service Combined

CSAT score	Count	%
5	225	71%
4	48	15%
3	21	7%
2	16	5%
1	8	2%
	318	**100%**



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Customer Service – Issues Log Resolution

Quarterly Update – 4th 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 Q4-FY 2026, 56 inquiries were reviewed, falling into the following categories:

Automatic Reimbursement	0
Call Review	0
Carrier Issue	0
Eligibility Data	0
Enrollment Request	18
Enrollment Status	12

General Questions	5
HRA	15
Mailings/Email	0
Reimbursement	11
Update Participant Information	0
Website Issues	0

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Health Reimbursement Arrangement (HRA)

Quarterly Update – 4th Quarter Fiscal Year 2026

Claim Activity for the Quarter	Q4 Total	Prior Quarter
HRA accounts	12,432	12,306
Number of payments	44,967	43,650
Accounts with no balance	8,195	7,985
Accounts with Direct Deposit	11,745	11,513
% of Accounts with Direct Deposit	94%	94%
Claims paid amount	$8,569,029	$8,540,376

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Health Reimbursement Arrangement (HRA) - Continued

Quarterly Update – 4th Quarter Fiscal Year 2026

Claims by Source	Q4 Total	Prior Quarter
Automatic Reimbursement Premium File	103,947	104,966
Mail	3,160	6,160
Website	3,759	4,963
Mobile App	1,781	2,368
TOTAL	112,647	118,457

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Performance Guarantees*

Quarterly Update – 4th Quarter Fiscal Year 2026

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.1 Days	Yes
Claim Financial Precision	≥ 98%	99.9%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.9%	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.	15 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.

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Performance Guarantees* - Continued

Quarterly Update – 4th Quarter Fiscal Year 2026

Category	Commitment	Outcome	PG MET
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	0.2%	Yes
Customer Satisfaction	≥ 80%	92.4%	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.

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Operations Report

Quarterly Update – 4th Quarter Fiscal Year 2026

HRA Available Balance Cap of $8,000

Effective May 29, 2026, Via Benefits processed the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. (Note that May 31, 2026 was on a Sunday so the process this year occurred on the last business day of May.) Allocation adjustments were made to 447 accounts for $777,251.87. Impacted participants can continue to receive monthly allocations if they are qualified for the HRA.

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Operations Report – Slide 2

Quarterly Update – 3rd Quarter Fiscal Year 2026

Fall 2026 Communications

- Fall "The Groove" Newsletter
  - "The Groove", is our digital newsletter communication that is normally sent bi-monthly. The version that is sent in mid/late September and will focus on educating participants on Medicare and the upcoming Medicare Open Enrollment Period that is from October 15 – December 7.

- HRA Qualification Reminder Notification
  - This communication reminds retirees that have a funding qualification requirement to contact Via Benefits during Medicare Open Enrollment if they want to change plans, so they do not negatively impact their HRA qualification. This communication is expected to mail in early/mid September.

- Fall Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days and have a positive available balance in their account. It is designed to remind the participant of their HRA balance so they can take action and submit new claims for reimbursement. The Balance Reminder is expected to start mailing in early/mid September.

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Operations Report – Slide 3

Quarterly Update – 3rd Quarter Fiscal Year 2026

Fall 2026 Retiree Meetings

WTW and Nevada PEBP will hosting four virtual retiree meetings on October 7 and 8, with a live attendance option at the PEBP office in Carson City. The meetings are 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 about Medicare, Medicare Open Enrollment, and the HRA

Registration links for the meetings will be available on the Nevada PEBP Via Benefits website for participants to access and register for the meeting that best meets situation.

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14.13

14. Receipt of quarterly vendor reports for the period ending June 30, 2026. (Information/Discussion)

14.1 Q4 UMR – Obesity and Diabetes Care Management
14.2 Q4 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
14.3 Q4 Sierra Healthcare Options – Utilization and Large Case Management
14.4 Q4 UnitedHealthcare – Basic Life Insurance
14.5 Q4 Express Scripts – Utilization Report
14.6 Q4 Express Scripts – Summary Report
14.7 Q4 CDHP Performance Report
14.8 Q4 LD PPO Performance Report
14.9 Q4 EPO Performance Report
14.10 Q4 HPN Performance Report
14.11 Q4 Dental Performance Report
14.12 Q4 WTW's Individual Marketplace (Via Benefits) Enrollment & Performance Report
14.13 Q4 Doctor on Demand Engagement Report



Included Health

Virtual Care Engagement Monthly Report

dr. on demand by Included Health

UMR-State of Nevada

April 2026

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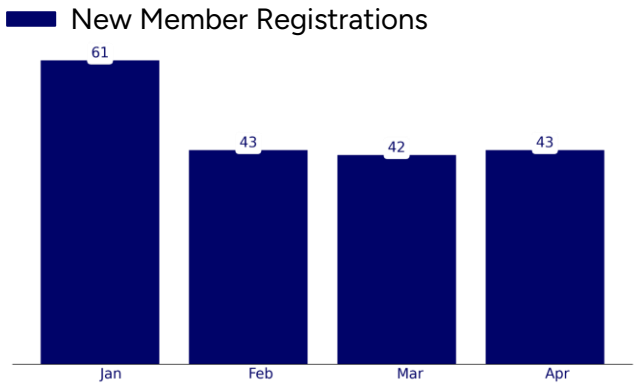
Member Engagement

43	324	423
Registrations This Month	Unique Visitors This Month	Total Visits This month

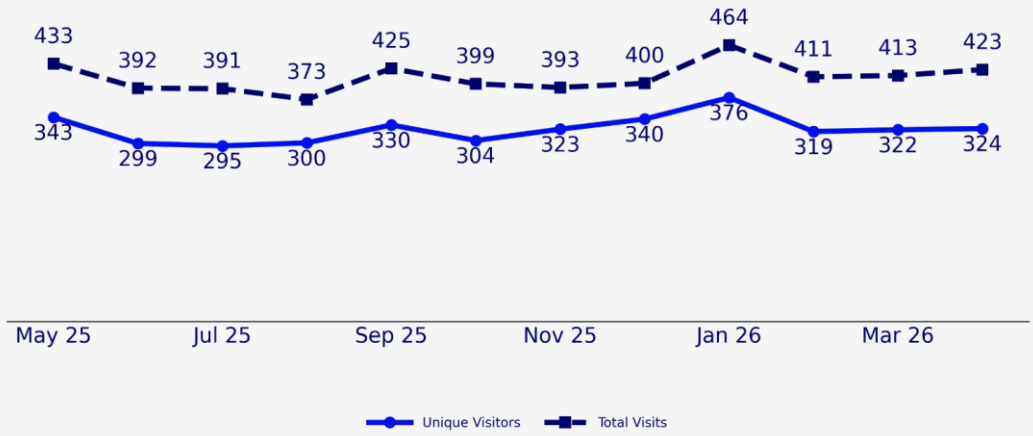
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement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

New Registrations (Year to Date)



48,935	14,218	29%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	189	0.3%
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

Visits Last 12 Months



29,407	8,543	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
1,711	992	1.7	2%
Visits Year to Date	Unique Visitors Year to Date	Avg Visits Per Visitor Year to Date	Engagement Rate (Visitors/Lives) Year to Date

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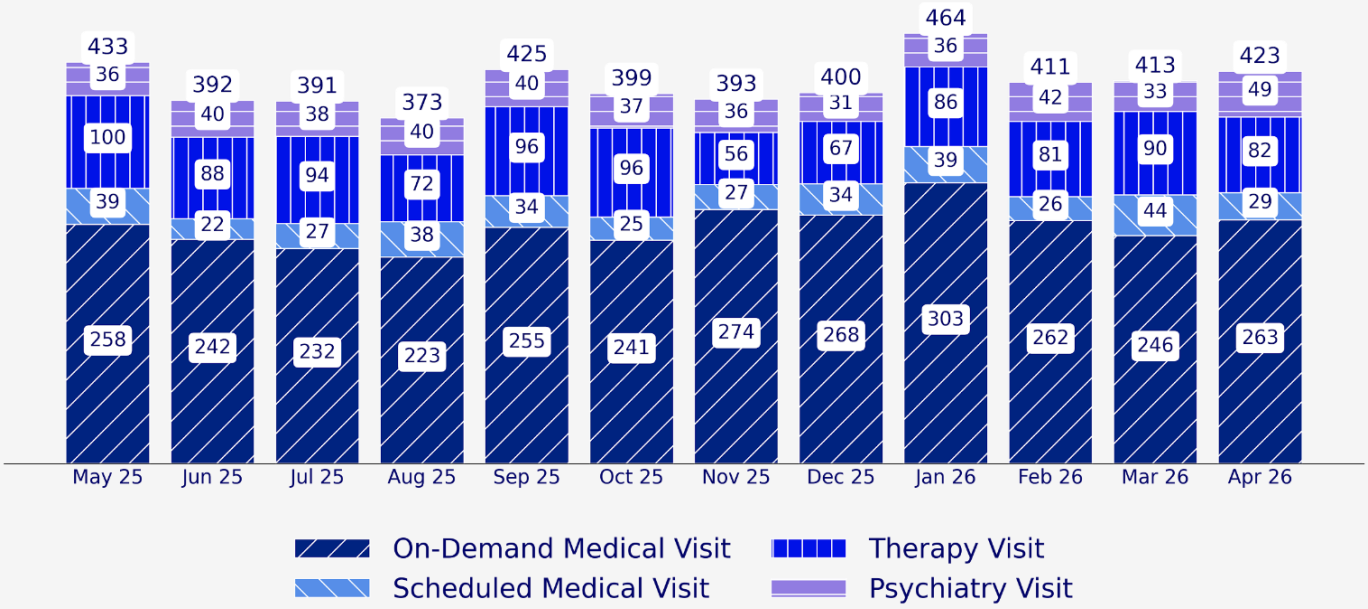
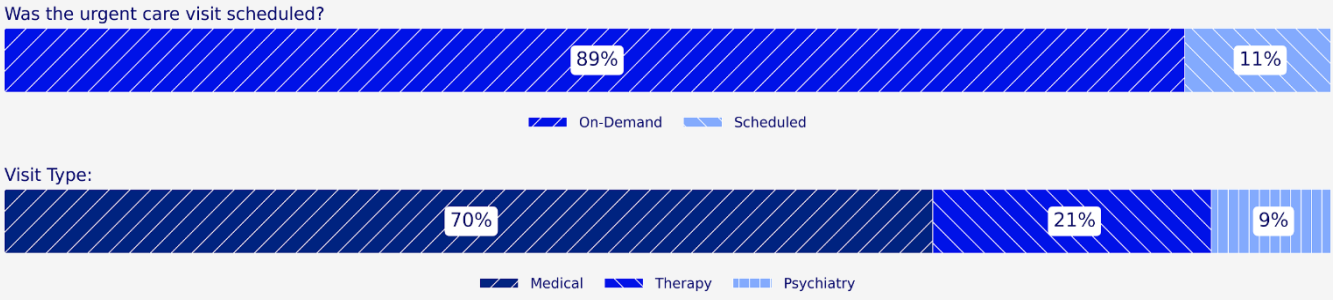
Member Engagement

Medical & Behavioral Health Visits (Rolling) - 4,917 Visits



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Wednesday

Most Popular Time for Visits Year to Date

Noon - 2PM

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

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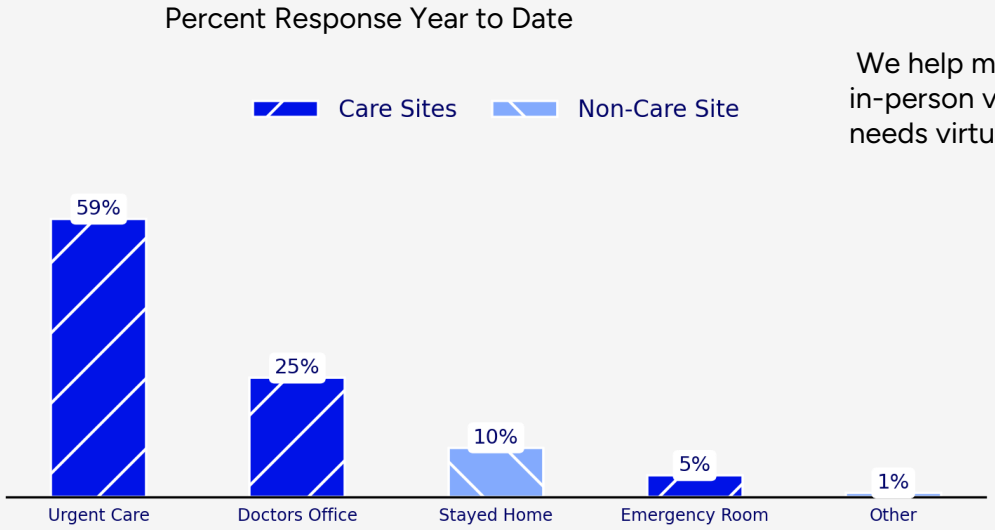
Supporting your population

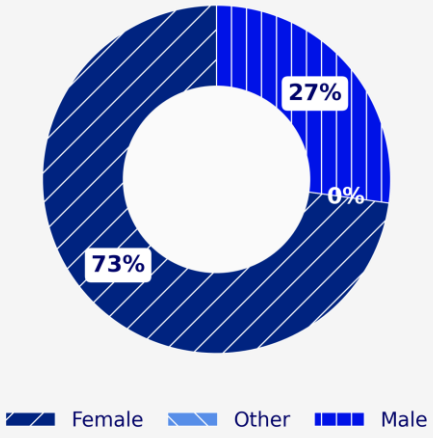
Member access, demographics, and experience

Without Included Health, where would you have gone?

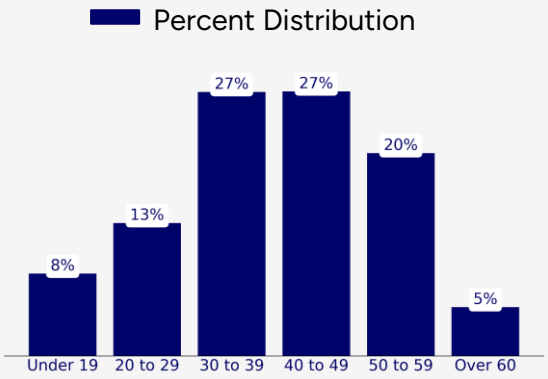


We help members avoid unnecessary in-person visits by treating their needs virtually.

Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	April	Year to Date
Average Member Rating	4.9 / 5 (N = 207)	4.9 / 5 (N = 926)
Median Wait Time for On-Demand Medical Appointments	14.7 min	10.8 min
Median Days to Scheduled Appointment (BH)	10.0 days	11.0 days

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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	143
Cough	130
Urinary tract infection (UTI)	117
Sore throat	94
Anxiety	81
Nasal congestion	77
Eye issue	51
Other injury	48
Influenza	48
Rash	46

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	404
Anxiety disorders	332
Mood disorders	186
Bacterial infection; unspecifi..	116
Urinary tract infections	110
Adjustment disorders	109
Administrative/social admission	70
Depression, unspecified	60
Influenza	56
Inflammation; infection of eye..	54

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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

463	83%	18	2%
Prescriptions This Month	of Medical and Psychiatry visits resulted in a prescription order Year to Date	Lab Orders This Month	of Medical visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
benzonatate 200 mg capsule	146
amoxicillin 875 mg-potassium c	109
fluticasone propionate 50 mcg/	91
albuterol sulfate hfa 90 mcg/a	89
nitrofurantoin monohydrate/mac	80
prednisone 20 mg tablet	69
azelastine 137 mcg (0.1 %) nas	64
doxycycline hyclate 100 mg cap	50
fluconazole 150 mg tablet	44
methylprednisolone 4 mg tablet	39

Top Labs	Count (YTD)
urinalysis complete, reflex culture	11
cbc w/ auto diff	5
cmp, serum or plasma	5
hba1c (hemoglobin a1c), blood	4
lipid panel, serum	4
o&p (ova & parasites), stool	3
unlisted lab	3
salmonella sp + shigella sp, culture, stool	3
urinalysis, complete	2
h pylori ag, stool	2

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

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Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow-up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care:** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

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Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

May 2026

dr+ on demand by Included Health

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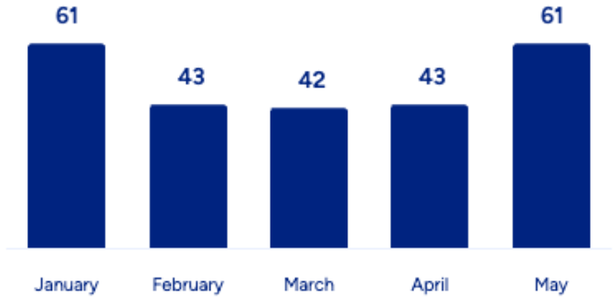
Member Engagement

61	297	380
Registrations This Month	Unique Visitors This Month	Total Visits This Month

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

New Registrations (Year to Date)



48,935	14,290	29%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	256	0.5%
Employee Covered Lives	Registration Year to Date	Registration Rate Year to Date

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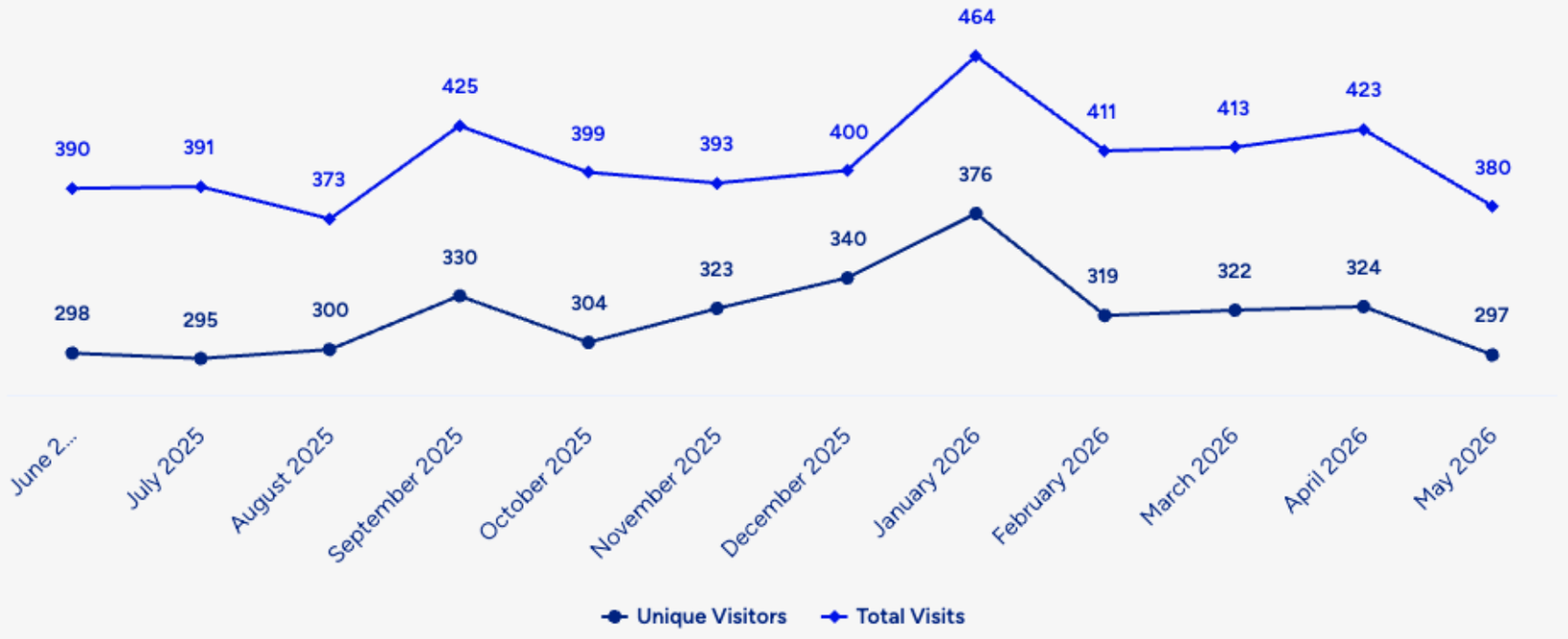
Visits Last 12 Months



29,782 Visits Lifetime to Date	**8,592** Unique Visitors Lifetime to Date	**3.5** Avg Visits Per Visitor Lifetime to Date	**18%** Engagement Rate (Visitors/Lives) Lifetime to Date
2,090 Visits Year to Date	**1,140** Unique Visitors Year to Date	**1.8** Avg Visits Per Visitor Year to Date	**2%** Engagement Rate (Visitors/Lives) Year to Date

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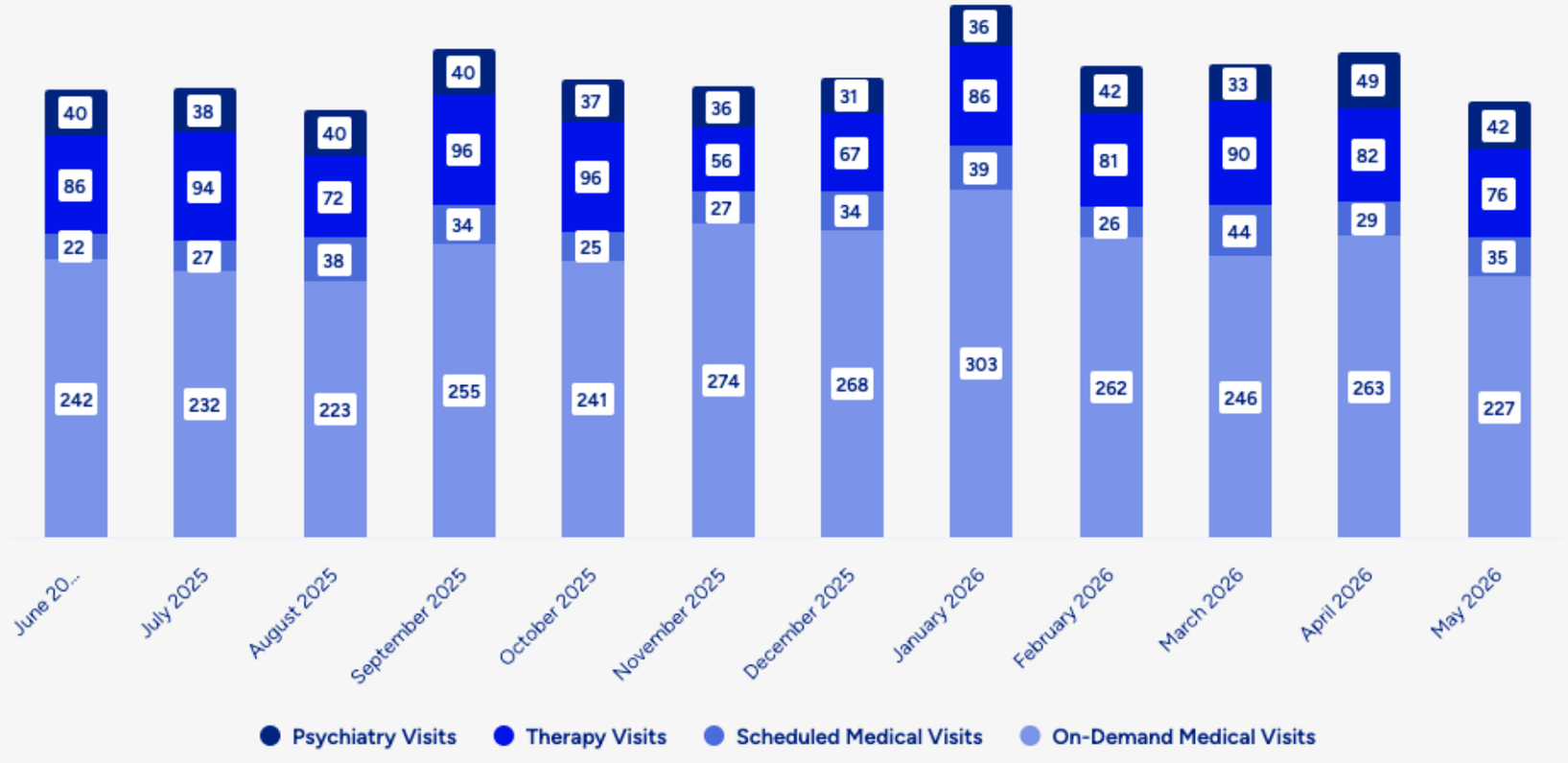
Medical & Behaviorial Health Visits (Rolling) - 4,863 Visits



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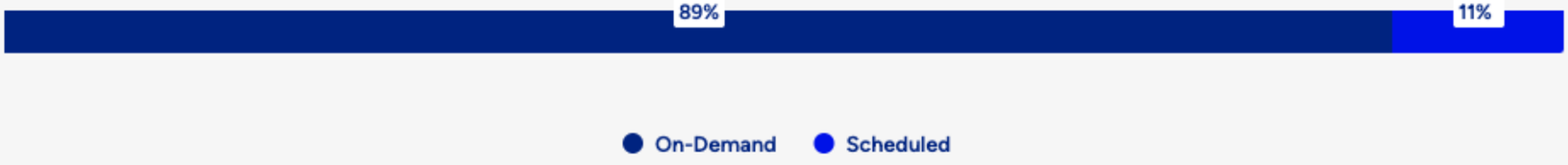
Member Demand by Visit Type Year to Date

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

8AM - 10AM

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

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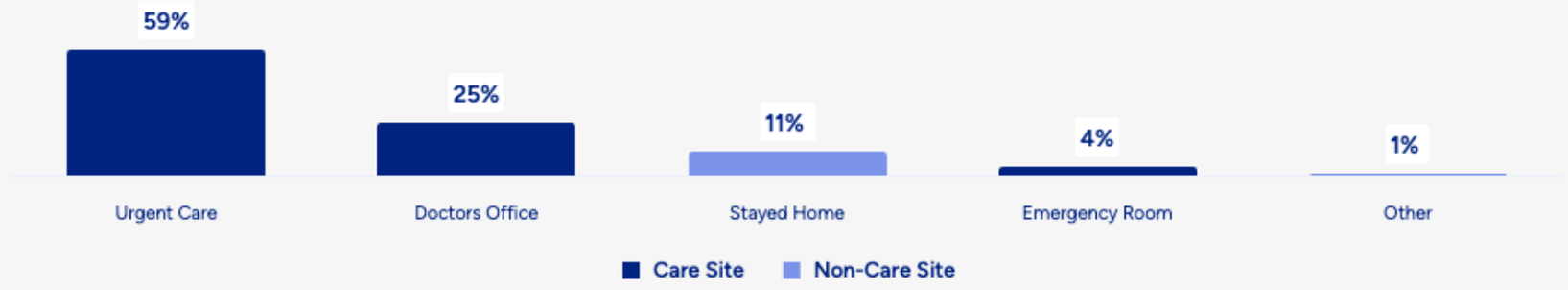
Supporting your population

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.

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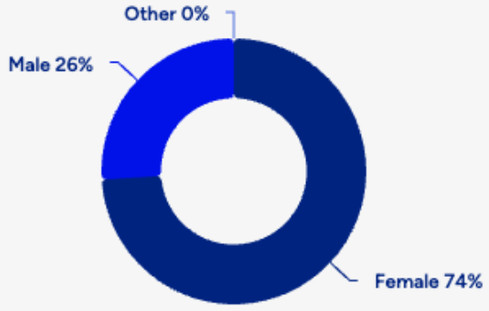
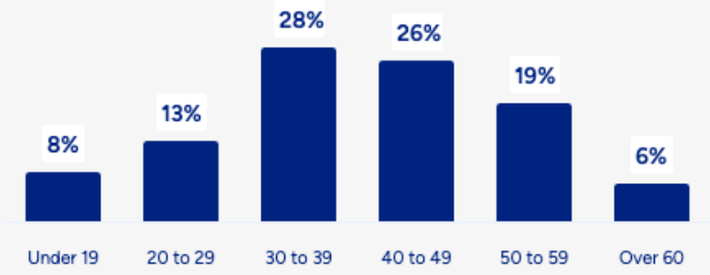
Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	May	Year to Date
Average Member Rating	4.9 / 5 (N = 211)	4.9 / 5 (N = 1,136)
Median Wait Time for On-Demand Medical Appointments	17.0 min	12.0 min
Median Days to Scheduled Appointment (BH)	9.0 days	11.0 days

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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	157
Cough	153
Urinary tract infection (UTI)	151
Sore throat	120
Anxiety	99
Nasal congestion	91
Other injury	64
Eye issue	64
Influenze	58
Prescription refill	57

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Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	475
Anxiety disorders	408
Mood disorders	241
Urinary tract infections	141
Adjustment disorders	131
Bacterial infection; unspecifi..	131
Depression, unspecified	83
Administrative/social admission	82
Viral infection	68
Inflammation; infection of eye..	66

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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

416
Prescriptions This Month

82%
of Medical and Psychiatry visits resulted in a prescription order Year to Date

19
Lab Orders This Month

2%
of Medical visits resulted in a lab order Year to Date

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Top Prescriptions and Testing Orders

Top Prescriptions	Count (YTD)
benzonatate 200 mg capsule	172
amoxicillin 875 mg-potassium c	122
albuterol sulfate hfa 90 mcg /a	112
fluticasone propionate 50 mcg/	109
nitrofurantoin monohydrate /mac	103
prednisone 20 mg tablet	87
azelastine 137 mcg (0.1 %) nas	76
doxycycline hyclate 100 mg cap	57
fluconazole 150 mg tablet	48
phenazopyridine 200 mg tablet	47

Top Labs	Count (YTD)
urinalysis complete, reflex culture	14
cbc w/ auto diff	6
cmp, serum or plasma	6
hba1c (hemoglobin a1c), blood	5
lipid panel, serum	5
culture, urine	5
tsh, ultra-sensitive, serum	3
unlisted lab	3
o&p (ova & parasites), stool	3
ct + ng rna, pcr, unspecified specimen	3

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

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Data & Metric Definitions

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow-up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care:** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical -acute, preventive and chronic -and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.

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Metric	Definition
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

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Included Health

Virtual Care Engagement Monthly Report

UMR-State of Nevada

June 2026

dr+ on demand by Included Health

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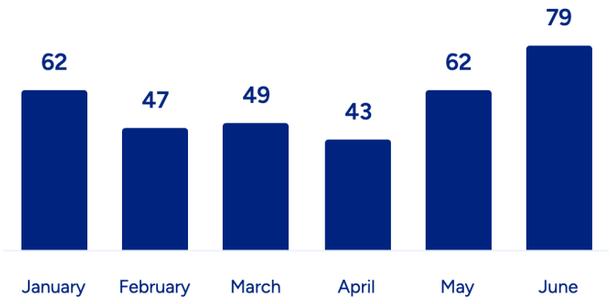
Member Engagement

79	313	395
Registrations This Month	Unique Visitors This Month	Total Visits This Month

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

New Registrations (Year to Date)



48,935	14,399	29%
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	342	1%
Employee Covered Lives	Registration Year to Date	Registration Rate Year to Date

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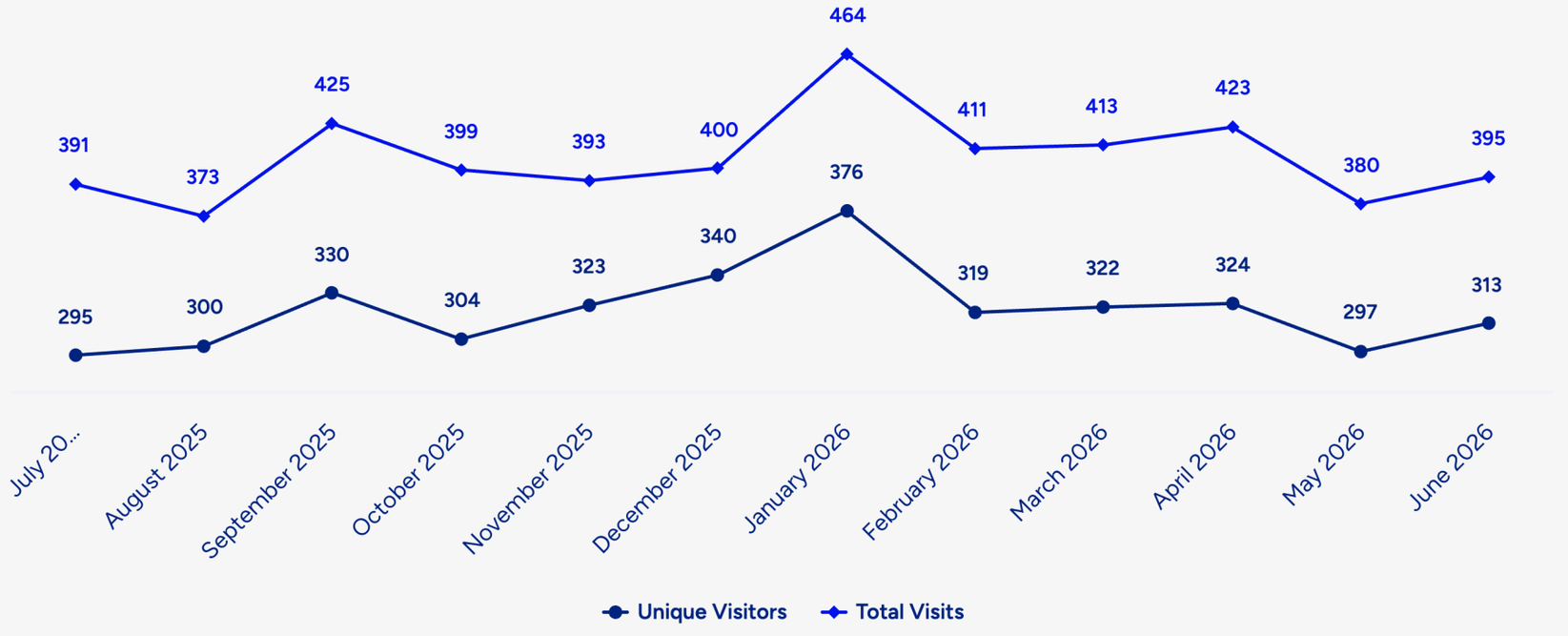
Visits Last 12 Months



30,178
Visits Lifetime to Date

8,687
Unique Visitors Lifetime to Date

3.5
Avg Visits Per Visitor Lifetime to Date

18%
Engagement Rate (Visitors/Lives) Lifetime to Date

2,485
Visits Year to Date

1,302
Unique Visitors Year to Date

1.9
Avg Visits Per Visitor Year to Date

3%
Engagement Rate (Visitors/Lives) Year to Date

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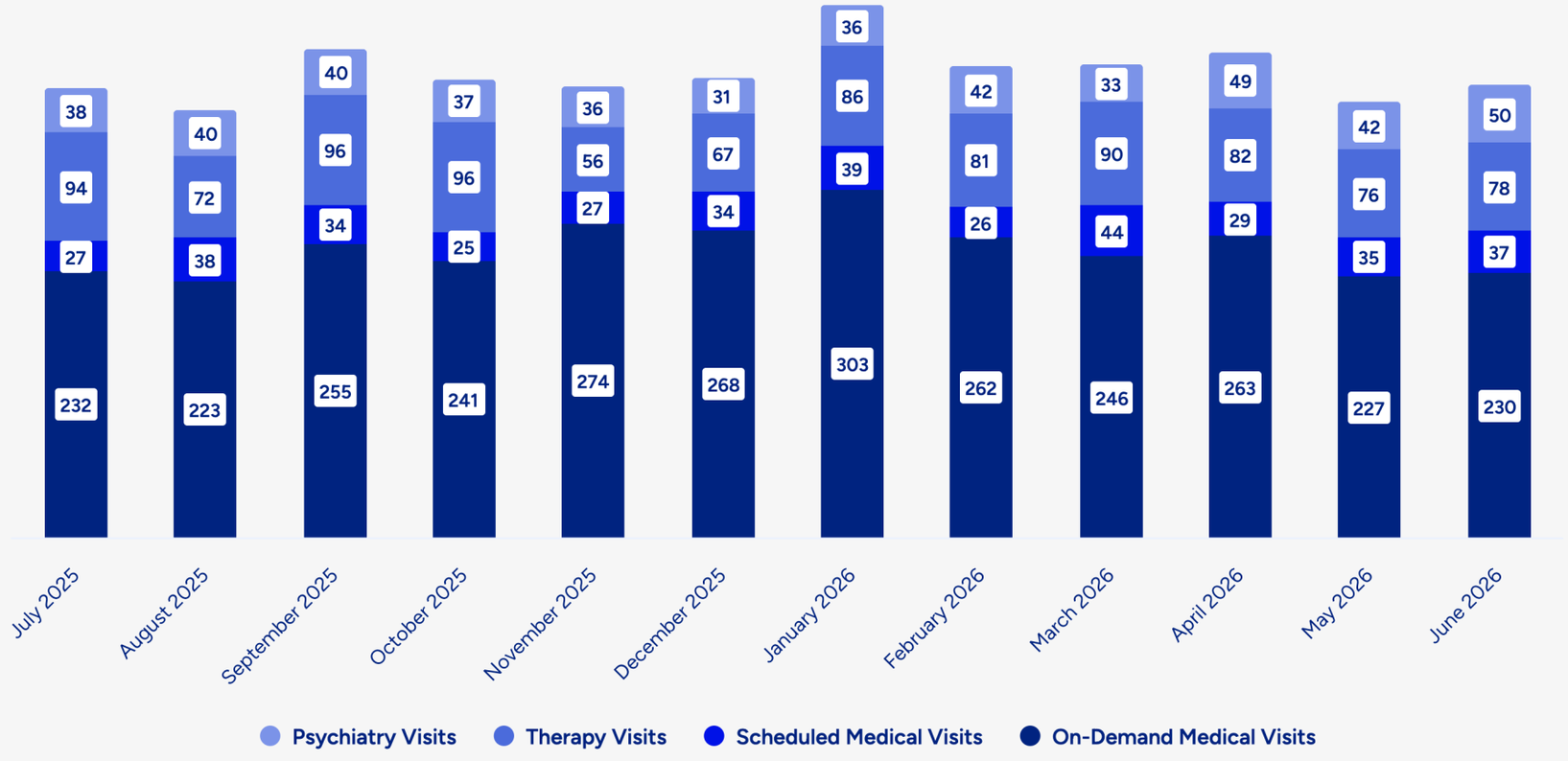
Medical & Behaviorial Health Visits (Rolling) - 4,866 Visits



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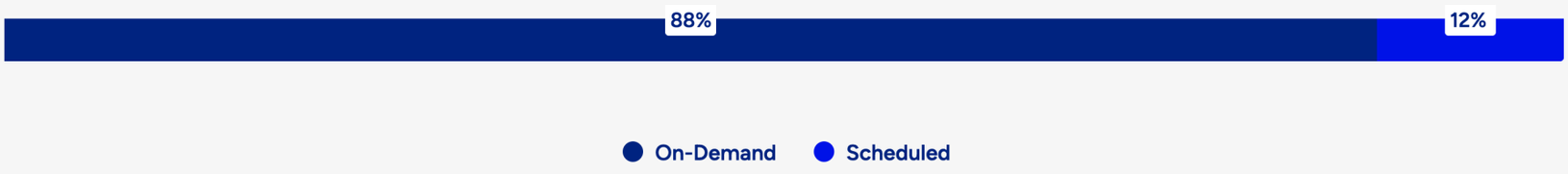
Member Demand by Visit Type Year to Date

Was the urgent care visit scheduled?



Visit Type



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

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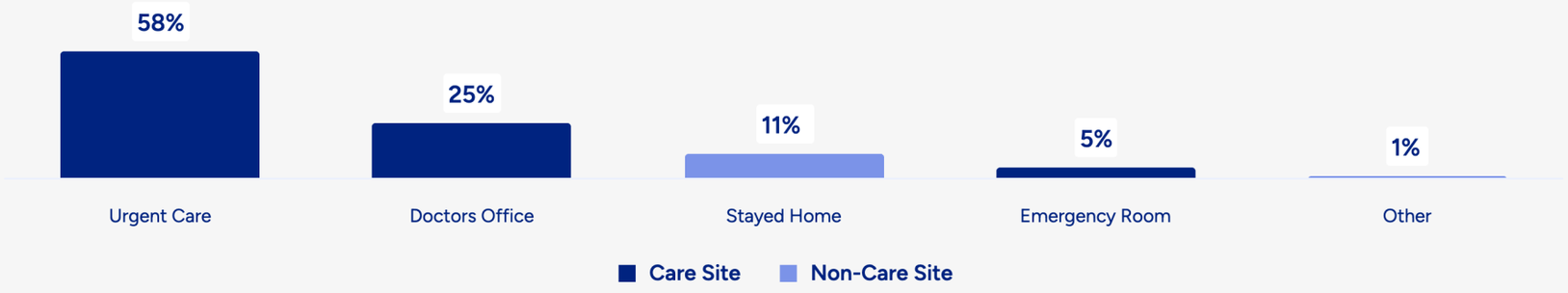
Supporting your population

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.

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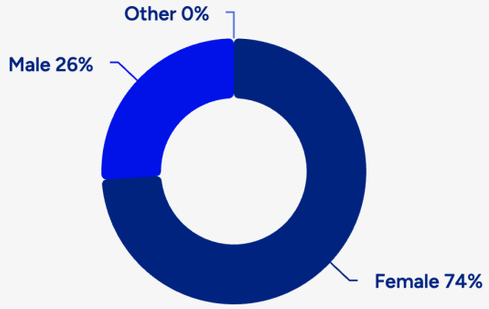
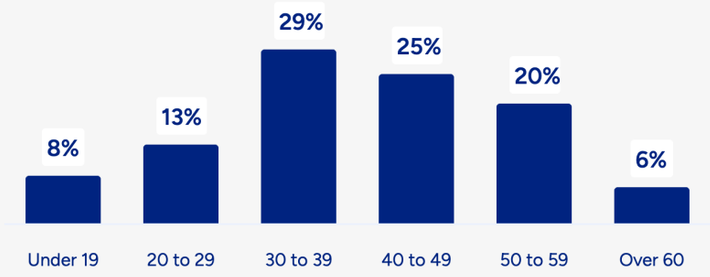
Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	June	Year to Date
Average Member Rating	4.9 / 5 (N = 230)	4.9 / 5 (N = 1,366)
Median Wait Time for On-Demand Medical Appointments	13.0 min	12.2 min
Median Days to Scheduled Appointment (BH)	13.0 days	12.0 days

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Member Clinical Needs

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Member Reported Visit Reasons

Top 10 Visit Reasons

Visit Reasons	Visits Year to Date
Urinary tract infection (UTI)	187
Cold	181
Cough	170
Sore throat	139
Anxiety	120
Nasal congestion	103
Other injury	77
Eye issue	77
Prescription refill	73
Rash	63

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Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits Year to Date
Other upper respiratory infect..	545
Anxiety disorders	496
Mood disorders	295
Urinary tract infections	173
Adjustment disorders	159
Bacterial infection; unspecifi..	150
Depression, unspecified	106
Administrative/social admission	99
Viral infection	80
Inflammation; infection of eye..	78

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Clinical Service Delivery

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Prescriptions and Testing Summary

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Top Prescriptions and Testing Orders

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albuterol sulfate hfa 90 mcg /a	130
nitrofurantoin monohydrate /mac	127
fluticasone propionate 50 mcg/	126
prednisone 20 mg tablet	100
azelastine 137 mcg (0.1 %) nas	87
doxycycline hyclate 100 mg cap	65
fluconazole 150 mg tablet	64
phenazopyridine 200 mg tablet	61

Top Labs	Count (YTD)
urinalysis complete, reflex culture	16
cmp, serum or plasma	7
cbc w/ auto diff	7
culture, urine	6
lipid panel, serum	6
hba1c (hemoglobin a1c), blood	6
unlisted lab	4
o&p (ova & parasites), stool	4
tsh, ultra-sensitive, serum	3
ct + ng rna, pcr, unspecified specimen	3

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15.

15. Public Comment.

16.

16. Adjournment.