



Joe Lombardo
Governor

**NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM**

3427 Goni Road, Suite 109
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NVHA.NV.GOV
PEBP.NV.GOV



Stacie Weeks
Director



Theresa Carsten
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization: Public Employees' Benefits Program

Date and Time of Meeting: October 24, 2025 9:00 a.m.

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

Video Conferencing: **This meeting will also be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at**
<https://www.youtube.com/live/z0nGz5hYmgM>

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

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

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

- Option #1** Join the webinar as an attendee <https://us06web.zoom.us/j/81237447363>
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: 812 3744 7363 then press #. When prompted for a Participant ID, please enter #.

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

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

AGENDA

1. Open Meeting; Roll Call.

2. Public Comment.

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

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

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

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

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

- 6.1 Presentation and potential adoption of redlined revisions arising from 81st, 82nd, and 83rd legislative sessions
- 6.2 Discussion regarding additional Board-suggested revisions to be made
- 6.3 Discussion on identifying a Board meeting to discuss a revised PEBP Strategic Plan

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

8. Presentation and possible action on Structure and Financial Results (Premiums Collected, Benefits Paid, Actuarial Value) of the Current PEBP Plans. (Richard Ward, Segal) **(For Possible Action)**
 - 8.1 Overview of current PEBP plans and possible revisions for future plan years: Consumer Driven Health Plan (CDHP), Low-Deductible Preferred Provider Organization (LDPPO), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO)
 - 8.2 Incurred but Not Reported (IBNR) for end of FY25
 - 8.3 Other Post Employment Benefits (OPEB/GASB) Measured for FY24 for FY25 Reporting
 - 8.4 Discussion on other models or information Board would like to review in November.
9. FY25 Year End Financial/ Budget Report. (Theresa Carsten, Executive Officer) (Information/Discussion)
10. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitation. (Theresa Carsten, Executive Officer,) **(For Possible Action)**
 - 10.1 Contract Overview
 - 10.2 New Contracts
 - 10.3 Contract Amendments
 - 10.4 Status of Current Solicitations
11. Executive Officer Report. (Theresa Carsten, Executive Officer) **(For Possible Action)**
12. Quarter 4 Vendor Reports. (Information/Discussion)
 - 12.1 Receipt of quarterly vendor reports for the period ending July 30, 2025:
 - 12.1.1 Q4 UMR – Obesity and Diabetes Care Management
 - 12.1.2 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
 - 12.1.3 Q4 UnitedHealthcare Basic Life Insurance
 - 12.1.4 Amplifon Performance Report
 - 12.2 Questions or discussion related to any reports provided (Board)
13. Public Comment.

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.
14. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at https://pebp.nv.gov. For additional information, contact Jessica Crane at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at https://pebp.nv.gov, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call.

2.

2. Public Comment.

3.

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

4.

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

**STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING**

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)

July 31, 2025

MEMBERS PRESENT

Ms. Blaine Harper, Member

VIA TELECONFERENCE:

Mr. Christopher Viton, Member

MEMBERS PRESENT

Ms. Joy Grimmer, Board Chair

IN PERSON:

Mr. Jim Wells, Member

Ms. Laura Rich, Member

Ms. Janell Woodward, Member

Mr. Jim Barnes, Member

Ms. Keiko Duncan, Member

MEMBERS EXCUSED:

Dr. Jennifer McClendon, Member

FOR THE BOARD:

Ms. Radhika Kunnel, Deputy Attorney General

FOR STAFF:

Mr. Nik Proper, Interim Executive Officer

Ms. Michelle Weyland, Chief Financial Officer

Ms. Brandee Mooneyhan, Lead Insurance Counsel

Ms. Leslie Bittleston, Quality Control Officer

Ms. Jessica Crane, Executive Assistant

OTHER PRESENTERS:

Joni Amato, Claim Technologies Incorporated

Richard Ward, Segal

1. Open Meeting; Roll Call.

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

2. Public Comment.

- Terri Laird – RPEN
- Kent Ervin – NV Faculty Alliance
- Amy Pason – Nevada Faculty Alliance
- Doug Unger – NV Faculty Alliance
- Ian Hartshorn – PEBP Member
- Dr. Dana Trippi – Provider
- Chris Syverson – NV Business Group on Health
- Tess Opferman – AFSCME

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

4. Applicant interviews for position of the Executive Officer of PEBP. (For Information)

4.1 Applicants to be interviewed: (approximately 1 hour per interview)

- Theresa Carsten
- Holly Luna

5. Discussion and possible action regarding recommendation to the Director of the Nevada Health Authority and the Governor regarding the appointment of the Executive Officer of the Public Employees' Benefits Program, pursuant to NRS 287.0424 (1). (Joy Grimmer, Board Chair)
(For Possible Action)

BOARD ACTION ON ITEM 5

MOTION: Motion to recommend Theresa Carsten to the Director and Governor for appointment to the Executive Officer of PEBP.

BY: Member Jim Wells

SECOND: Member Janell Woodward

VOTE: Unanimous; the motion carried

6. Consent Agenda. (Joy Grimmer, Board Chair) **(All Items for Possible Action)**

Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

6.1 Approval of Action Minutes from the May 22, 2025 PEBP Board Meeting.

6.2 Receipt of quarterly staff reports for the period ending March 31, 2025 and June 30, 2025:

- 6.2.1 Q4 Budget Report
- 6.2.2 Q3 Utilization Report
- 6.3 Receipt of quarterly vendor reports for the period ending March 31, 2025:
 - 6.3.1 Q3 UMR – Obesity Care Management
 - 6.3.2 Q3 UMR – Diabetes Care Management
 - 6.3.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management
 - 6.3.4 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
 - 6.3.5 Q3 Express Scripts – Summary Report
 - 6.3.6 Q3 Express Scripts – Utilization Report
 - 6.3.7 Q3 UnitedHealthcare – Basic Life Insurance
- 6.4 Approval of PEBP's revised Language Access Plan
- 6.5 Receipt of 2025 Legislative Session Recap

BOARD ACTION ON ITEM 6

MOTION: Motion to approve the consent agenda except for item 6.2.1.

BY: Member Laura Rich

SECOND: Member Jim Barnes

VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6.2.1

MOTION: Motion to approve agenda item 6.2.1.

BY: Member Jim Barnes

SECOND: Member Janell Woodward

VOTE: Unanimous; the motion carried

- 7. Executive Officer Report. (Nik Proper, Interim Executive Officer) (Information/Discussion)
- 8. Discussion and possible action on recommended Plan Design and Master Plan Document changes for Plan Year 2026 (July 1, 2025 – June 30, 2026) and Plan Year 2027 (July 1, 2026 – June 30, 2027). (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8

MOTION: Motion to approve and allow staff to make additional adjustments.

BY: Member Laura Rich

SECOND: Member Jim Barnes

VOTE: Unanimous; the motion carried

- 9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of January 1, 2025 – March 31, 2025. (Joni Amato, CTI) (**For Possible Action**)

BOARD ACTION ON ITEM 9

MOTION: Motion to approve agenda item 9.

BY: Member Laura Rich

SECOND: Member Jim Barnes

VOTE: Unanimous; the motion carried

10. Discussion and possible action on Pharmacy Benefit Manager Market Check. (Richard Ward, Segal) **(For Possible Action)**

BOARD ACTION ON ITEM 10

MOTION: Motion to approve the new favorable contract pricing as advised by Segal.

BY: Member Laura Rich

SECOND: Member Jim Barnes

VOTE: Unanimous; the motion carried

11. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitation. (Michelle Weyland, Chief Financial Officer)
(For Possible Action)

11.1 Contract Overview

11.2 New Contracts

11.3 Contract Amendments

11.4 Status of Current Solicitations

BOARD ACTION ON ITEM 11

MOTION: Motion to approve the contract and amendments that are outlined.

BY: Member Jim Wells

SECOND: Member Jim Barnes

VOTE: Unanimous; the motion carried

12. Election of Board Chair.¹ Eligible candidates are Joy Grimmer, Janell Woodward, Laura Rich, Jim Wells, Jennifer McClendon, Jim Barnes. (Joy Grimmer, Board Chair) **(For Possible Action)**

BOARD ACTION ON ITEM 12

MOTION: Motion to approve Jim Wells as Board Chair.

BY: Member Laura Rich

SECOND: Member Keiko Duncan

VOTE: Unanimous; the motion carried

13. Public Comment.

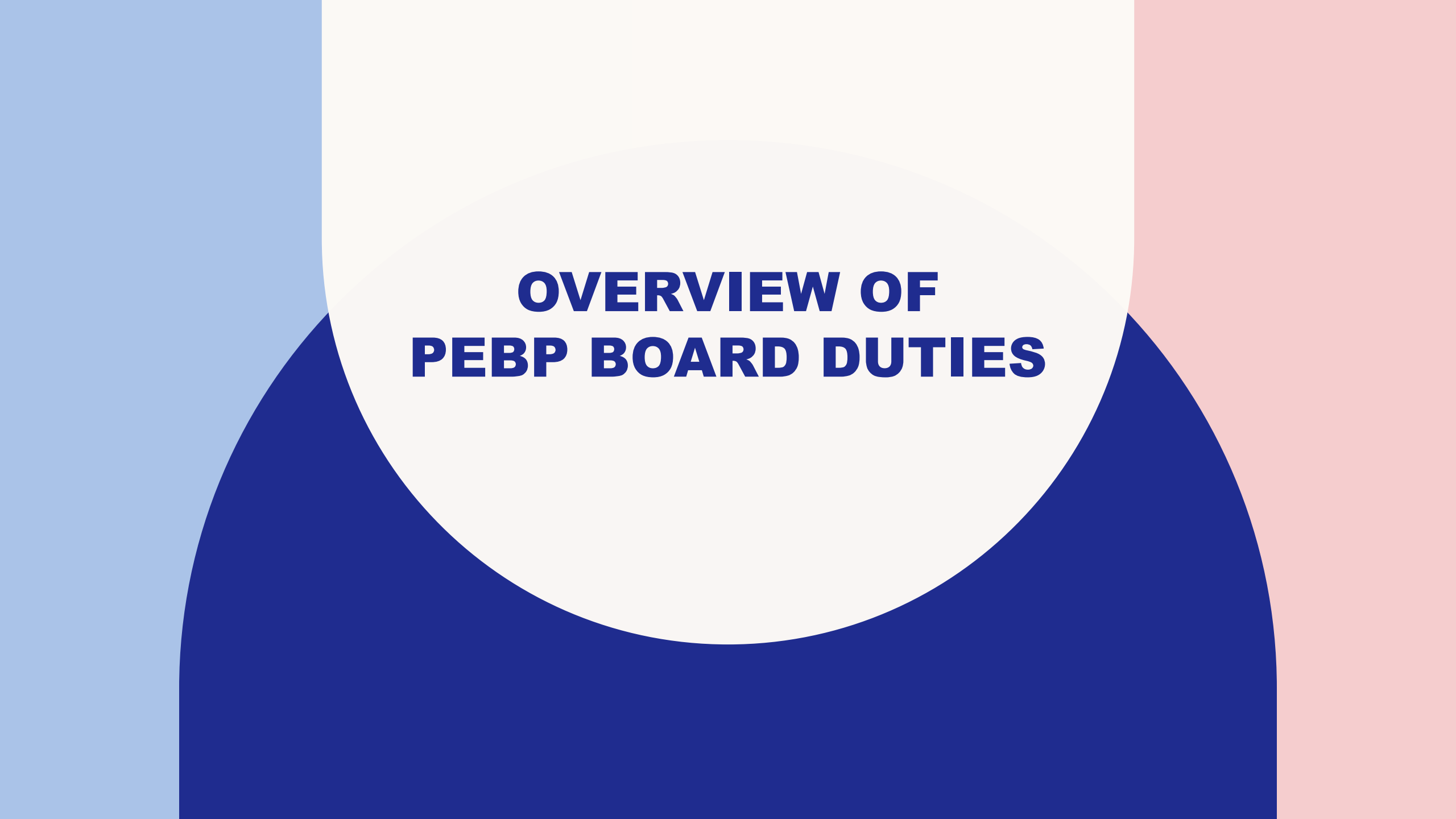
14. Adjournment.

- Board Chair Grimmer adjourned the meeting at 11:51 a.m.

¹ The Chair was previously appointed by the Governor. Effective July 1, 2025, “the Board shall elect one of its members to serve as the Chair,” while the Governor will designate one member to serve as Vice Chair. SB 494 §68.5, 83d Sess. (Nev. 2025) (amending NRS 287.0415). The statute provides that the Chair is to be elected “[a]t the beginning of each calendar year.” The current election is intended to allow a Board member to act as Chair until an election can be held at the first Board meeting in 2026, in compliance with NRS 287.0415(2).

5.

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

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OVERVIEW OF PEBP BOARD DUTIES

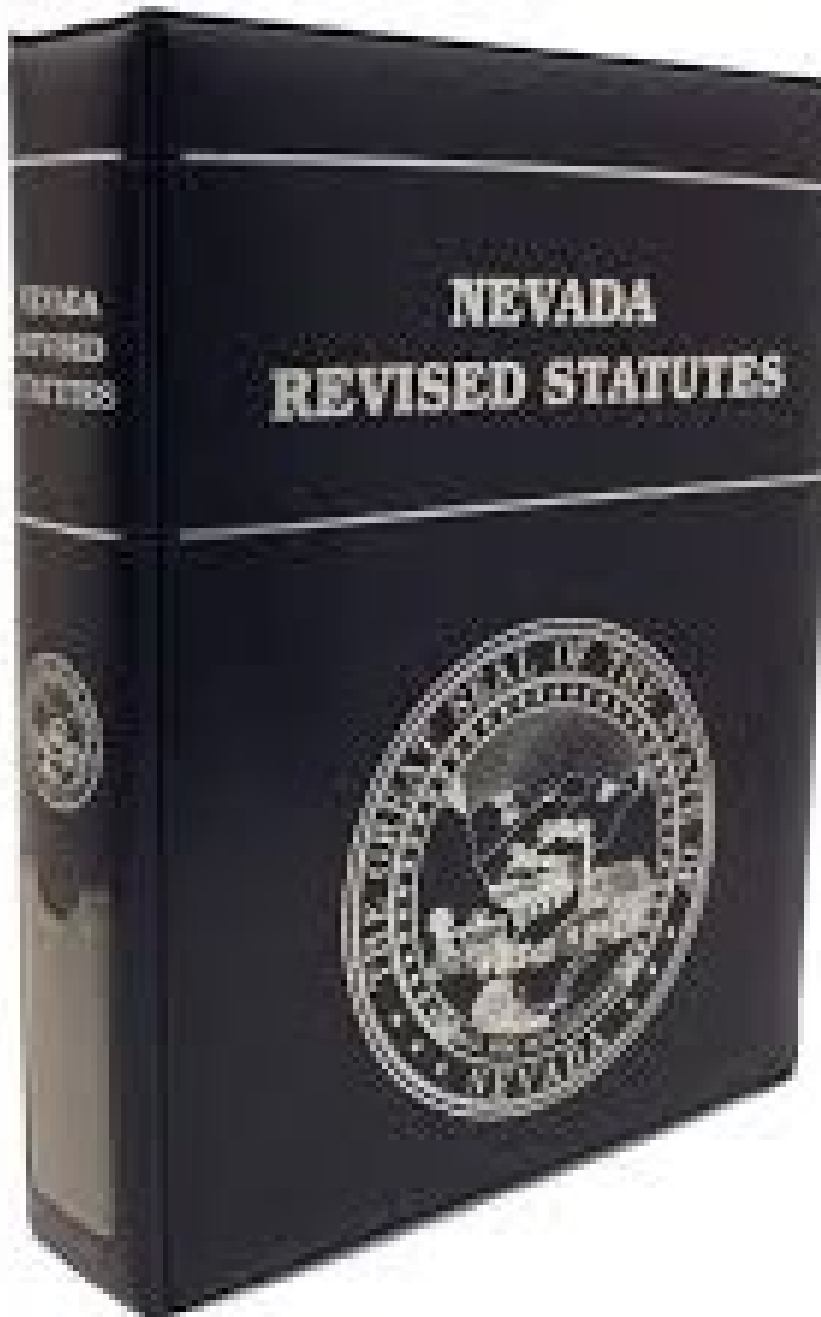
SOURCES

Nevada Revised Statutes

Including 2025 Legislative Updates

Nevada Administrative Code

Board Policies and Procedures



NEVADA REVISED STATUTES

NRS CHAPTER 287

Establishes PEBP and its Board

In part, sets forth Board powers and duties



SENATE BILL 494 (2025)

- Created the Nevada Health Authority (NVHA)
 - PEBP is part of new NVHA
 - Began July 1, 2025
 - NVHA was created to develop/implement improvements to access and minimize the costs of health care
 - Such plans will be periodically presented to Board for input
 - Will include recommendations to Board re: ways to improve value, quality and accessibility
- S.B. 494 adjusted some provisions of NRS Chapter 287

BOARD CHARACTERISTICS

NRS 287.041

- “There is hereby created the Board of the Public Employees’ Benefits Program.” NRS 287.041(1).
- Also addresses composition of board, appointment and qualifications of board members, and terms.
 - S.B. 494 adjusted some provisions; for example, some Board members now appointed by legislators

BOARD MEETINGS

NRS 287.0415

- Chair elected by Board members at beginning of each calendar year
- Vice chair designated by Governor
- Must meet at least once a quarter “and at other times upon the call of the Chair”
- Can be closed for certain specified purposes but generally must be public and comply with Nevada’s Open Meeting Law (NRS Chapter 241)
- Board may appoint advisory committees as it deems necessary in carrying out its duties

BOARD AND EXECUTIVE OFFICER

- Board interviews/ recommends candidates
- The EO shall, as directed by Director of NVHA and the Board, “manage the operations of the Program and assist in developing innovative purchasing and contracting strategies” in providing services under PEBP
- “The Board may delegate to the Executive Officer the exercise or discharge of any power, duty or function vested in or imposed upon the Board.” NRS 287.0424(1).
 - Captured in Board Policies & Procedures
 - Last revised January 2021
 - Revisions being discussed today



Annual Report

NRS 287.0425(1) requires the Executive Officer to submit to the Board (and others) an annual report regarding the administration and operation of the Program, which must include:

- Audited financial statement of the Program Fund for the immediately preceding fiscal year
- Audited financial statement of the Retirees' Fund for the immediately preceding fiscal year
- Report of the utilization of the Program by participants during the immediately preceding plan year
- Enrollment materials provided generally to participants/prospective participants for the current plan year



Biennial Reports

NRS 287.0425(2) requires the Executive Officer to submit to the Board (and others) a biennial report that includes:

- An independent certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees
- Compliance review: A review of the Program to determine whether it complies with federal and state laws relating to taxes and employee benefits.
- **New report required by S.B. 494 § 65.5:**
 - To extent resources are available, Board to compile report re: cost for retirees to obtain Medicare coverage through PEBP actuarially comparable to non-Medicare retiree coverage through PEBP
 - Due August 31 in even-numbered years (starting in 2026)



BOARD POWERS AND DUTIES

NRS 287.043

- Board shall establish and carry out PEBP program, which
 - Must include:
 - Program relating to group life, accident or health insurance, or any combination of these
 - May include:
 - Plan that offers flexibility in benefits, with rates based on experience of participants, or
 - Program to reduce taxable compensation of employees/participants

POWERS AND DUTIES CONT'D

- Board also charged with ensuring that Program is “funded on an actuarially sound basis and operated in accordance with sound insurance and business practices.”
 - New provision of S.B. 494 allows Board to use actuarial services/other appropriate resources of NVHA or NVHA contractors
- S.B. 494 added new provision that Board shall:

“Within the limits of available resources, maximize the benefits available to participants in the Program and the ability of such participants to access available benefits to promote the recruitment and retention of state employees, including, without limitation, by establishing programs to ensure the provision of high quality customer service to assist participants in navigating the benefits available under the Program.”

POWERS AND DUTIES CONT'D

- Adopt regulations necessary to carry out Program
- May use State Purchasing Division in procuring services OR new services established by NVHA for such procurement
- May make recommendations to the Legislature “concerning legislation that [the Board] deems necessary and appropriate regarding the Program”

SPECIFIC LAWS

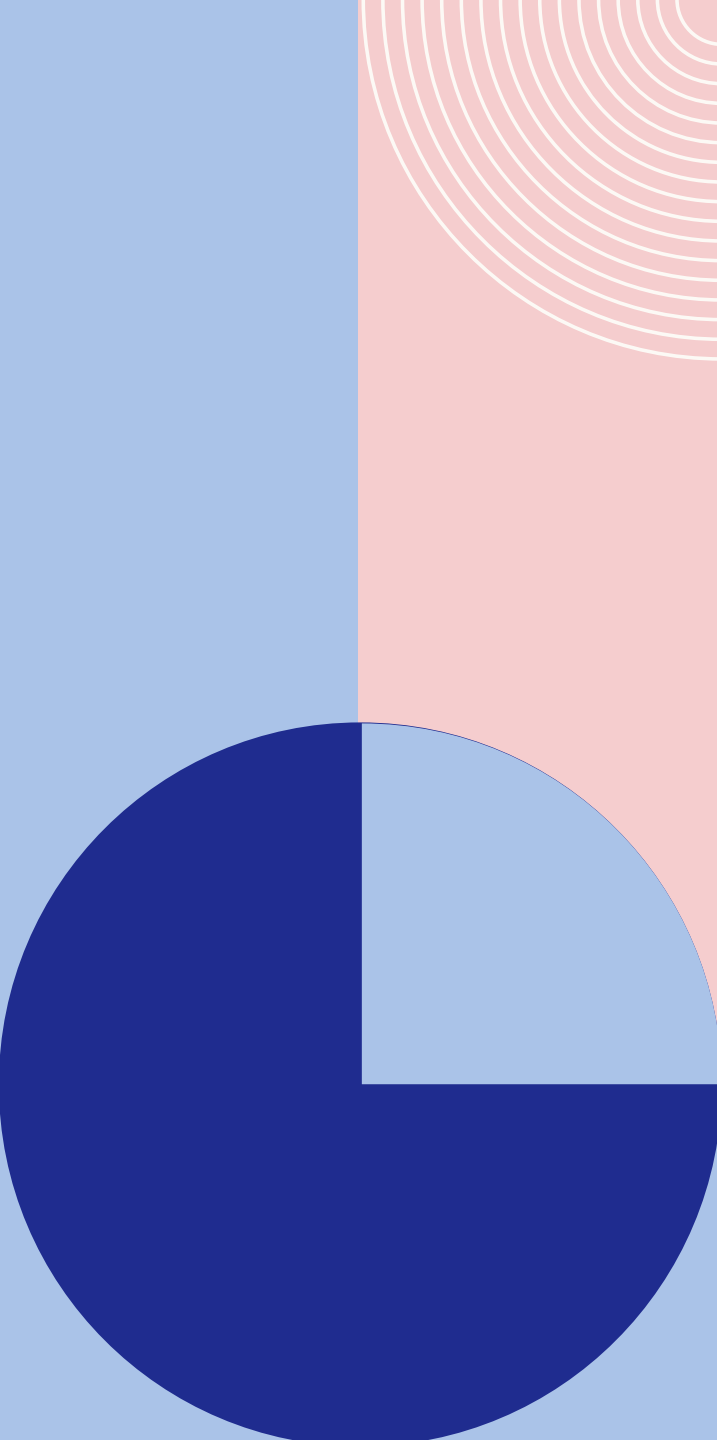
NRS 287.04335

Statute contains list of provisions relating to health insurance with which Board must comply, including, for example:

- Emergency medical services
- Certain screening/vaccinations
- Mammograms
- Systems for resolving complaints on insureds

CONTRACTS

- Board may enter into contracts relating to the administration of the Program. NRS 287.0434.



PURCHASING

NRS 287.04345/NVHA PROCUREMENT

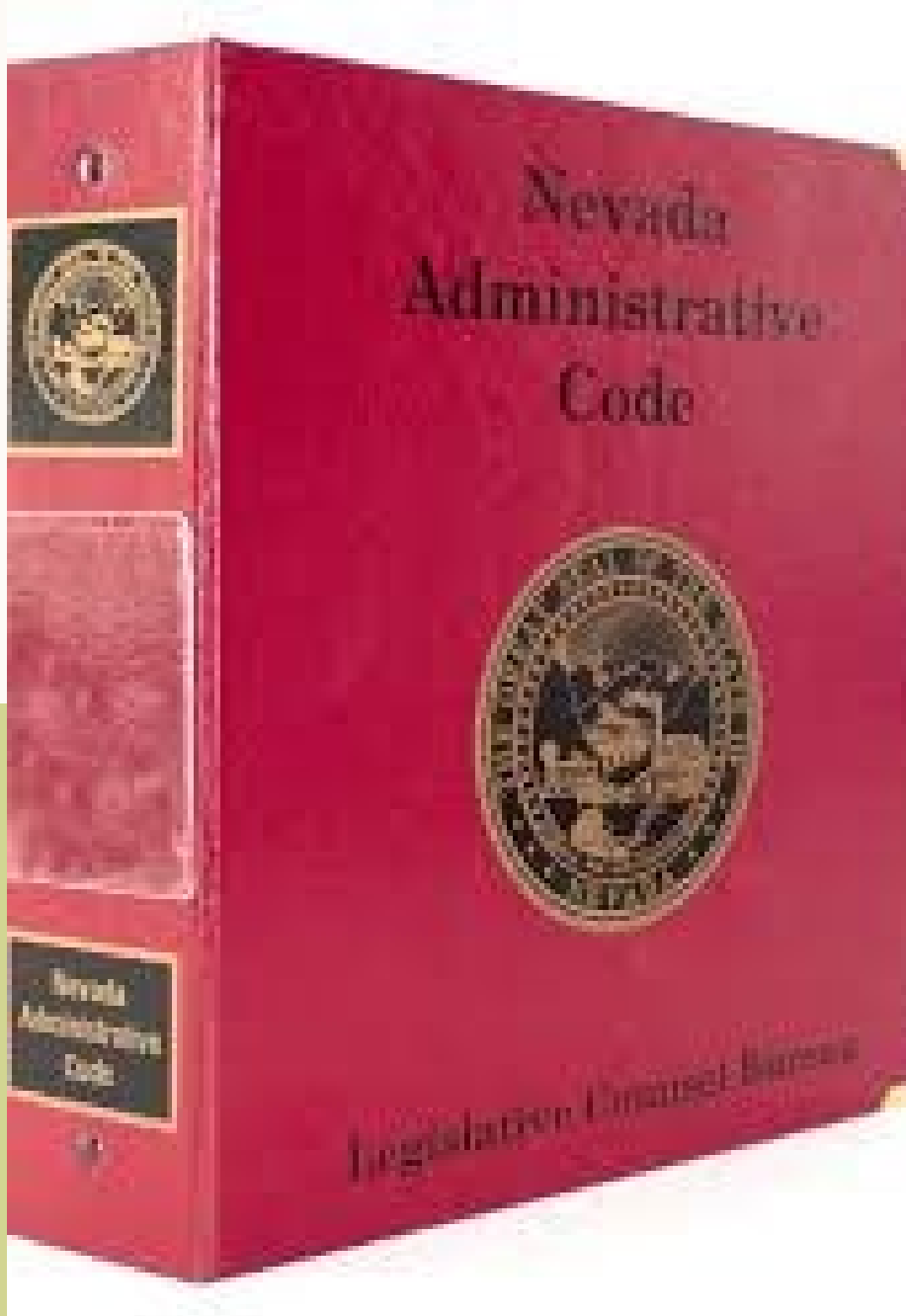
- S.B. 494 allows the Board to delegate to the Executive Officer any/all of the duties of a purchasing officer, including assisting a committee to evaluate proposals for a contract
- If Board chooses to review evaluation results, must be done in closed meeting; however, action on the contract, including award of contract, must be in open meeting

NRS CHAPTER 281A

- Nevada Ethics in Government Law
- Administered by Nevada Commission on Ethics (www.ethics.nv.gov)
- Board members are “public officers” subject to Ethics Law
- Some highlights:

Public officers shall **not**:

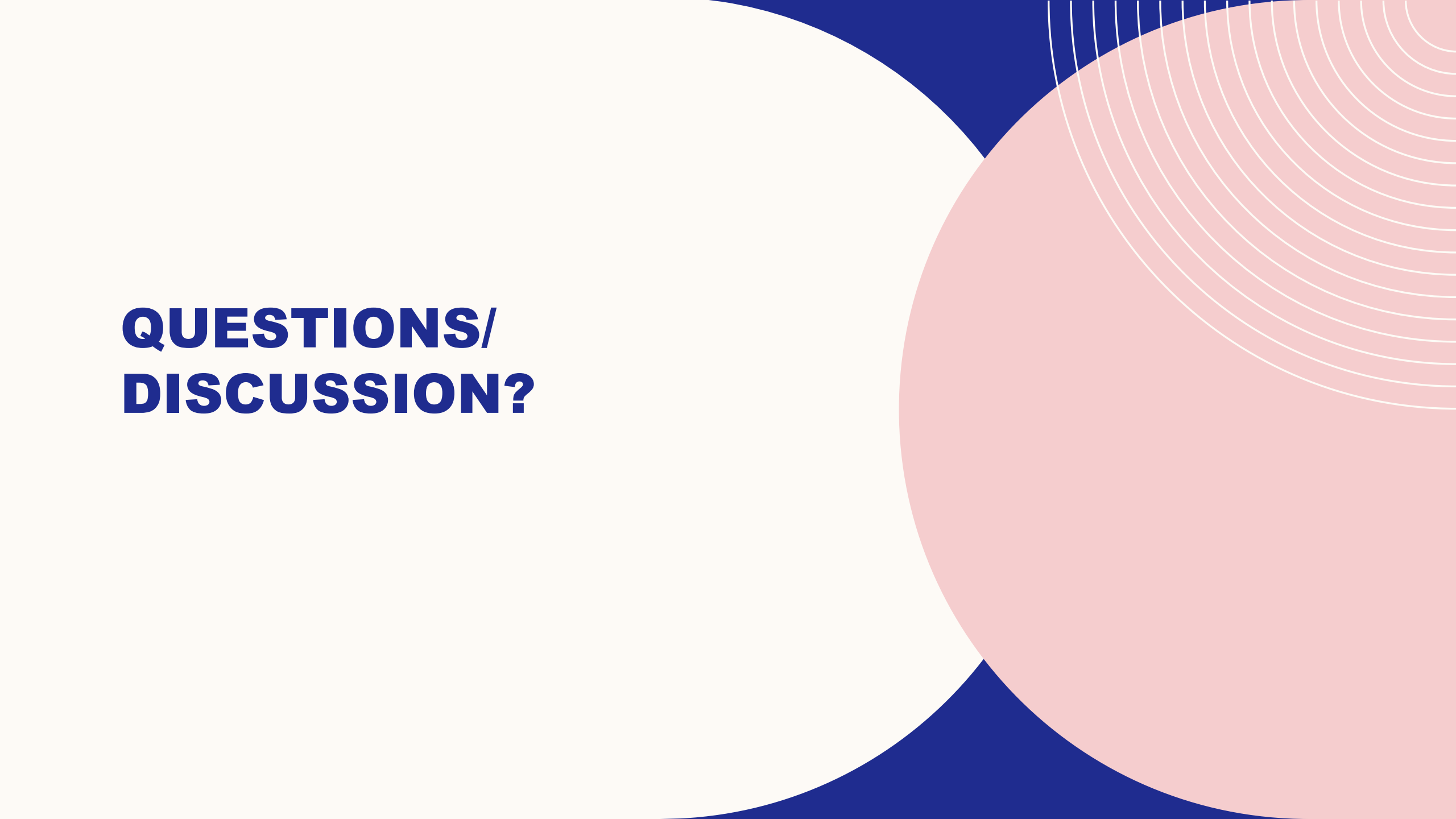
- Seek or accept any gift, service, favor, employment, engagement, emolument or economic opportunity which would tend improperly to influence a reasonable person in position to depart from the faithful and impartial discharge of public duties
- Use position to secure or grant unwarranted privileges, preferences, exemptions or advantages
- Participate as an agent of government in the negotiation or execution of a contract between the government and the public officer
- Accept compensation for performance of duties as a public officer
- Use information acquired through public duties or relationships, which by law or practice is not at the time available to people generally, to further a significant pecuniary interest
- Suppress any governmental report or other official document because it might tend to affect unfavorably a significant pecuniary interest
- Use governmental time, property, equipment or other facility to benefit a significant personal or pecuniary interest
- Attempt to benefit a significant personal or pecuniary interest of the public officer or employee or any person to whom the public officer or employee has a commitment in a private capacity through the influence of a subordinate.



NEVADA ADMINISTRATIVE CODE

NAC CHAPTER 287

- Regulations need to be revisited in light of NVHA
- Some pertinent provisions:
 - Chair determines agenda of Board meetings (NAC 287.174)
 - Any Board member may submit to the Executive Officer a request for a matter to be placed on a Board meeting agenda
 - All Board action must be approved by majority of the members present (NAC 287.176)
 - Motions require a second to the motion for consideration by the Board



**QUESTIONS/
DISCUSSION?**

6.

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

6.1

6.1 Presentation and potential adoption of redlined revisions
arising from 81st, 82nd, and 83rd legislative sessions



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Stacie Weeks
Director



Theresa Carsten
Executive Officer

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

~~January 2021~~

Duties, Policies and Procedures
January 2021

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I. INTRODUCTION

Nevada Revised Statutes (NRS) (<http://www.leg.state.nv.us/NRS/NRS-287.html>) Chapter 287.41 ~~Section 041 subsection 1~~ creates the Public Employees' Benefits Program (PEBP) Board (Board) to establish and carry out a Program for health, life, and other voluntary insurance benefits.

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

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

GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

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

II. APPOINTING AUTHORITY

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

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

III. GOVERNANCE

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

Board members are entrusted with the responsibility of exercising their duties in a manner that ensures the efficient and effective administration of the Program in compliance with all applicable Federal and State laws and regulations, including

those relating to ethics ([NRS Chapter 281A](#)), contracting ([NRS Chapter 333](#)) and the Nevada Open Meeting Law ([NRS Chapter 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 287.043(3), NRS 287.0434, NRS 287.04345 and NRS 333.300(4).~~
8. ~~Employ and appoint an~~ Interview qualified candidates for the position of Executive Officer and make recommendations to the Director and the Governor concerning the appointment, ~~subject to the approval of the Governor,~~ to oversee the day-to-day operations of the Program in accordance with [NRS 287.0424](#).
9. Delegate to the Executive Officer the authority to manage the Program within the parameters defined by the Board.
10. Evaluate the Executive Officer as needed in a public forum

adhering to all applicable open meeting law requirements.

11. To the extent money and resources are available, compile a report on or before August 31st of each even number year comparing benefits under Medicare to those under the Program for retirees, and submit the report to the Director of the Legislative Counsel Bureau in accordance with Senate Bill 494 (2005).

- a. The Board may use the resources of the Nevada Health Authority to prepare the report.

12. The Director of the Department of Administration appoints the Quality Control Officer for the Program. The Director shall define the duties of the Quality Control Officer with the concurrence of the Board. The Quality Control Officer serves at the pleasure of the Director.

B. BOARD MEMBER CONDUCT

Individual Board members shall:

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

C. BOARD MEETINGS

Board meetings shall be held in accordance with [NRS Chapter 287.0415](#) ~~Section 0415~~. The Board shall conduct business in accordance with

Duties, Policies and Procedures

January 2021

Nevada Administrative Codes (NAC) ~~Chapter 287.170 - 176~~ ~~Sections 170 - 176~~, (<http://www.leg.state.nv.us/NAC/NAC-287.html>), the Nevada Open Meeting Law (~~NRS Chapter 241~~) ~~pursuant to NRS 241~~, federal and state statutory and regulatory provisions and current Duties, Policies and Procedures, as applicable.

1. The board shall meet no less than once every calendar quarter. The Chair may call additional meetings as necessary.
2. Any Board member may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program, a request for a matter to be placed on the agenda.
3. At the first meeting of each calendar year, the Board will elect a ~~Vice~~ 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 is appointed pursuant to NRS 287.0424 ~~Chapter 287 Section 0424~~ and serves at the pleasure of the Board. The Executive Officer reports to the Board as a whole. ~~Pursuant to NRS Chapter 287 Section 0424, 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.

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- b. Management of Agency personnel, day-to-day operations and vendor performance matters.
 - c. Interpretation of NRS and NAC in performing functions of the Agency.
 - d. Approval of subrogation settlements and other financial settlements relating to claims processing.
 - e. Representation of the Agency to other pertinent governmental bodies.
 3. Consistent with Board policies and directions, the Agency shall work with the Governor's Finance Office (GFO) and the Legislative Counsel Bureau (LCB) to ensure that the Program is funded on an actuarially sound basis. The Agency shall ensure the use of funds and resources directly related to the purpose of the agency and the statutory intent for the use of those resources.
 4. Ensure the Agency notifies participants of health care benefit changes as approved by the Board.
 5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:
 - a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.
 - b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures.

- c. A review of recent Board actions and precedents and current issues being considered by the Board.
 - d. An overview of the funding and rate setting process.
 - e. The continuing education opportunities for the members pending available funding.
6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt and understanding by signing the "Acknowledgment Form for Employees."
7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
8. The Executive Officer will provide Agency employees with relevant education and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee attending a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.
9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

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

Each Board Member and each member of the Executive Staff will read the most current Ethics Manual and sign an acknowledgement of their understanding of the ethics requirements upon appointment or hire and receive annual Ethics Training provided by the staff of the Commission on

Ethics every subsequent year. The most current Ethics Manual may be found at: [ethics-manuals](http://ethics-nv.gov/uploadedFiles/ethicsnv.gov/content/Resources/EthicsManual2014.pdf).
<http://ethics-nv.gov/uploadedFiles/ethicsnv.gov/content/Resources/EthicsManual2014.pdf>

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: ncoc@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 Department of Human Resource Management.](#)

G. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

[Information regarding HIPAA is located within the United States Department of Health and Human Services.](#)

H. CONFIDENTIALITY

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

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

I. TRAVEL POLICY

1. ~~The authority for the~~ 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 ~~(SAM) Sections~~ 0200 (Travel) and 1400 (Fleet Services)
2. Board members are subject to the same travel requirements as Agency employees and will receive a copy of the Travel Policy and Procedures during their orientation. The Travel Policy and Procedures outline the requirements for submitting travel requests, travel reimbursements and necessary supporting documentation to the Agency.

IV. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

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

B. PROCUREMENT PROCESS

1. ~~The Program is subject to the provisions of chapter 333 of NRS.~~
2. The Board shall act as the chief of the using agency pursuant to ~~for the purposes of~~ 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

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- evaluator.
- c. For all other contracts including any that involve the procurement of services to PEBP members or actuarial services, the Board delegates ministerial and administrative duties as chief of the “using agency” to the Executive Officer. The Executive Officer should ensure that accurate and detailed information and supporting documentation, within the bounds of statute and regulation, is provided to the Board and other governing bodies when seeking to bid new contracts and amend existing contracts.
 - d. The Board retains the power and duty as chief of the using agency to appoint members of the Board to evaluation committees pursuant to [NRS 333.335](#).
 - e. The duty of negotiating and administering the contracts is delegated to the Executive Officer.
3. If a committee to evaluate proposals for a contract for the Program is established pursuant to [NRS 333.335](#), any number of members of the Board may be appointed to the evaluation committee. If one or more members of the Board are appointed to an evaluation committee:
- a. No action or deliberation regarding any business of the Board other than the confidential review of the proposals pursuant to [NRS 333.335](#) may be taken or conducted by the evaluation committee.
 - b. Except as otherwise provided above, a meeting of the evaluation committee is not subject to ~~chapter 241 of~~ [NRS 241](#).
4. ~~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](#). The Board shall review the results of any evaluation of proposals for a contract for the Program pursuant to NRS 333.335 in a closed meeting.~~
- a. The Executive Officer will provide an appropriate check list to assist the Board in their review of the RFP.
5. 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.
6. The Board shall review sufficient documentation to ensure justification for the recommended action(s) and validation of recommendations by PEBP management.
7. 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.
8. 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

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the Board at the next meeting after the conclusion of the audit and response from the vendor have been rendered.

9. The Board shall oversee significant scope of modifications and ensure a competitive bid process is followed for (but not limited to):
 - a. Changes in the scope of the competition or vendor status.
 - b. Changes which were not within the contemplation of the parties when the original contract was entered.
 - c. Changes that materially alter the contract.
 - d. Changes in the quantity of major items or portions of work;
or
 - e. Historically provided services under a separate contract.

C. Amendments

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

V. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

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

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

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

The Authority of the Board to establish rates are contained in [NRS 287.043 \(1\) and \(2\)](#) ~~Chapter~~
~~287 Section 043 subsections 1 and 2 found at:~~
~~http://www.leg.state.nv.us/NRS/NRS_287.html#NRS287Sec043~~

B. RESERVE POLICY

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

The IBNR Reserves will be funded at a 95% confidence level to pay all known claims incurred. The Catastrophic Reserves will be funded at a level of 50 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 Senate Bill 553 (2019))~~ (the Authorizations Act), "the Public Employees' Benefits Program, including, without limitation, the Board of the Public Employees' Benefits Program, shall not expend or otherwise obligate any reserves, either realized or projected, in excess of the amounts authorized in section 1 of this act for purposes of changing the health benefits, including, without limitation, reducing or off-setting participant premiums, available to state and nonstate active employees, retirees and covered dependents over the 2019-2021 biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

C. DEFINITIONS

As used herein the following terms mean:

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

5. **Premium** – The cost paid for fully-insured benefits (e.g., health maintenance organization membership, life insurance, etc.) as determined by insurance companies contracted with by PEBP. Premiums are passed through PEBP to the participants and employers.
6. **Rate** – The total monthly cost of coverage for a participant in each plan option and tier.
7. **Rating Methodology** – The basis for allocating costs between plan options and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.
8. **Subsidy (Contribution)** – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:
 - 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

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include scope of benefits offered by the plan and/or cost sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can

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

The Board makes its initial determination regarding plan design changes ~~not later than~~ approximately four to five months prior to Open Enrollment. Composite trend developed by the Plan actuaries is presented to the Board based on the final plan design changes. Final plan design is approved at the rate setting Board meeting to allow for flexibility and an opportunity to adjust rates at that meeting.

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

3. **Strategic Planning** – The Board will review, revise, and approve the program’s Strategic Plan on an annual basis. The Strategic Plan will be the guiding document designed to assist the Board and the Agency to develop and maintain a high-quality program of benefits at affordable prices. Every effort will be made to review and approve the Strategic Plan prior to the initial annual plan benefit design approval meeting.
4. **Establishing the Legislative Agenda** – Using the strategic plan as a basis, any revisions required to the Nevada Revised Statutes (NRS) to implement the strategic plan will be identified. The Agency will present Bill Draft Request (BDR) recommendations to the Board every even numbered year and develop approved summaries and BDRs in accordance with State mandated schedules. Administrative departments are required to submit non-budgetary Legislative Summaries to the Governor’s office by early April of each even numbered year. Upon approval of the Legislative Summary by the Governor’s office, completed BDRs are due by June 1st of each even numbered year. Legislative Summaries and final non-budgetary BDRs will be approved by the Board prior to submission.

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5. **Preparing the Biennial Budget Request** – Departments are required to submit their biennial budget requests no later than September 1st of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the spring of each even numbered year. A framework for the budget request will be presented to the Board in late spring or early summer, with final approval required at the July or August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1st.
6. **Program Reporting** – Per NRS 287.0425, the Executive Officer shall submit a report regarding the administration and operation of the Program to the Board, [the Director of NVHA](#), ~~and~~ the Director of the Office of Finance, and ~~to~~ the Director of the Legislative Counsel Bureau for transmittal to the appropriate committees of the Legislature or, if the Legislature is not in regular session, to the Legislative Commission and the Interim Retirement and Benefits Committee of the Legislature created by NRS 218E.420. Additionally, the Board receives reports on a prescribed schedule to assist in strategic planning, decision-making, and program design. Below is a list of the sources of information that will be considered by the Board when making all plan design and rate decisions, along with the timeframe of availability for each item. It is important to note that the information is provided to the Board throughout the year and is not limited to the Board meetings when rates are approved.
- a. Quarterly Vendor Reports – The reports provide utilization activity, participant contacts, provider updates, and other information applicable to each vendor’s relationship with PEBP.
 - b. Self-Insured Plan Utilization Reports – PEBP’s Chief Financial Officer provides a utilization report for the self-funded plan on a quarterly basis. In addition, an annual utilization report is provided within 90 days following each plan year. The utilization report provides the following data for the entire plan:
 - √ Executive summary and trend analysis
 - √ Plan demographics
 - √ Paid claims by benefit
 - √ Medical claims paid for inpatient/outpatient services
 - √ Surplus and loss summaries broken down by state and non-state groups and active employees, non-Medicare retirees and Medicare retirees
 - √ Costs by tier and age by medical, dental, prescription
 - √ Network utilization and cost sharing

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- √ Analysis of medical paid claims by major diagnostic category, large claims, and prevalence
 - √ Chronic conditions and wellness
 - √ Analysis of prescription drug utilization
- c. Disease management and wellness reports are made available to the Board in vendor quarterly reports. In addition, as each of these programs “mature”, they will be analyzed by PEBP and PEBP’s consultant/actuary on a cost / Benefit basis and the results reported to the Board.
- d. The results of any participant questionnaire will be reported to the Board as soon as practical upon compilation of the results.
- e. Differential cash will be reported in September to provide the most sound and consistent figures.
7. **Projected Expenses and Rate Calculations** – Any change in methodology for projecting expenses (such as changing from claims trends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP using the approved framework and rating methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the medical, prescription drug, and dental cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these Duties, Policies and Procedures (see Appendix A).

Appendix A - Plan Year Rating Methodology

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

Plan Design

- Plan Selection Options (medical, prescription, and vision):
 - √ Preferred Provider Organization (PPO) Consumer Driven Health Plan (CDHP) (Base Plan) – self-funded
 - √ Exclusive Provider Organization (EPO) Premier Plan – self-insured
 - √ Low-Deductible Copay plan (LD) – self-insured
 - √ Health Maintenance Organization (HMO) Plans – fully insured
 - √ Individual Market Medicare Exchange (IMME) – fully insured; only for retirees and their dependents who are eligible for premium free Medicare Part A; Medicare retirees who qualify for the exchange are not eligible for any other PEBP coverage (other than dental) unless they cover a dependent who is not eligible for the IMME.
- Self-Funded Plan Designs: See Master Plan Documents for details.
- Benefits other than medical, prescription, and vision: See Master Plan Documents for details.
 - √ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
 - √ Life Insurance - fully insured
 - √ Long Term Disability Insurance (LTD) – fully insured
 - √ Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if there is no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.
 - √ Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP is equal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryover limit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.

Duties, Policies and Procedures – Appendix A

Plan Year Rating Methodology

- √ Flexible Spending Account (FSA) – IRS section 125 voluntary plan guaranteed by PEBP. For active employees only, employees with an HSA are not eligible for a Medical FSA.
- √ Additional Life Insurance – voluntary; fully insured
- √ Long Term Care – 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.
- 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 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

Duties, Policies and Procedures – Appendix A Plan Year Rating Methodology

- √ Single
- √ Single + Spouse
- √ Single + Child(ren)
- √ Single + Family (Spouse and one or more children)

Rate Development

- PEBP's actuaries and HMO vendors will develop costs in accordance with the plan design approved by the Board and in accordance with the methodologies found in the Cost Projections section above.
- Enrollment projections are based on the average change in enrollment over the past 4 years and assumptions approved by the Executive Officer.
- The following costs, revenues and reserve adjustments will be allocated equally to all active employees and non-IMME retirees:
 - √ Life insurance (per \$1,000 of coverage)
 - √ Long Term Disability (active employees only)
 - √ PEBP operating costs
 - √ Contracted dental network and claims payment administrative fees
 - √ Miscellaneous Revenues (RGL 4254)
 - √ Treasurer's Interest (RGL 4326)
 - √ Cost of Medicare Part B premium credit (reduction to excess reserves, Category 86)
 - √ Projected credit due to NRS 287.046(4) (increase to excess reserves, Category 86)
 - √ IMME administrative costs for Health Reimbursement Arrangement
 - √ Life Insurance for IMME retirees
- The following costs, revenues and reserve adjustments will be allocated only to CDHP participants:
 - √ Contracted CDHP administrative fees
 - √ HSA/HRA plan contributions
 - √ CDHP Rx Rebates (RGL 4218)
 - √ Adjustments to Catastrophic Reserves (Category 85) in accordance with reserve policies.

Duties, Policies and Procedures – Appendix A

Plan Year Rating Methodology

- 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 plan solvency over the long term to a set 50 days on hand.
 - √ IBNR Reserves will be established at a level to achieve a 95% probability that all claims incurred can be paid.

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

Subsidy Allocation and Participant Contribution

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

Duties, Policies and Procedures – Appendix A

Plan Year Rating Methodology

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

Underwriting

- PEBP will underwrite all self-funded plans into one risk pool while continuing to maintain the required state and non-state risk pools.
- PEBP will use the following underwriting guidelines to factor administrative load into rates:
 - Use a per participant per month factor for claims
 - Add administrative fees on a per participant per month basis
 - Use one tier for all plans, products, state, and non-state
 - Maintain this factor static for the two-year budget cycle (at a minimum)

6.2

6.2 Discussion regarding additional Board-suggested revisions to be made

6.3

6.3 Discussion on identifying a Board meeting to discuss a revised PEBP Strategic Plan

7.

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



Joe Lombardo
Governor

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



Stacie Weeks
Director



Theresa Carsten
Executive Officer

AGENDA ITEM

X	Action Item
	Information Only

Date: October 24, 2025

Item Number: 7

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

Plan Design Changes: The following are changes to plan design; for board approval.

I. The following clarification will be effective July 1, 2025

Clarification: Condoms

#	Change Type	Proposed Clarification	Justification	Document/s
1	Condoms	Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception	PEBP Staff Recommendation for Clarification	Master Plan Documents for the EPO, CDHP, and the LDPPO
Condoms (<i>male and female</i>) are covered under this plan for individuals aged 13 and above. <i>For a pharmacist to submit a medical claim for condoms on a member's behalf, the member must have a valid prescription. For condoms purchased over the counter, a receipt for reimbursement may be submitted to UMR. Please see 'How to File a Claim' in the Claims Administration section.</i>				

Clarification: Prior Authorization

#	Change Type	Proposed Clarification	Justification	Document/s
1	Non-newborn circumcision	Include a prior authorization requirement for non-newborn circumcision for ages 8 weeks and older.	UMR Staff Recommendation	Master Plan Documents for the EPO, CDHP, and the LDPPO
<i>Circumcision for infants eight weeks and older.</i>				

Clarification: Prior Authorization

#	Change Type	Proposed Clarification	Justification	Document/s
1	Hospice	Clarify that prior authorization is required for hospice beginning 6 months.	UMR Staff Recommendation	Master Plan Documents for the EPO, CDHP, and the LDPPO
Change prior authorization from 185 days to beginning at 6 months.				

II. The following clarification will be effective January 1, 2026.**Clarification: Claims Processing**

#	Change Type	Proposed Clarification	Justification	Document/s
1	Claims	The time to approve/deny claims and pay approved claims	AB 52 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO
<i>While PEBP is not subject to the timeline requirements set forth in NRS 689B.255 or 695G.230, PEBP endeavors to let participants and providers know within 30 business days of receipt of the claim, if it is approved accepted or denied. However, claim processing may take much longer if the claim was not completed correctly or if all necessary information was not provided with the claim.</i> <i>Further, PEBP endeavors to let participants and providers know within 30 business days of receipt of all additional requested information (including a corrected claim), if it is approved or denied.</i>				

III. The following enhancement will be effective July 1, 2026.**Enhancement: Genetic Counseling & Fertility /Family Planning**

#	Change Type	Proposed Change	Justification	Document/s
1	Genetic Counseling & Screening	Noninvasive prenatal screening	SB 344 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO
Genetics is the study of how genes and how traits are passed down from one generation to the next. Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research. Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual				

#	Change Type	Proposed Change	Justification	Document/s
		or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available. Additional genetic testing/counseling will be covered in accordance with federal or state mandates. Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met: • The results will directly impact clinical decision-making and/or clinical outcome for the individual. • The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and • One of the following conditions is met: ○ The participant demonstrates signs/symptoms of a genetically linked heritable disease, or ○ The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease. <i>The Plan covers noninvasive prenatal screening, that is, drawing blood from a pregnant person to perform laboratory analysis on the DNA circulating in the maternal blood stream for the purpose of detecting chromosomal abnormalities in the fetus, at any time during pregnancy. Prior authorization is not required for such noninvasive prenatal screening.</i> The Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, case management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law. Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E. This list is not all-inclusive for what genetic tests may be covered. Contact the UM company for coverage details and prior authorization requirements for covered genetic testing.		

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

Enhancement: Genetic Counseling & Fertility /Family Planning

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

Clarification with enhancement: Genetic Counseling & Fertility /Family Planning

#	Change Type	Proposed Clarification	Justification	Document/s
1	Maternity/Family Planning:	Benefit Limitations and Exclusions section	AB 428 (2025)	Master Plan Documents for the EPO, CDHP, and the LDPPO
Maternity/Family Planning: <i>Except as otherwise specified in the Schedule of Benefits section, the</i> The following are not covered under the Plan. Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.				

#	Change Type	Proposed Clarification	Justification	Document/s
		- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs. - For nondurable supplies.		
		Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.		

Recommendation from PEBP Staff:

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

For Information:

1. Plan design changes for Plan Year 2027

- Speech Therapy Enhancement: Raise aged from 19 to 26 and include stuttering and stammering. (Approved)
- Wigs: Add Alopecia to the reasons to coverage of wigs. (Approved)
- Behavioral Health Visits: Clarity that visits equal therapy sessions for copay purposes. (Approved)
- Autism: SB 2052 (2023) (Approved)
- CDHP Deductible and HSA limit. (Approved)
- Prenatal screening under Genetic Counseling: SB 344 (2025) (On this report)

2. Plan design changes for Plan Year 2028

- Family Planning/Fertility: AB 428 (2025) (On this report)

8.

8. Presentation and possible action on Structure and Financial Results (Premiums Collected, Benefits Paid, Actuarial Value) of the Current PEBP Plans. (Richard Ward, Segal)
(For Possible Action)

- 8.1 Overview of current PEBP plans and possible revisions for future plan years: Consumer Driven Health Plan (CDHP), Low-Deductible Preferred Provider Organization (LDPPO), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO)
- 8.2 Incurred but Not Reported (IBNR) for end of FY25
- 8.3 Other Post Employment Benefits (OPEB/GASB)
Measured for FY24 for FY25 Reporting
- 8.4 Discussion on other models or information Board would like to review in November

8.1

8.1 Overview of current PEBP plans and possible revisions for future plan years: Consumer Driven Health Plan (CDHP), Low-Deductible Preferred Provider Organization (LDPPO), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO)



Nevada Public Employees' Benefits Program

October 24, 2025

| Agenda

- **Review Current Plans**
 - Benefits
 - Premiums
 - Enrollment
- **Reserves**
- **Trends and Cost Drivers**
- **Retiree Health (OPEB)**
- **Plan Year 2027 Plan Changes**

Current Plan Designs and Premiums

In-network benefits

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

* Actuarial Value based on FY22 and FY23 data.

** 30-day supply Tier 1 / Tier 2 / Tier 3 / Tier 4

***Deductible: \$100 Individual, \$200 Family

PY2025 Medical/Rx Plan Performance

- Total medical/Rx expenses exceeded revenue by \$25.6M for active and retired employees, including State and non-State
- CDHP subsidizes the other two plans

	CDHP	LDPPO	EPO/HMO	Total
Total Revenue*	\$148,788,900	\$135,852,600	\$83,293,500	\$367,935,000
Total Expenses**	\$126,905,700	\$162,008,800	\$104,638,600	\$393,553,100
Net	\$21,883,200	(\$26,156,200)	(\$21,345,100)	(\$25,618,100)
Avg Enrollment	14,176	12,188	6,279	32,643
Revenue PEPM***	\$875	\$929	\$1,106	\$939
Expenses PEPM	\$746	\$1,108	\$1,389	\$1,005
Net PEPM Difference	\$129	(\$179)	(\$283)	(\$65)

* 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).

** Incurred claim costs, fully insured HMO premiums, HSA contributions, HRA claims (excluding supplemental) and administrative costs, net of prescription drug rebates

*** Per Employee Per Month

PY2025 Medical/Rx Active State Employees

Participant Only Tier

- The CDHP rates subsidize the LDPPO and EPO/HMO rates
- For the CDHP, the subsidies exceed the total projected cost

	CDHP	LDPPO	EPO/HMO
Subsidized Rate	\$714.88	\$753.70	\$852.80
Base Subsidy	\$651.32	\$651.32	\$651.32
Planned Spend-down	\$8.30	\$17.12	\$20.24
Employee Premium	\$55.26	\$85.26	\$181.24
If No Cross-Subsidies Between Plans (if we just let the math flow – and no migration considered)			
Unsubsidized Rate	\$615.68	\$801.11	\$1,112.66
Base Subsidy	\$651.32	\$651.32	\$651.32
Planned Spend-down	\$8.30	\$17.12	\$20.24
Employee Premium	(\$43.94)	\$132.67	\$441.10

Does not consider migration, which would be significant and result in higher costs for each plan.

PY2025 Medical/Rx Active State Employees

Participant Only Tier

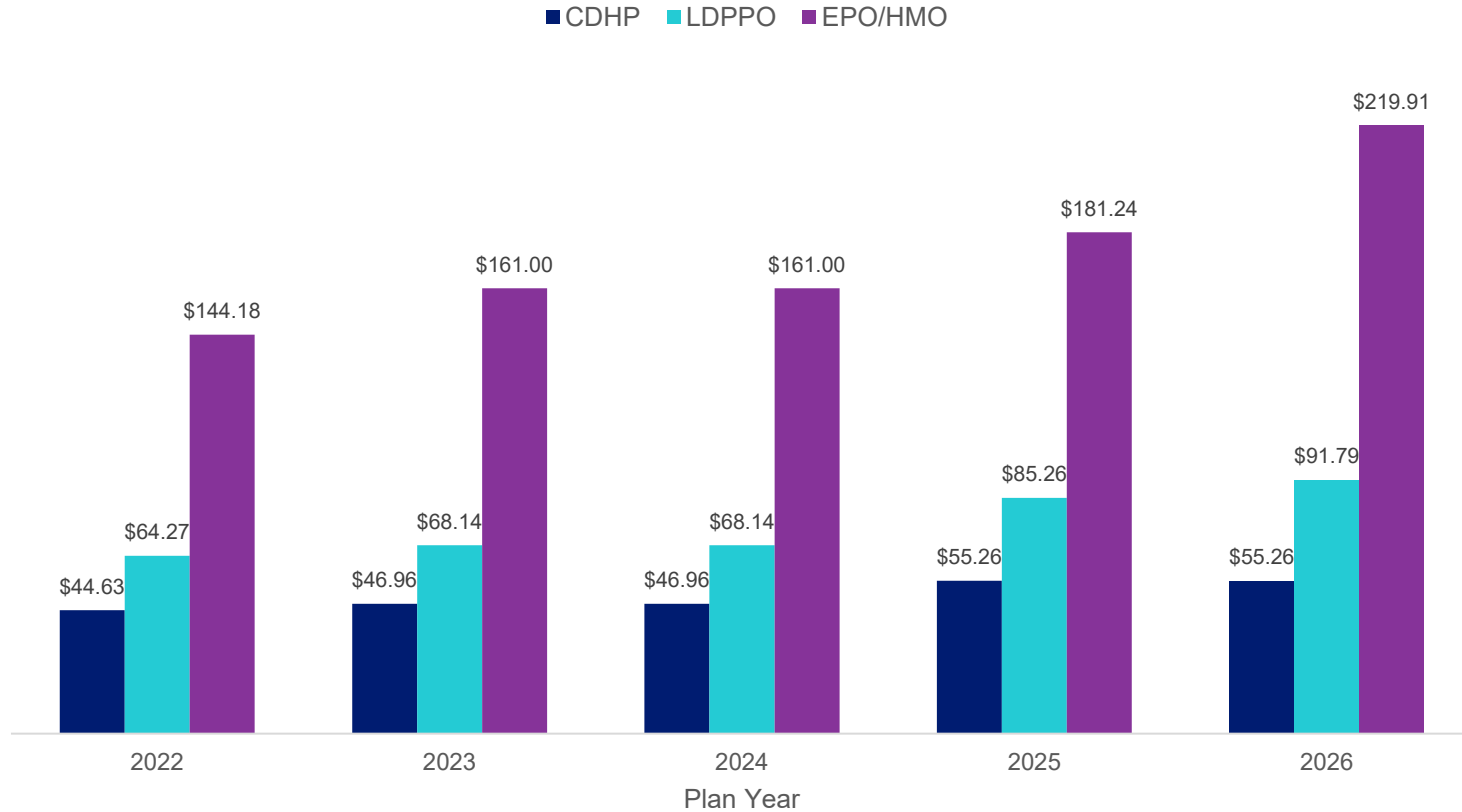
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If No Cross-Subsidies Between Plans (CDHP has \$0 premium – and no migration considered)			
Unsubsidized Rate	\$615.68	\$801.11	\$1,112.66
Base Subsidy	\$607.38	\$651.32	\$651.32
Planned Spend-down	\$8.30	\$17.12	\$20.24
Employee Premium	\$0	\$132.67	\$441.10

Does not consider migration, which would be significant and result in higher costs for each plan.

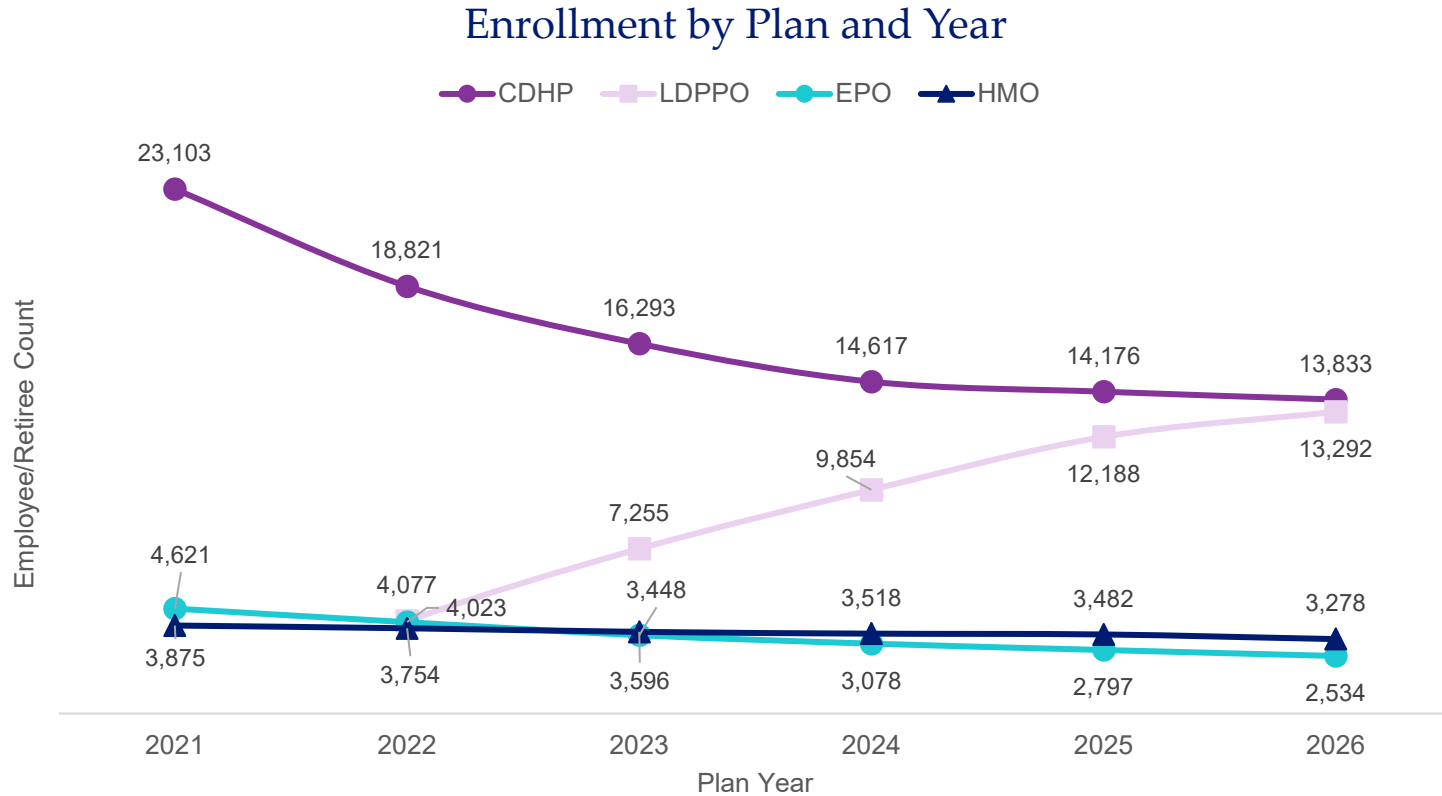
Historical Employee Only Premiums

Employee Only Premium (PEPM) by Plan



**EPO/HMO premiums are ~2.5x the LDPPO premiums
and ~4x the CDHP premiums.**

Migration to the LDPPO

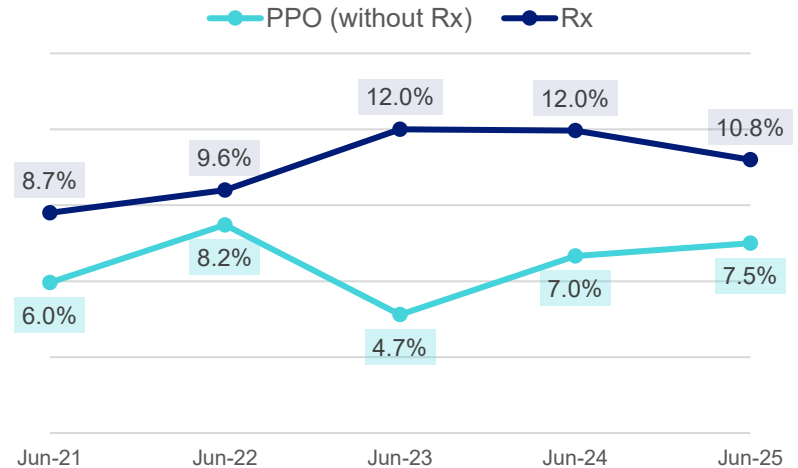


Members are migrating to the LDPPO from both the EPO/HMO and the CDHP

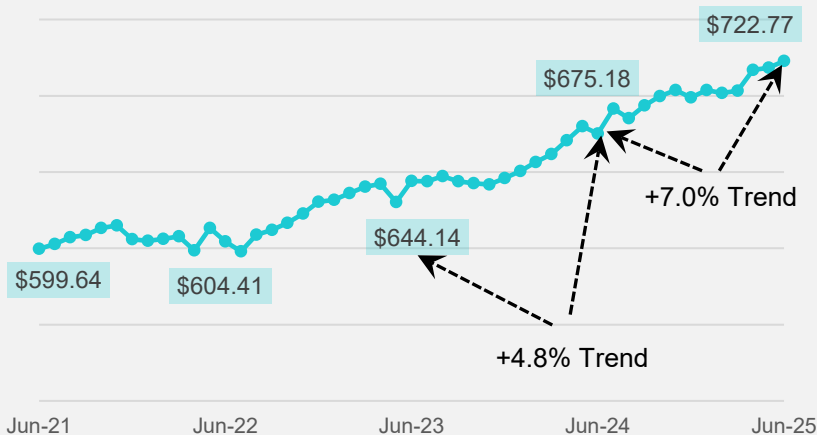
Medical/Rx Cost Trends

- Rx trend drivers¹
 - The number of patients utilizing Mounjaro and Ozempic continues to rise (2-3x that of prior period)
 - Specialty patients increasing by 15-20% in FY25
- Medical trend drivers²
 - HCCs account for \$2M increase between FY24/FY25
 - Cancer prevalence is 7.9% of members
 - Diabetes prevalence is 6.4% of members
 - MSK prevalence is 18.9% of members

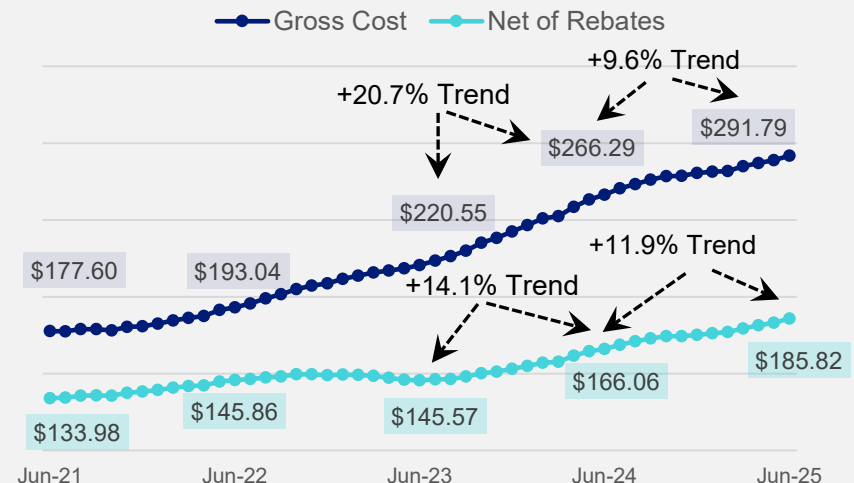
Industry Medical and Rx Annual Trend



Medical



Prescription Drug



¹ Based on ESI reporting through December 31, 2025

² Based on UMR reporting through December 31, 2025

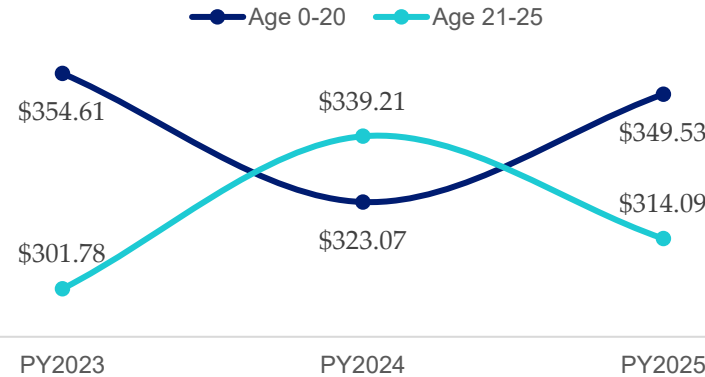
Dependent Costs PMPM

Self-insured plans

- The Affordable Care Act requires PEBP to cover all dependent children to age 26
 - Previous coverage was to age 21
- Over the last three years, dependent child enrollment has increased by 25% with the Age 21-25 dependent population.
- In PY2025
 - Total dependent costs = \$65.4M
 - Age 21-25 dependent costs = \$11.4M, or 17.5%
 - Age 21-25 dependents have lower pmpm costs than for those < age 21

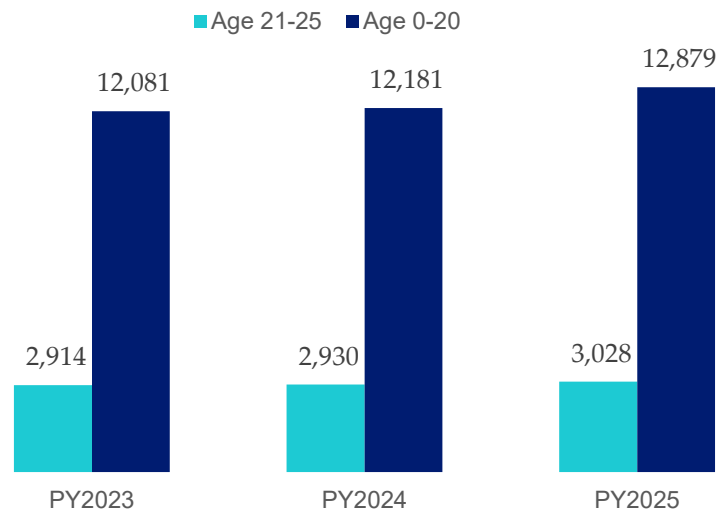
Medical/Rx Claims Cost for Dependents

Self-insured plans PMPM



Average Monthly Dependent Counts

Self-insured plans



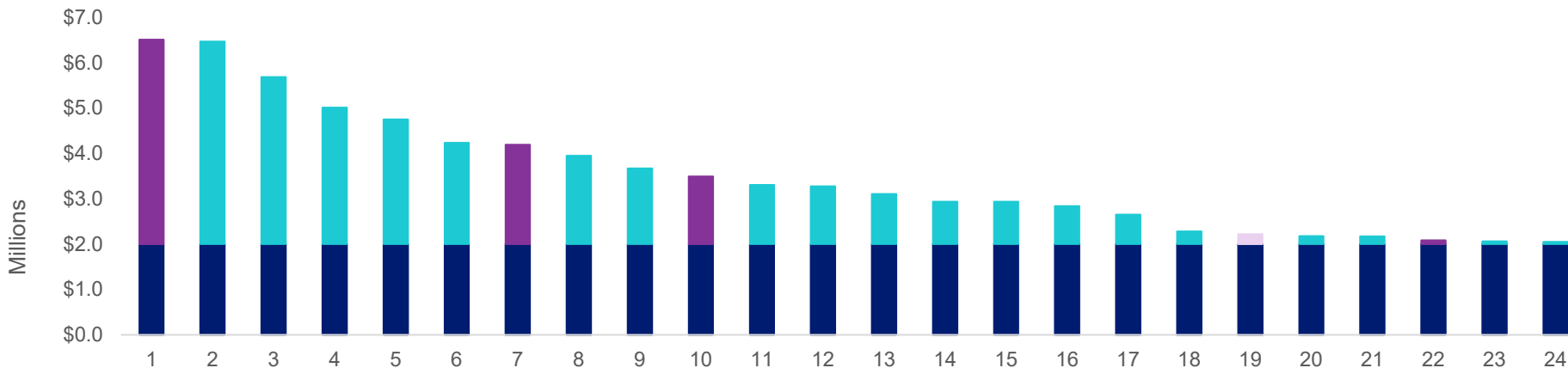
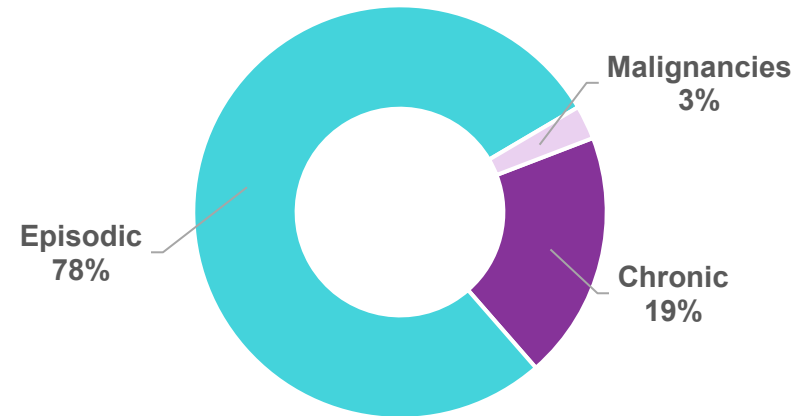
¹PMPM costs are shown for medical and prescription drug benefits before application of Rx rebate on an incurred basis.

Lifetime Maximum Benefit

July 1, 2018 through June 30, 2025

Self-insured plans

- The self-insured plans once included a lifetime maximum benefit of \$2.0M per patient.
- Lifetime maximums were eliminated from the plan design because of the Affordable Care Act.
- Over the last seven (7) years, 24 members have incurred plan costs exceeding \$2.0M, totaling \$84.1M. (\$36.1M in excess of \$2.0M.)
 - Most are episodic
- 15 of these patients are currently covered by PEBP
- 15 additional current PEBP members have at least \$1.5M in claims in the last 7 years.

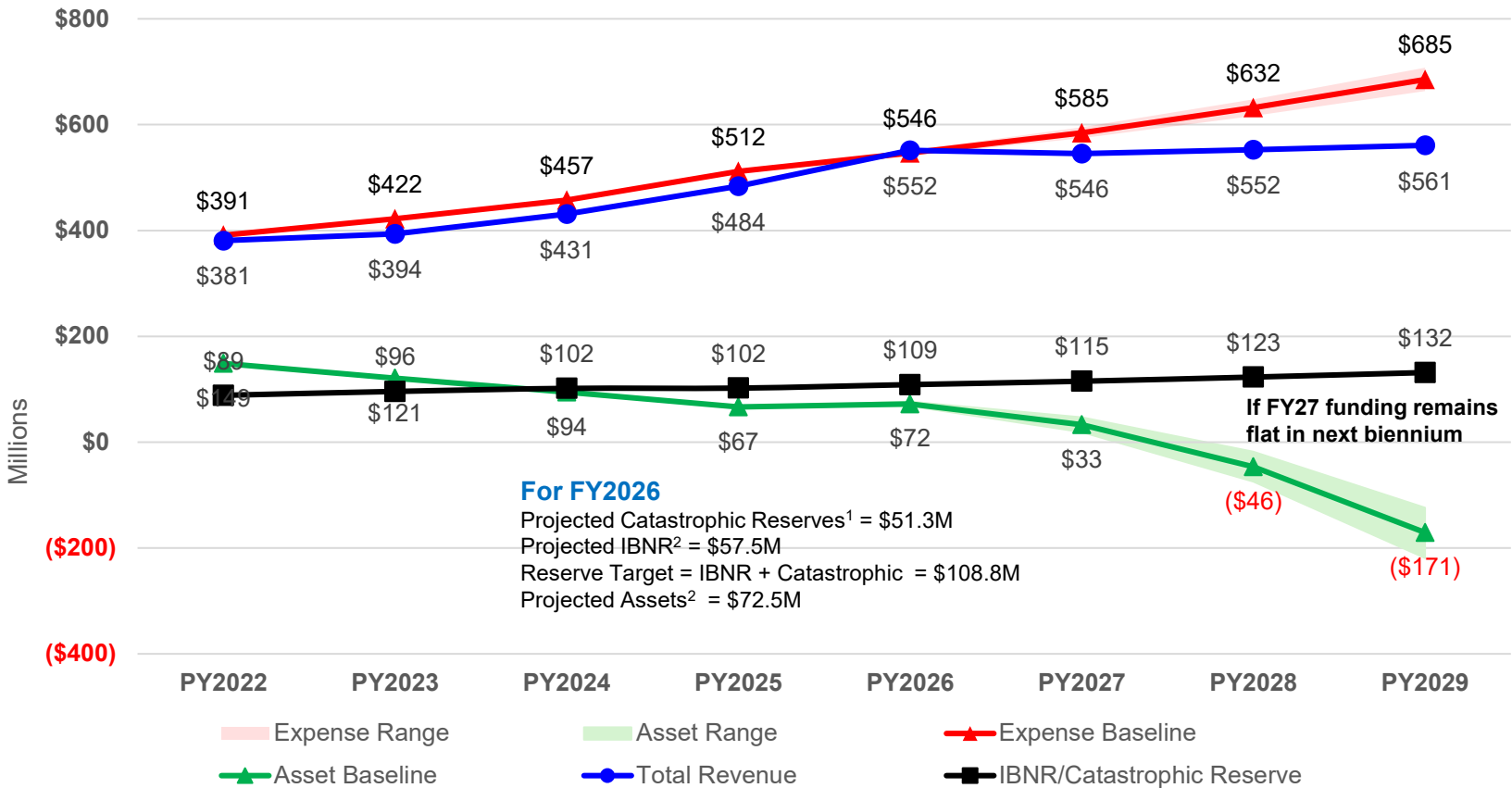


1. Lifetime costs are based on claims incurred beginning July 1, 2018 and ending June 30, 2025 for medical and prescription drug benefits. Claims cost shown are before pharmacy rebates are applied.

Reserves

- Leading up to FY2024, reserves were actively spent down
 - Plan changes, premium subsidies and supplemental HRAs
- Trend increase accelerated at the same time
- Recent large increase in AEGIS and REGI for FY2026 was sufficient to close the funding gap
- Decrease in AEGIS for FY2027 will resume spend-down, which will accelerate without additional increases, or cost reduction measures

	FY24	FY25	FY26	FY27
AEGIS	\$730	\$759	\$1,022	\$982
REGI	\$515	\$545	\$1,007	\$1,023



¹Catastrophic Reserve set at 50 days of claims for PY2024 and earlier; 45 days of claims for PY2025 and later.

² Assets and IBNR estimated for FY2026.

OPEB Valuation for GASB 74/75 Accounting

Governmental Accounting Standards Board (GASB) Statements No. 74 and 75 - accounting requirements focusing on other long-term retiree benefit costs

Other (i.e., other than pensions)

Post

Employment

Benefits (considered part of the benefit package)

Accounting treatment is like pension benefits

At PEBP, OPEB includes retiree healthcare and life insurance benefits

- Non-Medicare retirees can enroll in PEBP plans
- Medicare Exchange for Medicare retirees
- Retiree subsidies vary based on service
- Only employees hired before January 1, 2012, receive explicit subsidies
- All non-Medicare retirees benefit from the implicit subsidy (blended premiums)

GASB 74/75 Valuation

How is the “liability” calculated?

Main liability measure is the Total OPEB Liability (TOL), which is the portion of the **present value** of **future benefits** attributed to **past service**

- **Present value**

- Future benefit costs are discounted to one-point in time
- Because PEBP benefits are not prefunded (pay-as-you-go), discount rate is based on market municipal bond yields

- **Future benefits**

- Retiree benefits modeled using the substantive plan provisions and estimated retiree claims costs.
- **This includes direct/explicit subsidies, as well as indirect/implicit subsidies.**
- PERS assumptions used to model rates of termination, retirement, disability and death
- Additional healthcare assumptions regarding trend, participation and plan elections. For example, 85% of pre-2012 employees and 35% of post-2012 employees are assumed to participate

- **Attributed to past service**

- For current active employees, more of their present value of benefits will accrue as they continue to work
- For current retirees, accrued liability equals present value of future benefits (liability is fully accrued)

GASB 74/75 Valuation (\$ in millions)

Valuation Date	June 30, 2024	June 30, 2023
Net benefit payments	\$68.5	\$69.4
Total OPEB Liability (accrued liability)	\$1,344	\$1,427
Plan Fiduciary Net Position (assets)	<u>-14</u>	<u>-31</u>
Net OPEB Liability (unfunded liability)	\$1,358	\$1,458
Covered Payroll	\$2,587	\$2,372
Ratio of NOL to covered payroll	52.5%	61.5%
Discount Rate	3.93%	3.65%

- **TOL is roughly 20 times the size of current annual benefit payments**
- **TOL decreased mainly due to:**
 - Lower than expected claims costs
 - Decrease to participation assumptions for future retirees
 - Increase to discount rate from 3.65% to 3.93%
- **Ratio of NOL to covered payroll is used to compare plans**
 - PEBP's accrued long-term liability is roughly 53% of one year's payroll
 - Employees hired on or after January 1, 2012, receive zero explicit premium support
 - 71% of active employees (21,741 of 30,699) hired after January 1, 2012

Approved Plan Changes

Approved at the July Board meeting

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

Medical Pharmacy Coupon Program

Implement coupon program for specialty drugs administered through the medical benefit

Why?

- UMR program that could reduce costs for both PEBP and patients
- Leverages manufacturer coupons like ESI's SaveOnSP, but for drugs administered in an inpatient setting
- SaveOnSP applies only to outpatient medications

Next steps

- Review program details with UMR (is the CDHP eligible?)
- Evaluate member impact versus plan savings (shared savings terms)



Care Access

Streamline Access to Care

Why?

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

What?

- Remove Prior Authorization requirement for biopsy coverage
 - Nearly 100% approval rate
 - Removes administrative step that slows access to care
 - Net cost to PEBP
- Cover diagnostic breast imaging and colonoscopies at 100%
 - Would need to be subject to deductible in CDHP
 - Removes barrier to early detection
 - May be net cost to PEBP in short-term, but provide long-term benefits to PEBP and patients

Next Steps

- Determine cost and member impact

PY2024

# PAs	1,194
<u>Cost</u>	<u>\$50</u>
Total Fees	\$59,700

PY2025

# PAs	807
<u>Cost</u>	<u>\$50</u>
Total Fees	\$40,350

Network Lab Access and Education

Steerage and Member Education

Why?

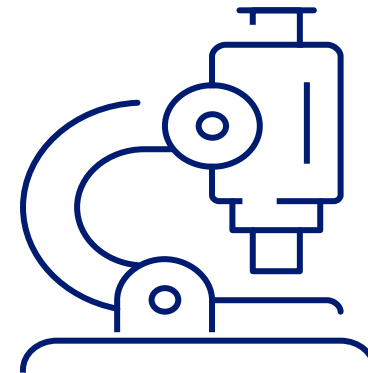
- Patients often utilize labs as directed by physician without considering network status
- Result can be higher costs for PEBP and for member

What?

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

Next Steps

- Determine cost and member impact



Vision

Modernize and Update Vision Benefit

Why?

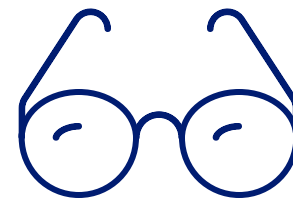
- \$100 Annual Benefit Maximum may be out-of-step with current market
- Covered services/materials varies by plan
- Provider network would reduce costs – for both PEBP and members

What?

- Add hardware coverage to CDHP to align with LDPPO and EPO coverage
- Increase current \$100 annual benefit limit to align with market
- Implement a vision provider network

Next Steps

- Develop specific options
- Benchmark benefits
- Determine cost impact
- Review contracting options to access provider network



Pharmacy

Copay Incentives to Steer Towards Lower Net Cost Options

Why?

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

What?

- Increase Non-Preferred Brand cost share from \$75 to 30% coinsurance with a min/max
 - Incentivize more generic and Preferred Brand utilization
- Implement three-tier specialty copay structure
 - Increasing availability of biosimilars
 - Cost structure will incentivize biosimilars when available
 - Structure analogous to Generic, Preferred Brand and non-preferred Brand approach

3-Tier Specialty Drug

Tier 1	Biosimilars
Tier 2	Biosimilar alternatives not available
Tier 3	Biosimilar alternatives available

Next Steps

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



Income Based Premiums

Review Means-Based Premium Structures

Why?

- Distribute employee premium costs according to income level
- Larger portion of premium increase is borne by higher earners

Considerations

- Generally, more applicable for active employees, but Medicare uses means-based premiums
- For public sector employers, sometimes there is not sufficient spread in income levels to result in meaningful variation

Next Steps

- Develop specific options



EPO/HMO

Review Viability of EPO/HMO and Consider Alternatives

Why?

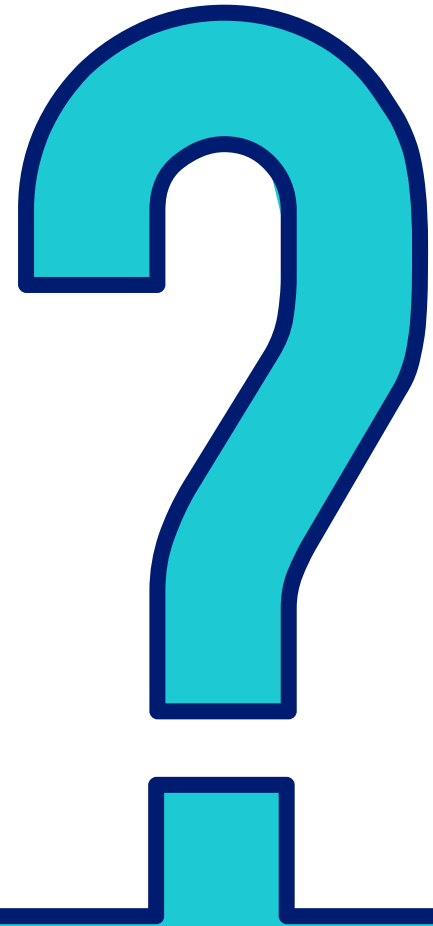
- While there is a 9% rate cap guarantee for FY2027 HMO premiums, there is no guarantee for FY2028 or FY2029
- EPO and HMO blended for rating purposes and EPO has benefited from lower HMO premiums
- HMO network and EPO network have significant provider overlap
 - Both include Southwest Medical
- EPO and LDPPO networks are the same and the difference in actuarial value is ~3%
- EPO is in-network only and many employees enroll in EPO without adequate network access
- Ongoing migration from EPO/HMO in recent years

Next Steps

- Develop specific options
 - Could include changes to CDHP and/or LDPPO
- Review cost impact and risk distribution
- Consider provider disruption and access to care



Questions



8.2

8.2 Incurred but Not Reported (IBNR) for end of FY25



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August 6, 2025

Michelle Weyland
Chief Financial Officer
Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706

Re: Estimate of IBNR as of June 30, 2025

Dear Michelle:

Segal has completed its evaluation of the State of Nevada Public Employees' Benefits Program (PEBP) liability for claims that were Incurred but Not Reported (IBNR) as of June 30, 2025. The reserve is calculated to estimate the outstanding liability for covered services received prior to July 1, 2025 and paid after June 30, 2025. Our estimate of incurred but not reported (IBNR) claims includes unreported claims, reported but unprocessed claims, and claims processed but unpaid by your administrator. Segal has estimated the reserves for the PEBP's self-insured active and retiree medical, prescription drug, and dental plans to be **\$54,601,000** as of June 30, 2025. This is a decrease of \$836,000 or 1.5% from the prior reserve estimate as of June 30, 2024.

The IBNR estimates by coverage as of June 30, 2025 are shown in the following table. Medical and dental IBNR estimates include a 10% catastrophic margin. Prescription drug IBNR estimates do not include a margin due to the minimal time between claim adjudication and plan payment. Included in the FY2025 Prescription Drug IBNR figures is an estimate of incurred but not paid tertiary claims attributable to the SaveOnSP program in the amount of \$424,000.

Benefit Plan	FY2024			FY2025		
	CDHP	Premier (EPO)	Copay	CDHP	Premier (EPO)	Copay
Medical	\$20,236,000	\$9,915,000	\$13,936,000	\$16,153,000	\$10,241,000	\$17,534,000
10% Margin	\$2,024,000	\$991,000	\$1,394,000	\$1,614,000	\$1,025,000	\$1,753,000
Prescription Drugs	<u>\$1,891,000</u>	<u>\$965,000</u>	<u>\$1,893,000</u>	<u>\$1,562,000</u>	<u>\$769,000</u>	<u>\$2,033,000</u>
Total Medical IBNR	\$24,151,000	\$11,871,000	\$17,223,000	\$19,329,000	\$12,035,000	\$21,320,000
	Dental			Dental		
Dental		\$1,993,000			\$1,742,000	
10% Margin		<u>\$199,000</u>			<u>\$175,000</u>	
Total Dental IBNR		\$2,192,000			\$1,917,000	
	Total			Total		
Total All Reserves	\$55,437,000			\$54,601,000		

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

	CDHP	Premier (EPO)	Copay	Total
FY2024	24,065	5,702	18,969	48,735
FY2025	22,946	5,166	23,220	51,333
Percent Change	-4.6%	-9.4%	22.4%	5.3%

Our estimate does not include any amounts for accounts payable due to claims paid by UMR or Express Scripts prior to July 1, 2025, that had been recorded on the carrier's lag report as paid on or before June 30, 2025. Furthermore, if your financial statements identify actual amounts known to be paid after June 30, 2025 for services that were incurred prior to July 1, 2025 (e.g. recorded as an account payable) from the unknown amounts, those known amounts should be subtracted from the estimated liability we have provided so that the total amount of known and unknown liability remains equal to our estimated IBNR. A breakdown of liabilities by coverage, plan, State/Non-State and eligibility status can be found in Exhibits I, II and III. A description of our standard calculation methodology, which was employed for our Medical, Prescription Drug, and Dental estimates, is also enclosed.

Our Medical and Dental estimates rely upon claims paid through June 30, 2025, as furnished by UMR. Our Prescription Drug estimates rely upon claims paid through June 30, 2025 as furnished by Express Scripts. We did not audit this data, and our review was limited to determining that it appears to be reasonable and acceptable for the projection of outstanding liabilities under the plan. The estimated number of months of claims covered by the IBNR are shown below, by plan and coverage.

Benefit Plan	FY2024			FY2025		
	CDHP	Premier (EPO)	Copay	CDHP	Premier (EPO)	Copay
Medical	2.6	2.7	2.0	2.2	2.8	1.8
Prescription Drugs	0.6	0.6	0.6	0.5	0.5	0.5
	Dental			Dental		
Dental	0.9			0.7		
	Overall			Overall		
Total IBNR	1.9	2.0	1.5	1.6	2.0	1.4

Catastrophic Reserve

PEBP recently determined the appropriate Catastrophic Reserve level to be 45 days of claims. Previously the level was based on 50 days of claims. We have estimated the Catastrophic Reserve to be \$46.5 million as of June 30, 2025 for PEBP's CDHP, Premier (EPO) and Copay plans. This is based on the projected total claims incurred for FY2025 (\$388,556,000).

Plan	As of 6/30/2024 (50 days)	As of 6/30/2025 (45 days)
CDHP	\$19,619,000	\$16,539,000
Premier (EPO)	\$9,391,000	\$8,305,000
Copay	\$17,964,000	\$21,681,000
Total	\$46,974,000	\$46,525,000

Actuarial Certification

We certify to the best of our knowledge, the data, methods, and assumptions used to develop the estimated liability for IBNR claims are reasonable and are calculated in accordance with generally accepted and consistently applied actuarial principles. Although our conclusions are based on assumptions and methods that are reasonable for this purpose, actual experience can vary from our estimate, and this difference may be material. This estimate is intended to measure PEBP's liability for unpaid claims as of June 30, 2025 and it should not be relied upon for any other purpose.

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

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

Sincerely yours,



Richard Ward, FSA, FCA, MAAA
West Region Market Director, Public Sector

Exhibit I Medical IBNR Estimate

Plan	IBNR Reserves as of June 30, 2024	IBNR Reserves as of June 30, 2025	Change %	% of Prior 12 Months Paid Claims	10% Margin	Total IBNR with Margin
CDHP						
State						
Actives	\$15,767,000	\$11,207,000	-28.9%	17.1%	\$1,120,000	\$12,327,000
<u>Retirees</u>	<u>\$4,011,000</u>	<u>\$4,502,000</u>	<u>12.2%</u>	<u>22.3%</u>	<u>\$450,000</u>	<u>\$4,952,000</u>
Sub-total	\$19,778,000	\$15,709,000	-20.6%	18.3%	\$1,570,000	\$17,279,000
Non-State						
Actives	\$14,000	\$4,000	-71.4%	16.9%	\$0	\$4,000
<u>Retirees</u>	<u>\$444,000</u>	<u>\$440,000</u>	<u>-0.9%</u>	<u>22.3%</u>	<u>\$44,000</u>	<u>\$484,000</u>
Sub-total	\$458,000	\$444,000	-3.1%	22.2%	\$44,000	\$488,000
<i>Plan Total</i>	<i>\$20,236,000</i>	<i>\$16,153,000</i>	<i>-20.2%</i>	<i>18.4%</i>	<i>\$1,614,000</i>	<i>\$17,767,000</i>
EPO						
State						
Actives	\$8,926,000	\$9,142,000	2.4%	24.3%	\$915,000	\$10,057,000
<u>Retirees</u>	<u>\$930,000</u>	<u>\$1,057,000</u>	<u>13.7%</u>	<u>16.1%</u>	<u>\$106,000</u>	<u>\$1,163,000</u>
Sub-total	\$9,856,000	\$10,199,000	3.5%	23.1%	\$1,021,000	\$11,220,000
Non-State						
Actives	\$1,000	\$1,000	0.0%	25.1%	\$0	\$1,000
<u>Retirees</u>	<u>\$58,000</u>	<u>\$41,000</u>	<u>-29.3%</u>	<u>16.1%</u>	<u>\$4,000</u>	<u>\$45,000</u>
Sub-total	\$59,000	\$42,000	-28.8%	16.2%	\$4,000	\$46,000
<i>Plan Total</i>	<i>\$9,915,000</i>	<i>\$10,241,000</i>	<i>3.3%</i>	<i>23.1%</i>	<i>\$1,025,000</i>	<i>\$11,266,000</i>
Copay						
State						
Actives	\$12,399,000	\$16,112,000	29.9%	15.6%	\$1,611,000	\$17,723,000
<u>Retirees</u>	<u>\$1,494,000</u>	<u>\$1,389,000</u>	<u>-7.0%</u>	<u>11.4%</u>	<u>\$139,000</u>	<u>\$1,528,000</u>
Sub-total	\$13,893,000	\$17,501,000	26.0%	15.2%	\$1,750,000	\$19,251,000
Non-State						
Actives	\$4,000	\$3,000	-25.0%	18.6%	\$0	\$3,000
<u>Retirees</u>	<u>\$39,000</u>	<u>\$30,000</u>	<u>-23.1%</u>	<u>11.6%</u>	<u>\$3,000</u>	<u>\$33,000</u>
Sub-total	\$43,000	\$33,000	-23.3%	12.0%	\$3,000	\$36,000
<i>Plan Total</i>	<i>\$13,936,000</i>	<i>\$17,534,000</i>	<i>25.8%</i>	<i>15.2%</i>	<i>\$1,753,000</i>	<i>\$19,287,000</i>
Grand Total	\$44,087,000	\$43,928,000	-0.4%	17.7%	\$4,392,000	\$48,320,000

Exhibit II Prescription Drug IBNR Estimate

Plan	IBNR Reserves as of June 30, 2024	IBNR Reserves as of June 30, 2025	Change %	% of Prior 12 Months Paid Claims	10% Margin	Total IBNR with Margin
CDHP	\$1,891,000	\$1,562,000	-17.4%	4.32%	\$0	\$1,562,000
EPO	\$965,000	\$769,000	-20.3%	4.31%	\$0	\$769,000
Copay	\$1,893,000	\$2,033,000	7.4%	4.32%	\$0	\$2,033,000
Grand Total	\$4,749,000	\$4,364,000	-8.1%	4.32%	\$0	\$4,364,000

- Estimates do not reflect the impact of any pharmaceutical manufacturer rebates due to PEBP resulting from the utilization of brand drugs.
- Estimates for PY2024 include an estimate of SaveOnSP tertiary claims IBNR of \$385,000.
- Estimates for PY2025 include an estimate of SaveOnSP tertiary claims IBNR of \$424,000.

Exhibit III Dental IBNR Estimate

Plan	IBNR Reserves as of June 30, 2024	IBNR Reserves as of June 30, 2025	Change %	% of Prior 12 Months Paid Claims	10% Margin	Total IBNR with Margin
State						
Actives	\$1,294,000	\$1,163,000	-10.1%	6.0%	\$117,000	\$1,280,000
Retirees	<u>\$520,000</u>	<u>\$441,000</u>	<u>-15.2%</u>	<u>6.2%</u>	<u>\$44,000</u>	<u>\$485,000</u>
Sub-total	\$1,814,000	\$1,604,000	-11.6%	6.1%	\$161,000	\$1,765,000
Non-State						
Actives	\$0	\$0	0%	0.0%	\$0	\$0
Retirees	<u>\$179,000</u>	<u>\$138,000</u>	<u>-22.9%</u>	<u>6.2%</u>	<u>\$14,000</u>	<u>\$152,000</u>
Sub-total	\$179,000	\$138,000	-22.9%	6.2%	\$14,000	\$152,000
Grand Total	\$1,993,000	\$1,742,000	-12.6%	6.1%	\$175,000	\$1,917,000

**Exhibit IV
FY2025 Average Employee Count**

Group	Medical			Dental
	CDHP	Premier (EPO)	Copay	
State				
Active	11,661	2,283	11,238	28,265
Retiree	<u>2,220</u>	<u>468</u>	<u>924</u>	<u>9,792</u>
Sub-total	13,881	2,751	12,162	38,057
Non-State				
Active	5	2	3	9
Retiree	<u>291</u>	<u>44</u>	<u>25</u>	<u>3,596</u>
Sub-total	296	46	28	3,605
Total	14,177	2,797	12,190	41,662

**Medical IBNR – CDHP Plan
As of 6/30/2025**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-22	27,460	\$7,847,265	\$8,270,908	\$8,270,908	\$0	1.000
Jan-23	27,114	\$8,225,387	\$8,602,663	\$8,602,663	\$0	1.000
Feb-23	27,034	\$9,261,679	\$8,133,468	\$8,133,468	\$0	1.000
Mar-23	26,936	\$9,865,013	\$8,611,727	\$8,611,727	\$0	1.000
Apr-23	26,900	\$10,013,727	\$7,837,740	\$7,837,740	\$0	1.000
May-23	26,835	\$8,709,598	\$8,286,577	\$8,286,577	\$0	1.000
Jun-23	26,737	\$8,885,100	\$10,892,851	\$10,892,851	\$0	1.000
Jul-23	24,375	\$6,646,289	\$5,738,663	\$5,739,744	\$1,082	1.000
Aug-23	24,246	\$7,988,183	\$6,376,872	\$6,381,555	\$4,683	0.999
Sep-23	24,228	\$6,894,503	\$6,646,859	\$6,653,151	\$6,292	0.999
Oct-23	24,133	\$6,527,649	\$6,511,250	\$6,518,505	\$7,254	0.999
Nov-23	24,166	\$5,520,070	\$6,964,539	\$6,979,577	\$15,038	0.998
Dec-23	24,156	\$7,596,119	\$8,551,389	\$8,579,370	\$27,981	0.997
Jan-24	23,958	\$7,458,376	\$7,808,227	\$7,857,896	\$49,669	0.994
Feb-24	23,900	\$7,504,222	\$7,970,632	\$8,028,570	\$57,938	0.993
Mar-24	23,916	\$11,626,218	\$8,667,062	\$8,755,604	\$88,542	0.990
Apr-24	23,938	\$8,920,000	\$7,717,026	\$7,829,234	\$112,208	0.986
May-24	23,901	\$9,869,511	\$9,075,399	\$9,229,376	\$153,977	0.983
Jun-24	23,861	\$7,939,869	\$7,997,970	\$8,156,336	\$158,366	0.981
Jul-24	22,708	\$8,330,921	\$6,194,951	\$6,325,634	\$130,682	0.979
Aug-24	22,719	\$6,351,604	\$5,105,063	\$5,247,540	\$142,477	0.973
Sep-24	22,666	\$5,510,809	\$5,815,498	\$6,023,603	\$208,105	0.965
Oct-24	22,843	\$8,108,876	\$7,011,980	\$7,316,474	\$304,494	0.958
Nov-24	22,987	\$6,304,611	\$6,630,367	\$7,019,691	\$389,324	0.945
Dec-24	23,062	\$6,618,606	\$6,872,815	\$7,365,479	\$492,664	0.933
Jan-25	23,001	\$8,193,085	\$7,173,327	\$7,802,449	\$629,123	0.919
Feb-25	23,026	\$7,717,819	\$5,922,554	\$6,568,438	\$645,883	0.902
Mar-25	23,142	\$7,096,659	\$6,633,241	\$7,717,169	\$1,083,928	0.860
Apr-25	23,120	\$7,112,834	\$7,095,400	\$8,837,726	\$1,742,326	0.803
May-25	23,092	\$8,218,416	\$5,393,383	\$8,587,478	\$3,194,095	0.628
Jun-25	22,991	\$8,236,150	\$1,623,831	\$8,130,393	<u>\$6,506,562</u>	0.200
					\$16,152,692	

**Medical IBNR – EPO Plan
As of 6/30/2025**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-22	6,396	\$3,679,316	\$4,785,492	\$4,785,492	\$0	1.000
Jan-23	6,125	\$3,852,655	\$3,590,673	\$3,590,673	\$0	1.000
Feb-23	6,341	\$4,521,105	\$3,576,801	\$3,576,801	\$0	1.000
Mar-23	6,326	\$6,014,425	\$4,158,714	\$4,158,714	\$0	1.000
Apr-23	6,282	\$5,455,147	\$3,425,362	\$3,425,362	\$0	1.000
May-23	6,232	\$3,925,372	\$3,878,473	\$3,878,473	\$0	1.000
Jun-23	6,210	\$4,245,484	\$3,785,687	\$3,785,687	\$0	1.000
Jul-23	5,793	\$3,004,259	\$2,744,319	\$2,744,319	\$0	1.000
Aug-23	5,786	\$3,297,665	\$3,789,571	\$3,789,855	\$284	1.000
Sep-23	5,777	\$2,890,826	\$2,769,651	\$2,862,752	\$93,101	0.967
Oct-23	5,752	\$3,952,026	\$3,024,704	\$3,163,941	\$139,237	0.956
Nov-23	5,760	\$1,995,604	\$3,578,179	\$3,769,443	\$191,264	0.949
Dec-23	5,724	\$3,733,951	\$4,286,513	\$4,541,142	\$254,629	0.944
Jan-24	5,698	\$4,051,380	\$3,648,240	\$3,854,596	\$206,356	0.946
Feb-24	5,674	\$3,805,413	\$4,677,355	\$4,960,712	\$283,357	0.943
Mar-24	5,654	\$4,442,152	\$3,664,497	\$3,886,513	\$222,016	0.943
Apr-24	5,623	\$4,461,463	\$3,627,767	\$3,853,104	\$225,337	0.942
May-24	5,616	\$4,360,688	\$3,426,348	\$3,635,875	\$209,527	0.942
Jun-24	5,562	\$4,194,295	\$3,124,804	\$3,300,436	\$175,632	0.947
Jul-24	5,289	\$3,581,201	\$4,696,992	\$5,000,514	\$303,521	0.939
Aug-24	5,264	\$5,823,463	\$3,264,308	\$3,470,547	\$206,239	0.941
Sep-24	5,210	\$3,245,820	\$2,970,770	\$3,187,862	\$217,092	0.932
Oct-24	5,185	\$4,872,237	\$3,020,541	\$3,257,950	\$237,409	0.927
Nov-24	5,183	\$3,030,454	\$2,634,249	\$2,848,579	\$214,331	0.925
Dec-24	5,171	\$3,479,509	\$2,673,863	\$2,921,760	\$247,897	0.915
Jan-25	5,162	\$3,083,424	\$3,153,257	\$3,519,495	\$366,238	0.896
Feb-25	5,149	\$3,271,006	\$3,081,737	\$3,553,324	\$471,587	0.867
Mar-25	5,128	\$3,752,103	\$3,180,455	\$3,789,669	\$609,214	0.839
Apr-25	5,104	\$3,124,905	\$3,793,997	\$4,904,410	\$1,110,413	0.774
May-25	5,096	\$3,174,621	\$2,327,379	\$3,816,623	\$1,489,244	0.610
Jun-25	5,052	\$3,960,565	\$581,864	\$3,349,177	<u>\$2,767,313</u>	0.174
					\$10,241,239	

**Medical IBNR – Copay Plan
As of 6/30/2025**

Month	Member Count	Paid Amount	Incurred & Paid to Date	Completed Incurred	Remaining Outstanding	Completion Factor
Dec-22	14,128	\$4,246,235	\$5,402,864	\$5,402,864	\$0	1.000
Jan-23	14,194	\$4,282,337	\$4,672,971	\$4,672,971	\$0	1.000
Feb-23	14,425	\$4,852,493	\$5,376,832	\$5,376,832	\$0	1.000
Mar-23	14,491	\$6,531,113	\$5,354,964	\$5,354,964	\$0	1.000
Apr-23	14,659	\$6,743,319	\$5,349,767	\$5,349,767	\$0	1.000
May-23	14,811	\$5,485,271	\$5,547,273	\$5,547,273	\$0	1.000
Jun-23	14,972	\$5,349,647	\$5,319,087	\$5,319,087	\$0	1.000
Jul-23	17,759	\$5,065,337	\$6,250,817	\$6,251,003	\$186	1.000
Aug-23	18,008	\$6,442,734	\$9,067,309	\$9,068,239	\$929	1.000
Sep-23	18,339	\$5,863,848	\$5,311,877	\$5,314,384	\$2,507	1.000
Oct-23	18,519	\$5,881,837	\$7,133,951	\$7,138,851	\$4,899	0.999
Nov-23	18,673	\$5,177,145	\$7,364,967	\$7,381,939	\$16,971	0.998
Dec-23	18,844	\$6,651,476	\$7,103,659	\$7,125,589	\$21,931	0.997
Jan-24	18,936	\$8,538,175	\$7,092,232	\$7,120,381	\$28,149	0.996
Feb-24	19,222	\$7,388,745	\$6,397,482	\$6,431,653	\$34,171	0.995
Mar-24	19,520	\$8,876,485	\$7,783,928	\$7,837,415	\$53,487	0.993
Apr-24	19,770	\$7,528,493	\$8,426,499	\$8,495,298	\$68,799	0.992
May-24	19,925	\$9,361,820	\$8,469,110	\$8,552,131	\$83,021	0.990
Jun-24	20,108	\$6,954,505	\$7,482,815	\$7,575,166	\$92,351	0.988
Jul-24	22,286	\$8,135,506	\$9,552,406	\$9,701,203	\$148,797	0.985
Aug-24	22,452	\$8,058,047	\$9,319,562	\$9,510,986	\$191,424	0.980
Sep-24	22,640	\$8,393,008	\$9,080,328	\$9,278,427	\$198,099	0.979
Oct-24	22,863	\$9,884,211	\$9,034,914	\$9,270,790	\$235,876	0.975
Nov-24	23,095	\$8,268,082	\$8,987,051	\$9,274,368	\$287,317	0.969
Dec-24	23,281	\$9,962,336	\$9,259,588	\$9,658,322	\$398,734	0.959
Jan-25	23,294	\$11,019,613	\$9,878,517	\$10,550,604	\$672,087	0.936
Feb-25	23,567	\$10,908,527	\$8,898,540	\$9,666,801	\$768,262	0.921
Mar-25	23,688	\$9,439,762	\$9,974,507	\$11,189,855	\$1,215,348	0.891
Apr-25	23,795	\$11,540,412	\$9,315,562	\$11,192,213	\$1,876,651	0.832
May-25	23,869	\$10,582,025	\$7,222,897	\$10,712,560	\$3,489,662	0.674
Jun-25	23,812	\$9,210,135	\$1,790,462	\$9,433,202	<u>\$7,642,740</u>	0.190
					\$17,532,398	

Data, Assumptions, and Methodology

We have relied upon claims and membership data provided by UMR, Express Scripts and LifeWorks, with payments through June 30, 2025. We accepted this information without audit and have relied upon the source for the accuracy of the data; however, we did review the information for reasonableness and consistency. On the basis of this review, we believe the data and information provided to be sufficiently complete and accurate, and that it is appropriate for the purposes intended.

Assumptions and Methodology – Segal IBNR reserve model

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

Calculation Methodology

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

1. *Claims Lag Method* - The first method estimates incurred claims by determining the payment patterns for each month of incurred claims. For example, for claims incurred in September 2024, we will review claims paid in September, October, November, and each succeeding month through June 2025. We review each month's payment patterns and utilize these cashflows to estimate the remaining claims to be paid that have been incurred for each month.
2. *Claims Projection Method* – The second method develops a projected per capita total incurred claims estimate for each month. This estimate is based on the expected total incurred claims for prior months, trended forward and adjusted for plan changes. The per capita incurred claims are multiplied by that month's enrollment and the total paid claims reported to date are subtracted to determine the expected incurred but not paid for that month.

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

8.3

8.3 Other Post Employment Benefits (OPEB/GASB)
Measured for FY24 for FY25 Reporting

State of Nevada Retiree Health and Life Insurance Plan

**Governmental Accounting Standards Board Statements
No. 74 and No. 75 Actuarial Valuation of Other
Postemployment Benefits (OPEB) Measured
as of June 30, 2024**

For June 30, 2025 Employer Reporting



This valuation report should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of the Plan.

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August 25, 2025

Board of Trustees
State of Nevada Public Employees' Benefits Program
3427 Goni Rd, Suite #109
Carson City, NV 89706

Dear Board Members:

We are pleased to submit this Governmental Accounting Standards Board Statements No. 74 and No. 75 (GASB 74/75) Actuarial Valuation of Other Postemployment Benefits (OPEB) Measured as of June 30, 2024 for June 30, 2025 Employer Reporting for the State of Nevada Retiree Health and Life Insurance Plan. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB Liability (NOL), and analyzes the preceding year's experience.

The actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices for the exclusive use and benefit of the Board of Trustees. The actuarial valuation is based on the plan of benefits verified by the Plan and reliance on participant, premium, claims and expense data provided by the Plan or from vendors employed by the Plan. Segal does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The measurements shown in this actuarial valuation may not be applicable for other purposes. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience or rates of return on assets differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. The scope of the assignment did not include performing an analysis of the potential change of such future measurements except where noted.

Further, in our opinion, the assumptions used in this valuation and described in Appendix B are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Appendix C.

The actuarial calculations were completed under the supervision of Mehdi Riazi, FSA, FCA, EA, MAAA. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. To the best of my knowledge, the information supplied in the actuarial valuation is complete and accurate. The assumptions used in this actuarial valuation were selected by the Board of Trustees based upon our analysis and recommendations. In my opinion, the assumptions are reasonable and take into account the experience of the State of Nevada Retiree Health and Life Insurance Plan and reasonable expectations. In addition, in my opinion, the combined effect of these assumptions is expected to have no significant bias.

Segal makes no representation or warranty as to the future status of the Plan and does not guarantee any particular result. This document does not constitute legal, tax, accounting or investment advice or create or imply a fiduciary relationship. The Board of Trustees is encouraged to discuss any issues raised in this report with the Plan's legal, tax and other advisors before taking, or refraining from taking, any action.

Sincerely,



Richard Ward, FSA, FCA, MAAA
Senior Vice President



Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary

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Section 1: Actuarial Valuation Summary

Purpose and basis

This report presents the results of our actuarial valuation of the State of Nevada's (the "State") Public Employees Benefits Program (PEBP) Retiree Health and Life Insurance Plan as of June 30, 2024, required by Governmental Accounting Standards Board (GASB) Statement No. 74, Financial Reporting for Postemployment Benefit Plans Other than Pension Plans and GASB Statement No. 75, Accounting and Financial Reporting for Postemployment Benefits Other than Pensions. The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. This valuation is based on:

- The benefit provisions of the State of Nevada PEBP Retiree Health and Life Insurance Plan, as administered by Nevada PEBP;
- The characteristics of covered active members, terminated vested members, and retired members and beneficiaries as of July 1, 2024, provided by the Nevada PEBP and Nevada Public Employees' Retirement System (PERS);
- The assets of the Plan as of June 30, 2024, provided by the Nevada PEBP;
- Health care trends and other medical related assumptions; and
- Other (non-health) actuarial assumptions, regarding employee terminations, retirement, death, disability, etc. based on the State of Nevada PERS Actuarial Experience Study as of June 30, 2020, dated September 10, 2021.

Highlights of the valuation

Accounting and financial reporting

- For GASB 75 reporting as of June 30, 2025, the Net OPEB Liability (NOL) was measured as of June 30, 2024. The Plan Fiduciary Net Position (plan assets) and the Total OPEB Liability (TOL) were valued as of the measurement date. Consistent with the provisions of GASB 75, the assets and liabilities measured as of June 30, 2024 are not adjusted or rolled forward to the June 30, 2025 reporting date.
- The NOL as of June 30, 2024 is \$1,358,189,677, a decrease of \$99,781,288, from the prior valuation NOL of \$1,457,970,965. The difference between actual and expected actuarial accrued liabilities was the net effect of several factors:

Section 1: Actuarial Valuation Summary

- Valuation assumption changes decreased the NOL by \$102,980,118. This was a net result of a decrease in obligations due to updating participation assumptions, updating the valuation-year per capita health cost assumptions, and an increase to the discount rate from 3.65% to 3.93%, partially offset by raising the future trend on valuation-year per capita health costs.
- An actuarial experience gain decreased the NOL by \$9,533,121. This was the net result of gains and losses due to demographic changes, actual benefit payments that were different from expected, and fund investment performance. We have taken these actuarial gains and losses into account in reviewing our assumptions for the current valuation.
- The annual OPEB expense decreased from \$58,580,976 to \$34,733,261 for the year ending June 30, 2024. The decrease to the OPEB expense was mainly due to the new deferred inflows arising from this year's assumption changes.
- Per discussions with PEBP and its auditors, the impact of changes in proportion are now amortized over the plan's average expected remaining service lifetime. Previously, these changes were immediately recognized. The deferred outflows and inflows related to changes in proportion have been restated as if changes in proportion had been amortized over the plan's average expected remaining service lifetime since the inception of GASB 75. This change does not impact the plan's GASB 74 disclosures, only the GASB 75 components related to changes in proportion.

Funding (pay-as-you-go)

- It is our understanding that Nevada PEBP funds OPEB Plan benefits on a pay-as-you-go basis. Under GASB Statements No. 74 and No. 75, if the State were to begin pre-funding OPEB benefits, it would be able to take advantage of a higher discount rate than what is being currently used, which would result in a lower reported liability.

Related Items

- At the request of the PEBP, we are including two additional metrics to assist the State with its bond offering discussions. These additional items are not required disclosures under GASB Statement No. 74. The Actuarially Determined Contribution (ADC) provided below is not based on a formally adopted funding policy nor is it meant to represent a measure of accountability for the State of Nevada. The ADC was determined in a manner consistent with GASB's OPEB reporting framework prior to Statements Nos. 74 and 75.
 - The Present Value of Benefits (PVB) as of June 30, 2024 was \$1,691,234,661. This PVB was based on the same data, methods, and actuarial assumptions as the June 30, 2024 TOL, including a 3.93% discount rate.
 - The ADC for Fiscal Year Ending 2025 was \$127,290,105. This hypothetical ADC consists of the plan's service cost plus a payment towards a 25-year, level-dollar amortization of the NOL. The ADC was developed using the same data, methods, and actuarial assumptions, including a 3.93% discount rate, as those used to develop the June 30, 2024 NOL.

Section 1: Actuarial Valuation Summary

Summary of key valuation results

Valuation Result	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Disclosure elements:		
• Total OPEB Liability	\$1,344,358,275	\$1,427,443,647
• Plan Fiduciary Net Position (Assets)	-13,831,402	-30,527,318
• Net OPEB Liability	1,358,189,677	1,457,970,965
• Plan Fiduciary Net Position as a percentage of Total OPEB Liability	-1.03%	-2.14%
• OPEB expense	\$34,733,261	\$58,580,976
• Total payroll	2,587,396,605	2,372,044,778
Key assumptions as of June 30:		
• Discount rate	3.93%	3.65%
• Inflation rate	2.50%	2.50%

Section 1: Actuarial Valuation Summary

Important information about actuarial valuations

An actuarial valuation is a tool to measure future uncertain obligations of a postretirement health plan. As such, it will never forecast the precise future stream of benefit payments. It is an estimated forecast – the actual cost of the plan will be determined by the benefits and expenses paid, not by the actuarial valuation.

In order to prepare a valuation, Segal relies on a number of input items. These include:

Input Item	Description
Plan of benefits	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. For example, a plan may provide health benefits to post-65 retirees that coordinates with Medicare. If so, changes in the Medicare law or administration may change the plan's costs without any change in the terms of the plan itself. It is important for the State to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary included in our report to confirm that Segal has correctly interpreted the plan of benefits.
Participant data	An actuarial valuation for a plan is based on data provided to the actuary by the plan. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is not necessary to have perfect data for an actuarial valuation: the valuation is an estimated forecast, not a prediction. The uncertainties in other factors are such that even perfect data does not produce a "perfect" result. Notwithstanding the above, it is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Assets	The valuation is based on the fair value of assets as of the valuation date, as provided by the Plan.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. To determine the future costs of benefits, Segal collects claims, premiums, and enrollment data in order to establish a baseline cost for the valuation measurement, and then develops short- and long-term health care cost trend rates to project increases in costs in future years. This forecast also requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of each participant for each year, as well as forecasts of the plan's benefits for each of those events. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets or, if there are no assets, a rate of return based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions the actuary selects within that range. That is, there is no right answer (except with hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model necessarily uses approximations and estimates that may lead to significant changes in our results but will have no impact on the actual cost of the plan. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Section 1: Actuarial Valuation Summary

Input Item	Description
Models	Segal valuation results are based on proprietary actuarial modeling software. The valuation models generate a comprehensive set of liability and cost calculations that are presented to meet accounting standards and client requirements. Our Actuarial Technology and Systems unit, comprising both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary. Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

- The actuarial valuation is prepared for use by the Nevada PEBP. It includes information for compliance with accounting standards and for the plan's auditor. Segal is not responsible for the use or misuse of its report, particularly by any other party.
- An actuarial valuation is a measurement at a specific date – it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted. The actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.
- Sections of this report may include actuarial results that are shown to the nearest dollar, but that does not imply precision.
- Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
- Segal does not provide investment, legal, accounting, or tax advice and is not acting as a fiduciary to the Plan. This valuation is based on Segal's understanding of applicable guidance in these areas and of the Plan's provisions, but they may be subject to alternative interpretations. The State should look to their other advisors for expertise in these areas.
- If the State is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.

Section 1: Actuarial Valuation Summary

- While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
- Segal's report shall be deemed to be final and accepted by the State upon delivery and review. The State should notify Segal immediately of any questions or concerns about the final content.

Section 2: GASB Information

General information about the OPEB plan

Plan administration. The Public Employees' Benefits Program (PEBP) of the State of Nevada administers the OPEB plan - a multiple-employer, cost-sharing OPEB plan that is used to provide OPEB for permanent full-time employees of the State.

Plan membership. At June 30, 2024, Plan membership consisted of the following:

Membership	Medical
Retired members or beneficiaries currently receiving benefits ¹	12,547
Vested terminated members entitled to but not yet receiving benefits ²	19,730
Active members ¹	<u>30,699</u>
Total	62,976

Benefits provided. Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service.

Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of \$195 if retired prior to January 1, 1994, or \$13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994. Medicare retirees hired between January 1, 2010 and December 31, 2011 require 15 years of service to qualify for an HRA contribution.

¹ Retiree, beneficiary, and active counts only include State participants.

² Vested terminated counts include Non-State participants. The Nevada PERS census data, determined as the best source for vested terminated participants, does not differentiate between State and non-State participants. The participation assumption for vested terminated members has been adjusted downward to reflect only future State retirees from this group.

Section 2: Employer GASB 75 Exhibits

Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.

Duration of coverage. Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012. Medicare retirees hired between January 1, 2010 and December 31, 2011 require 15 years of service to qualify for an HRA contribution.

Dependent coverage. Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member \$135.10 towards the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65 but are required to pay the full blended premiums. Surviving spouses and children of Police/Fire employees killed in the line of duty are allowed to join or continue the plan, and their full premium is paid by the employer.

Life insurance. Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO, or Medicare Exchange is provided a basic life insurance benefit of \$12,500 free of charge. Retirees can purchase additional coverage at their own expense.

Retiree contributions. Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2024 through June 30, 2025. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

Coverage Tier	CDHP PPO	LD PPO	HMO/EPO
Retiree	\$263.82	\$293.82	\$389.80
Retiree + Spouse	635.73	695.72	887.69
Surviving Spouse	708.40	747.22	846.32

Section 2: Employer GASB 75 Exhibits

Retiree contributions (continued). Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium (\$)
5	+400.50
6	+360.45
7	+320.40
8	+280.35
9	+240.30
10	+200.25
11	+160.20
12	+120.15
13	+80.10
14	+40.05
15	0.00
16	-40.05
17	-80.10
18	-120.15
19	-160.20
20+	-200.25

Section 2: Employer GASB 75 Exhibits

Exhibit A: Net OPEB Liability

Components of the Net OPEB Liability	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Total OPEB Liability	\$1,344,358,275	\$1,427,443,647
Plan Fiduciary Net Position	-13,831,402	-30,527,318
Net OPEB Liability	1,358,189,677	1,457,970,965
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	-1.03%	-2.14%

The Net OPEB Liability was measured as of June 30, 2024 and 2023. Plan Fiduciary Net Position (plan assets) was valued as of the measurement dates and the Total OPEB Liability was determined from actuarial valuations using data as of July 1, 2024 and 2022, respectively.

Section 2: Employer GASB 75 Exhibits

Actuarial assumptions. The Total OPEB Liability was measured by an actuarial valuation as of June 30, 2024 using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Assumption Type	Assumption
Inflation	2.50%
Salary increases	4.20% to 9.10%, for Regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Discount rate	3.93%
Health care cost trend rates	
• Medical/Prescription Drug	8.00% graded down 0.25% to ultimate 4.50% over 14 years
• Retiree premiums	Premium increases were expected to be in-line with the underlying medical and prescription drug claims trend assumption.
• Dental	4.00% graded down 0.25% to ultimate 3.00% over 4 years
• Administrative costs	3.00%
• Part B Reimbursement	7.63%, effective July 1, 2025, then 1.00%

The actuarial assumptions used in the June 30, 2024 valuation which are not unique to the OPEB valuation were based on the 2020 Actuarial Experience Study conducted for the Public Employees' Retirement System of the State of Nevada, dated September 10, 2021.

Detailed information regarding all actuarial assumptions can be found in Appendix B.

Section 2: Employer GASB 75 Exhibits

Exhibit B: Determination of discount rate and investment rates of return

Since the State funds this Plan on a pay-as-you-go-basis, GASB requires the discount rate be based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). To comply with this requirement, the discount rate is based on an index of 20-year, tax-exempt general obligation bonds. Specifically, the chosen rate is 3.93%, the Bond Buyer 20-Bond GO Index rate published closest to, but not later than, the measurement date of June 30, 2024.

Exhibit C: Discount rate and trend sensitivity

The following presents the NOL of the State as well as what the State's NOL would be if it were calculated using a discount rate that is 1-percentage-point lower (2.93%) or 1-percentage-point higher (4.93%) than the current rate. Also, shown is the NOL as if it were calculated using health care cost trend rates that were 1-percentage-point lower or 1-percentage-point higher than the current health care trend rates.

Item	1% Decrease (2.93%)	Current Discount Rate (3.93%)	1% Increase (4.93%)
Net OPEB Liability (Asset)	\$1,488,951,973	\$1,358,189,677	\$1,244,567,477

Item	1% Decrease in Health Care Cost Trend Rates	Current Health Care Cost Trend Rates	1% Increase in Health Care Cost Trend Rates
Net OPEB Liability (Asset)	\$1,294,283,024	\$1,358,189,677	\$1,430,924,725

Section 2: Employer GASB 75 Exhibits

Exhibit D: Schedule of changes in Net OPEB Liability

Components of the Net OPEB Liability	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Total OPEB Liability		
Service cost	\$45,430,700	\$46,423,873
Interest	52,520,569	50,767,999
Change of benefit terms	0	0
Differences between expected and actual experience	-9,533,121	-7,880,015
Changes of assumptions	-102,980,118	-14,550,157
Benefit payments, including refunds of member contributions	-68,523,402	-69,433,076
Net change in Total OPEB Liability	-\$83,085,372	\$5,328,624
Total OPEB Liability – beginning	1,427,443,647	1,422,115,023
Total OPEB Liability – ending	\$1,344,358,275	\$1,427,443,647
Plan Fiduciary Net Position		
Contributions – employer ¹	\$85,015,893	\$58,858,467
Contributions – employee	0	0
Net investment income	203,425	140,002
Benefit payments, including refunds of member contributions ²	-68,523,402	-69,433,076
Administrative expense	0	0
Other	0	0
Net change in Plan Fiduciary Net Position	\$16,695,916	-\$10,434,607
Plan Fiduciary Net Position – beginning	-30,527,318	-20,092,711
Plan Fiduciary Net Position – ending	-\$13,831,402	-\$30,527,318

¹ Employer contributions reflect contributions to the retiree health benefits trust plus contributions related to benefits that were not reimbursed by the retiree health benefits trust.

² Benefit payments were calculated using actual underlying claims, premiums, and HRA benefits, net of retiree contributions.

Section 2: Employer GASB 75 Exhibits

Components of the Net OPEB Liability	Current	Prior
Net OPEB Liability		
Net OPEB Liability – ending	\$1,358,189,677	\$1,457,970,965
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	-1.03%	-2.14%
Covered payroll	\$2,587,396,605	\$2,372,044,778
Plan Net OPEB Liability as percentage of covered payroll	52.49%	61.46%

Notes to Schedule:

- **Benefit changes:**

None

- **Changes of assumptions:**

The valuation-year per capita health care costs were updated. This change decreased the TOL.

The future trend rates on valuation-year per capita health care costs and the plan's Part B reimbursement were updated. This change increased the TOL.

The participation assumptions were updated. This change decreased the TOL.

The discount rate was raised from 3.65% to 3.93%. This change decreased the TOL.

Section 2: Employer GASB 75 Exhibits

Exhibit E: OPEB expense

Components of OPEB expense	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Service cost	\$45,430,700	\$46,423,873
Interest	52,520,569	50,767,999
Expensed portion of current-period changes in proportion and differences between employer's contributions and proportionate share of contributions	0	0
Current-period benefit changes	0	0
Expensed portion of current-period difference between expected and actual experience in the Total OPEB Liability	-1,808,941	-1,495,259
Expensed portion of current-period changes of assumptions	-19,540,819	-2,760,941
Member contributions	0	0
Projected earnings on OPEB plan investments	-54,984	-87,300
Expensed portion of current-period differences between actual and projected earnings on OPEB plan investments	-29,689	-10,542
Administrative expense	0	0
Other	0	0
Recognition of beginning of year deferred outflows of resources as OPEB expense	20,491,312	32,134,668
Recognition of beginning of year deferred inflows of resources as OPEB expense	-62,274,887	-66,391,522
OPEB expense	\$34,733,261	\$58,580,976

Section 2: Employer GASB 75 Exhibits

Exhibit F: Deferred outflows and inflows of resources

Deferred Outflows and Inflows	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Deferred outflows of resources		
Changes in proportion and differences between employer's contributions and proportionate share of contributions	\$35,638,069	\$15,091,406
Changes of assumptions	0	20,491,312
Net difference between projected and actual earnings on OPEB plan investments	0	0
Difference between expected and actual experience in the Total OPEB Liability	0	0
Total deferred outflows of resources	\$35,638,069	\$35,582,718
Deferred inflows of resources		
Changes in proportion and differences between employer's contributions and proportionate share of contributions	\$35,638,069	\$15,091,406
Changes of assumptions	131,800,156	91,488,046
Net difference between projected and actual earnings on OPEB plan investments	349,546	423,394
Difference between expected and actual experience in the Total OPEB Liability	17,369,782	28,600,700
Total deferred inflows of resources	\$185,157,553	\$135,603,546

Per discussions with PEBP and its auditors, the impact of changes in proportion are now amortized over the plan's average expected remaining service lifetime. Previously, these changes were immediately recognized. The deferred outflows and inflows related to changes in proportion have been restated as if changes in proportion had been amortized over the plan's average expected remaining service lifetime since the inception of GASB 75. This change does not impact the plan's GASB 74 disclosures, only the GASB 75 components related to changes in proportion.

Section 2: Employer GASB 75 Exhibits

Deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized as follows:

Reporting date for employer under GASB 75 year ended June 30:

2025	N/A	-\$41,783,575
2026	-\$69,877,708	-48,498,260
2027	-25,702,529	-4,323,081
2028	-25,646,188	-4,266,740
2029	-22,528,620	-1,149,172
2030	-5,764,439	0
Thereafter	0	0

The net effect of the collective deferred outflows of resources and deferred inflows of resources is recognized over the average of the expected remaining service lives of all employees that are provided with benefits through Nevada PEBP determined as of June 30, 2023 (the beginning of the measurement period ending June 30, 2024).

The average of the expected service lives of all employees was 5.27 and was determined by:

- Calculating each active employee's expected remaining service life as the present value of \$1 per year of future service at zero percent interest.
- Setting the remaining service life to zero for each nonactive or retired member.
- Dividing the sum of the above amounts by the total number of active employee, nonactive and retired members.

Section 2: Employer GASB 75 Exhibits

Exhibit G: Schedule of recognition of change in total Net OPEB Liability

Increase (Decrease) in OPEB Expense Arising from the Recognition of the
Effects of Differences between Expected and Actual Experience on Total OPEB Liability

Reporting Date for Employer under GASB 75 Year Ended June 30	Differences between Expected and Actual Experience	Recognition Period (Years)	2025	2026	2027	2028	2029	2030	Thereafter
2021	-\$72,984,434	4.79	-\$12,037,098	\$0	\$0	\$0	\$0	\$0	\$0
2022	-2,313,154	3.98	-569,572	0	0	0	0	0	0
2023	-19,315,612	3.98	-4,853,169	-4,756,105	0	0	0	0	0
2024	-7,880,015	5.27	-1,495,259	-1,495,259	-1,495,259	-1,495,259	-403,720	0	0
2025	-9,533,121	5.27	-1,808,941	-1,808,941	-1,808,941	-1,808,941	-1,808,941	-488,416	0
Total			-\$20,764,039	-\$8,060,305	-\$3,304,200	-\$3,304,200	-\$2,212,661	-\$488,416	\$0

Section 2: Employer GASB 75 Exhibits

Increase (Decrease) in OPEB Expense Arising from the Recognition of the Effects of Assumption Changes

Reporting Date for Employer under GASB 75 Year Ended June 30	Assumption Changes	Recognition Period (Years)	2025	2026	2027	2028	2029	2030	Thereafter
2021	\$124,244,784	4.79	\$20,491,312	\$0	\$0	\$0	\$0	\$0	\$0
2022	-937,989	3.98	-230,961	0	0	0	0	0	0
2023	-159,738,443	3.98	-40,135,287	-39,332,582	0	0	0	0	0
2024	-14,550,157	5.27	-2,760,941	-2,760,941	-2,760,941	-2,760,941	-745,452	0	0
2025	-102,980,118	5.27	-19,540,819	-19,540,819	-19,540,819	-19,540,819	-19,540,819	-5,276,023	0
Total			-\$42,176,696	-\$61,634,342	-\$22,301,760	-\$22,301,760	-\$20,286,271	-\$5,276,023	\$0

Section 2: Employer GASB 75 Exhibits

Increase (Decrease) in OPEB Expense Arising from the Recognition of the Effects of Differences between Projected and Actual Earnings on OPEB Plan Investments

Reporting Date for Employer under GASB 75 Year Ended June 30	Differences between Projected and Actual Earnings	Recognition Period (Years)	2025	2026	2027	2028	2029	2030	Thereafter
2021	-\$196,153	5.00	-\$39,229	\$0	\$0	\$0	\$0	\$0	\$0
2022	-432,452	5.00	-86,490	-86,492	0	0	0	0	0
2023	-281,706	5.00	-56,341	-56,341	-56,341	0	0	0	0
2024	-52,702	5.00	-10,540	-10,540	-10,540	-10,540	0	0	0
2025	-148,441	5.00	-29,689	-29,688	-29,688	-29,688	-29,688	0	0
Total			-\$222,289	-\$183,061	-\$96,569	-\$40,228	-\$29,688	\$0	\$0

Section 2: Employer GASB 75 Exhibits

Total Increase (Decrease) in OPEB Expense

Reporting Date for Employer under GASB 75 Year Ended June 30	Total Increase (Decrease) in OPEB Expense	2025	2026	2027	2028	2029	2030	Thereafter
2021	\$51,064,197	\$8,414,985	\$0	\$0	\$0	\$0	\$0	\$0
2022	-3,683,595	-887,023	-86,492	0	0	0	0	0
2023	-179,335,761	-45,044,797	-44,145,028	-56,341	0	0	0	0
2024	-22,482,874	-4,266,740	-4,266,740	-4,266,740	-4,266,740	-1,149,172	0	0
2025	-112,661,680	-21,379,449	-21,379,448	-21,379,448	-21,379,448	-21,379,448	-5,764,439	0
Total		-\$63,163,024	-\$69,877,708	-\$25,702,529	-\$25,646,188	-\$22,528,620	-\$5,764,439	\$0

Section 2: Employer GASB 75 Exhibits

Exhibit H: Schedule of reconciliation of Net OPEB Liability

Item	Current	Prior
Reporting date for employer under GASB 75	June 30, 2025	June 30, 2024
Measurement date	June 30, 2024	June 30, 2023
Net OPEB Liability		
Beginning Net OPEB Liability	\$1,457,970,965	\$1,442,207,734
OPEB expense	34,733,261	58,580,976
Employer contributions	-85,015,893	-58,858,467
New net deferred inflows/outflows	-91,282,231	-18,216,132
Change in allocation of prior deferred inflows/outflows	0	0
New net deferred inflows/outflows due to change in proportion	0	0
Recognition of prior deferred inflows/outflows	41,783,575	34,256,854
Recognition of prior deferred inflows/outflows due to change in proportion	0	0
Ending Net OPEB Liability	\$1,358,189,677	\$1,457,970,965

Section 2: Employer GASB 75 Exhibits

Exhibit I: Statement of Plan Fiduciary Net Position

Item	Amounts as of June 30, 2024
Assets	
• Cash and deposits	\$2,803,705
Receivables	
• Intergovernmental Receivable	\$29,273
• Due From Other Funds	148,807
• Total receivables	\$178,080
Total Assets	\$2,981,785
Liabilities	
Payables	
• Due to Other Funds	\$16,813,187
Total liabilities	\$16,813,187
Net position restricted for OPEB	-\$13,831,402

Appendices

Appendix A: Summary of participant data

As of June 30

Statistic	Amount
Number of retirees	12,283
Average age of retirees	70.87
Number of spouses	2,281
Average age of spouses	68.27
Number of surviving spouses	264
Average age	76.36
Number inactive vested ¹	19,730
Average age	49.19
Number of actives ²	30,699
Average age	45.02
Average service	8.78

¹ Based on discussions with the State, we agreed to use the June 30, 2024 Nevada PERS census data for vested terminated participants. Only vested terminated employees who were younger than age 65 as of the valuation date were included. The PERS database was the best source of data available for vested terminated participants. However, we were not able to determine which vested terminated PERS participants were State employees. As a result, the participation assumption for current vested terminated participants was adjusted downward to reflect the fact that the census data includes State and Non-State vested terminated participants.

² Of the 30,699 active State employees, 21,741 were hired on or after January 1, 2012.

Appendices

Appendix B: Statement of actuarial assumptions, methods and models

Data

Detailed census data, premium data and/or claim experience, and summary plan descriptions for OPEB were provided by the Plan.

Actuarial cost method

Entry Age Normal level percent of pay

Asset valuation method

Market Value

Measurement date

June 30, 2024

Actuarial valuation date

June 30, 2024

Discount rate

3.93%, based on bond index as of June 30, 2024

Inflation rate

2.50%

Expected return

2.50%, same as inflation rate assumption

Appendices

Demographic assumptions

The demographic and salary increase assumptions that are common to the PERS pension valuation were based on the 2020 Actuarial Experience Study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021.

The demographic assumptions that are unique to the GASB 74 and 75 valuation (such as enrollment elections, dependent coverage assumptions, and relative ages of spouses) are based on the plan's experience and are reviewed every full valuation.

Appendices

Salary increases (%)

Inflation: 2.50% plus

Productivity pay increases: 0.50% plus

Merit and promotion salary increases:

Years of Service	Regular	Police/Fire
0 – 1	6.10	11.50
1 – 2	5.00	8.20
2 – 3	4.40	5.80
3 – 4	4.00	5.20
4 – 5	3.70	4.90
5 – 6	3.40	4.70
6 – 7	3.30	4.40
7 – 8	3.20	4.20
8 – 9	3.00	4.00
9 – 10	2.80	3.90
10 – 11	2.60	3.50
11 – 12	2.30	2.80
12 – 13	2.10	2.20
13 – 14	1.90	2.00
14 – 15	1.80	1.90
15 – 16	1.70	1.70
16 – 17	1.60	1.70
17 – 18	1.50	1.70
18 – 19	1.40	1.70
19 – 20	1.30	1.70
20 & Over	1.20	1.60

Future salary increases are assumed to occur at the beginning of the year.

Appendices

Mortality rates

Healthy Preretirement:

- **Regular Members:** Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.
- **Police/Fire Members:** Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.

Healthy Postretirement:

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

Disabled Postretirement:

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

Beneficiaries:

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

Appendices

Termination rates (%) before retirement

Years of Service	Regular	Police/Fire
0 – 1	15.75	14.50
1 – 2	12.75	8.25
2 – 3	10.25	6.50
3 – 4	8.25	5.50
4 – 5	7.50	4.50
5 – 6	6.50	4.25
6 – 7	5.75	3.25
7 – 8	5.25	2.50
8 – 9	4.75	2.50
9 – 10	4.50	1.90
10 – 11	4.25	1.40
11 – 12	3.25	1.25
12 – 13	3.00	1.00
13 – 14	2.75	0.90
14 – 15	2.25	0.80
15 – 16	2.25	0.70
16 – 17	2.25	0.60
17 – 18	2.00	0.50
18 – 19	1.75	0.40
19 – 20	1.75	0.30
20 – 21	1.75	0.30
21 – 22	1.75	0.30
22 – 23	1.75	0.30
23 – 24	1.75	0.30
24 – 25	1.50	0.30
25 & Over	1.50	0.30

No termination is assumed after a member reaches the earliest retirement age.

Appendices

Disability rates (%)

Age	Regular	Police/Fire
22	0.01	0.00
27	0.03	0.06
32	0.04	0.16
37	0.10	0.32
42	0.20	0.50
47	0.30	0.80
52	0.55	0.70
57	0.70	0.50
62	0.30	0.30
65 & Over	0.00	0.00

Disability rates are applied only for members with:

- 5 to 30 years of service for Regular members with a date of membership before July 1, 2015,
- Less than 33 1/3 years of service for Regular members with a date of membership on or after July 1, 2015,
- Less than 25 years of service for Police/Fire members with a date of membership before January 1, 2010, or
- Less than 30 years of service for Police/Fire members with a date of membership on or after January 1, 2010.

Appendices

Actives' retirement rates (%)

Regular members with an effective date of membership before January 1, 2010:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
45	0.00	0.10	0.10	0.50	20.00	20.00
46	0.00	0.20	0.20	1.00	20.00	20.00
47	0.00	0.30	0.30	1.50	20.00	20.00
48	0.00	0.40	0.40	2.00	20.00	20.00
49	0.00	0.50	0.50	2.00	20.00	20.00
50	0.20	0.60	0.70	2.00	20.00	20.00
51	0.30	0.70	1.00	2.00	20.00	20.00
52	0.40	0.80	1.20	3.00	20.00	20.00
53	0.50	1.00	1.50	3.00	20.00	20.00
54	0.60	1.20	2.00	3.00	20.00	20.00
55	0.80	1.50	3.00	3.00	20.00	20.00
56	1.00	2.00	3.50	4.00	20.00	20.00
57	1.50	2.50	4.00	7.00	20.00	20.00
58	2.00	3.00	5.00	7.00	20.00	20.00
59	2.50	4.00	7.00	11.00	20.00	20.00
60	5.00	11.00	18.00	25.00	21.00	21.00
61	6.00	10.00	15.00	20.00	21.00	21.00
62	7.00	11.00	16.00	20.00	20.00	20.00
63	8.00	11.00	16.00	20.00	20.00	20.00
64	9.00	11.00	16.00	20.00	20.00	20.00
65	18.00	19.00	22.00	22.00	25.00	25.00
66	18.00	19.00	22.00	22.00	25.00	25.00
67	18.00	19.00	22.00	22.00	25.00	25.00
68	18.00	19.00	22.00	22.00	25.00	25.00
69	18.00	19.00	22.00	22.00	25.00	25.00
70	20.00	20.00	25.00	30.00	30.00	30.00
71	20.00	20.00	25.00	30.00	30.00	30.00
72	20.00	20.00	25.00	30.00	30.00	30.00
73	20.00	20.00	25.00	30.00	30.00	30.00
74	20.00	20.00	25.00	30.00	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Appendices

Regular members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
45	0.00	0.00	0.00	0.00	20.00	20.00
46	0.00	0.00	0.00	0.00	20.00	20.00
47	0.00	0.00	0.00	0.00	20.00	20.00
48	0.00	0.00	0.00	0.00	20.00	20.00
49	0.00	0.00	0.00	0.00	20.00	20.00
50	0.00	0.00	0.00	0.00	20.00	20.00
51	0.00	0.00	0.00	0.00	20.00	20.00
52	0.00	0.40	0.70	1.70	20.00	20.00
53	0.00	0.60	0.90	1.80	20.00	20.00
54	0.00	0.80	1.30	1.90	20.00	20.00
55	0.20	1.00	2.00	2.00	20.00	20.00
56	0.40	1.40	2.50	2.90	20.00	20.00
57	0.60	1.90	3.00	5.20	20.00	20.00
58	0.80	2.30	3.90	5.40	20.00	20.00
59	1.00	3.20	5.60	8.80	20.00	20.00
60	2.00	4.00	6.00	10.00	21.00	21.00
61	3.50	6.00	10.00	15.00	21.00	21.00
62	4.00	10.30	15.00	18.70	20.00	20.00
63	5.00	10.30	15.00	18.70	20.00	20.00
64	7.00	10.30	15.00	18.70	20.00	20.00
65	17.00	17.80	20.60	20.60	25.00	25.00
66	17.00	17.80	20.60	20.60	25.00	25.00
67	17.00	17.80	20.60	20.60	25.00	25.00
68	17.00	17.80	20.60	20.60	25.00	25.00
69	17.00	17.80	20.60	20.60	25.00	25.00
70	19.00	18.70	23.40	28.10	30.00	30.00
71	19.00	18.70	23.40	28.10	30.00	30.00
72	19.00	18.70	23.40	28.10	30.00	30.00
73	19.00	18.70	23.40	28.10	30.00	30.00
74	19.00	18.70	23.40	28.10	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Appendices

Regular members with an effective date of membership on or after July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 29 Years of Service	30 – 33.3 Years of Service	33.3 & Over Years of Service
45	0.00	0.00	0.00	0.00	7.20	20.00
46	0.00	0.00	0.00	0.00	8.30	20.00
47	0.00	0.00	0.00	0.00	9.40	20.00
48	0.00	0.00	0.00	0.00	10.40	20.00
49	0.00	0.00	0.00	0.00	11.50	20.00
50	0.00	0.00	0.00	0.00	12.60	20.00
51	0.00	0.00	0.00	0.00	13.70	20.00
52	0.00	0.40	0.60	1.50	14.80	20.00
53	0.00	0.50	0.80	1.60	15.80	20.00
54	0.00	0.70	1.20	1.70	16.90	20.00
55	0.20	0.90	1.80	1.80	18.00	20.00
56	0.40	1.30	2.30	2.60	18.00	20.00
57	0.50	1.70	2.70	4.70	18.00	20.00
58	0.70	2.10	3.50	4.90	18.00	20.00
59	0.90	2.90	5.00	7.90	18.00	20.00
60	1.80	3.60	5.40	9.00	18.90	21.00
61	3.20	5.40	9.00	13.50	18.90	21.00
62	3.60	9.30	13.50	16.80	18.00	20.00
63	4.50	9.30	13.50	16.80	18.00	20.00
64	6.30	9.30	13.50	16.80	18.00	20.00
65	15.30	16.00	18.50	18.50	22.50	25.00
66	15.30	16.00	18.50	18.50	22.50	25.00
67	15.30	16.00	18.50	18.50	22.50	25.00
68	15.30	16.00	18.50	18.50	22.50	25.00
69	15.30	16.00	18.50	18.50	22.50	25.00
70	17.10	16.80	21.10	25.30	27.00	30.00
71	17.10	16.80	21.10	25.30	27.00	30.00
72	17.10	16.80	21.10	25.30	27.00	30.00
73	17.10	16.80	21.10	25.30	27.00	30.00
74	17.10	16.80	21.10	25.30	27.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Appendices

Police/Fire members with an effective date of membership before January 1, 2010:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 22 Years of Service	23 – 24 Years of Service	25 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.10	0.00	0.00	0.00	0.00
41	0.00	0.20	0.00	20.00	20.00	0.00
42	0.00	0.30	1.00	20.00	20.00	0.00
43	0.00	0.40	2.00	20.00	20.00	0.00
44	0.00	0.50	3.00	20.00	20.00	0.00
45	0.00	0.70	3.50	20.00	20.00	20.00
46	0.00	0.90	4.00	20.00	20.00	20.00
47	0.00	1.10	4.50	20.00	20.00	20.00
48	0.00	1.30	5.00	20.00	20.00	20.00
49	0.00	1.50	6.50	20.00	20.00	20.00
50	1.50	4.50	16.00	23.00	23.00	23.00
51	1.50	4.50	13.00	23.00	23.00	23.00
52	1.50	5.00	13.00	23.00	23.00	23.00
53	1.50	6.00	13.00	23.00	23.00	23.00
54	1.50	7.00	13.00	23.00	23.00	23.00
55	4.50	11.00	18.00	25.00	25.00	25.00
56	4.50	11.00	18.00	25.00	25.00	25.00
57	4.50	11.00	18.00	25.00	25.00	25.00
58	4.50	11.00	18.00	25.00	25.00	25.00
59	4.50	11.00	18.00	25.00	25.00	25.00
60	5.00	18.00	26.00	35.00	35.00	35.00
61	6.00	18.00	26.00	35.00	35.00	35.00
62	7.00	18.00	26.00	35.00	35.00	35.00
63	8.00	18.00	26.00	35.00	35.00	35.00
64	9.00	18.00	26.00	35.00	35.00	35.00
65	20.00	25.00	40.00	50.00	50.00	50.00
66	20.00	25.00	40.00	50.00	50.00	50.00
67	20.00	25.00	40.00	50.00	50.00	50.00
68	20.00	25.00	40.00	50.00	50.00	50.00
69	20.00	25.00	40.00	50.00	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Appendices

Police/Fire members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00	0.00
43	0.00	0.00	1.50	10.90	20.00	0.00
44	0.00	0.00	2.40	12.00	20.00	0.00
45	0.00	0.00	2.90	13.10	20.00	20.00
46	0.00	0.00	3.40	14.20	20.00	20.00
47	0.00	0.00	3.90	15.40	20.00	20.00
48	0.00	0.00	4.50	16.50	20.00	20.00
49	0.00	0.00	6.00	17.60	20.00	20.00
50	0.00	2.10	15.00	21.50	23.00	23.00
51	0.00	2.30	12.20	21.50	23.00	23.00
52	0.00	2.80	12.20	21.50	23.00	23.00
53	0.00	3.50	12.20	21.50	23.00	23.00
54	0.00	4.40	12.20	21.50	23.00	23.00
55	2.80	7.20	16.90	23.40	25.00	25.00
56	3.00	7.80	16.90	23.40	25.00	25.00
57	3.20	8.40	16.90	23.40	25.00	25.00
58	3.40	9.10	16.90	23.40	25.00	25.00
59	3.50	9.70	16.90	23.40	25.00	25.00
60	4.10	16.90	24.30	32.80	35.00	35.00
61	5.10	16.90	24.30	32.80	35.00	35.00
62	6.10	16.90	24.30	32.80	35.00	35.00
63	7.20	16.90	24.30	32.80	35.00	35.00
64	8.30	16.90	24.30	32.80	35.00	35.00
65	18.70	23.40	37.50	46.80	50.00	50.00
66	18.70	23.40	37.50	46.80	50.00	50.00
67	18.70	23.40	37.50	46.80	50.00	50.00
68	18.70	23.40	37.50	46.80	50.00	50.00
69	18.70	23.40	37.50	46.80	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Appendices

Police/Fire members with an effective date of membership on or after July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00
43	0.00	0.00	1.50	10.90	0.00
44	0.00	0.00	2.40	12.00	0.00
45	0.00	0.00	2.90	13.10	20.00
46	0.00	0.00	3.40	14.20	20.00
47	0.00	0.00	3.90	15.40	20.00
48	0.00	0.00	4.50	16.50	20.00
49	0.00	0.00	6.00	17.60	20.00
50	0.00	2.10	15.00	21.50	23.00
51	0.00	2.30	12.20	21.50	23.00
52	0.00	2.80	12.20	21.50	23.00
53	0.00	3.50	12.20	21.50	23.00
54	0.00	4.40	12.20	21.50	23.00
55	2.80	7.20	16.90	23.40	25.00
56	3.00	7.80	16.90	23.40	25.00
57	3.20	8.40	16.90	23.40	25.00
58	3.40	9.10	16.90	23.40	25.00
59	3.50	9.70	16.90	23.40	25.00
60	4.10	16.90	24.30	32.80	35.00
61	5.10	16.90	24.30	32.80	35.00
62	6.10	16.90	24.30	32.80	35.00
63	7.20	16.90	24.30	32.80	35.00
64	8.30	16.90	24.30	32.80	35.00
65	18.70	23.40	37.50	46.80	50.00
66	18.70	23.40	37.50	46.80	50.00
67	18.70	23.40	37.50	46.80	50.00
68	18.70	23.40	37.50	46.80	50.00
69	18.70	23.40	37.50	46.80	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00

Appendices

Vested terminated retirement rates

Inactive vested participants with less than 10 years of service are assumed to retire at age 65. Those with 10 or more years of service are assumed to retire at age 60.

Higher education retirement rates

For Higher Education employees, the assumed rates of retirement are the same as those used for Regular employees, except no rates of retirement are assumed unless the member has at least 5 years of service and is at least 60 years old.

Unknown data for participants

Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male. Active participants with unknown dates of hire were assumed to enter at age 36.

Participants with unknown Regular or Police/Fire indicators were assumed to be General employees. Participants with unknown State or Non-State indicators were assumed to be State employees.

Participation and coverage election

85% of active employees with active healthcare coverage.

40% of actives without active coverage and future vested terminated employees.

35% for future retirees who would be required to pay the full “un-subsidized” rates for coverage.

35% for eligible surviving spouses of active employees. Surviving spouses of retirees are assumed to continue coverage after the retiree’s death.

5% of current vested terminated employees. The census data provided for current vested terminated participants as of the valuation date was from the PERS and Judges pension valuations. This census data for current vested terminated participants includes many participants who are in the pension plans, but who were never participants in the retiree healthcare plan. In other words, they worked for employers who are not participating in the State’s retiree healthcare plan. The participation assumption of 5% reflects the fact that the census data includes participants who we know will not be eligible for the State’s retiree healthcare benefits at retirement.

All current and future retirees are assumed to be eligible for Medicare at age 65.

Appendices

Dental coverage is assumed for all participants on the non-Exchange health plans. No separate dental participation assumption is needed for retirees who are on the Medicare Exchange because the maximum HRA benefit is valued for each retiree.

Life insurance coverage is provided to all retirees who have healthcare coverage, either through the Exchange or non-Exchange health plans. Reinstated retirees do not receive the \$12,500 basic life insurance benefit.

Dependents

Demographic data was available for spouses of current retirees. For future retirees, male participants were assumed to be three years older than their spouses and female participants were assumed to be two years younger than their spouses. Of those actives who elect to continue their health coverage at retirement, 30% of males and 15% of females were assumed to have an eligible spouse who also opts for health coverage at that time.

Per capita cost development

Per-capita claims costs for the self-insured CDHP PPO, LD PPO, and EPO were based on retiree claims experience furnished by PEBP for periods July 1, 2022 through June 30, 2024. Claims were developed on an incurred basis and were adjusted for plan changes. The historical claims were trended forward to the valuation year using a 5.0% assumption for medical costs and 8.0% - 10.0% assumptions for prescription drug costs. Per-capita costs for the fully-insured HMO were based on the premiums charged by the insurer, effective July 1, 2024, and the demographics of the active employees and retirees who elected the HMO. A weighted average set of per capita costs was developed based on the enrollment in each of the plan options. Actuarial factors were used to estimate individual costs by age in accordance with ASOP 6, and to reflect Medicare offsets for those participants who are eligible for Medicare.

Per-capita claims costs for the self-insured dental plan were based on retiree claims experience furnished by PEBP for periods July 1, 2022 through June 30, 2024. Dental claims were developed on an incurred basis and include administrative expenses. The historical claims were trended forward to the valuation year using a 2.0% assumption.

Appendices

Per capita health costs

The annual per capital dental claims cost for the plan year 2024/2025 was estimated to be \$402.

2024/2025 medical and prescription drug claims costs, excluding assumed expenses, are shown in the table below for retirees and for spouses at selected ages. These costs are net of deductibles and other benefit plan cost sharing provisions. The blended claims estimates shown below were used for all current and future retirees, regardless of their current health plan election, and were based on the health plan distribution of current retirees. Post-65 claims costs apply to Medicare-eligible retirees that are not in an Exchange plan.

Medical and Prescription Drug Claims

Age	Male	Female
50	\$9,017	\$9,521
55	10,174	10,335
60	11,715	11,204
64	14,237	12,163
65	5,501	4,569
70	6,178	5,111
75	6,825	5,374
80	7,147	5,736
85+	7,483	6,122

CDHP PPO - HRA Contributions

An annual HRA contribution of \$348 was added to projected incurred medical and prescription drug claims costs. The \$348 dollar benefit equals the \$600 annual HRA benefit for retirees who elect the CDHP PPO multiplied by the assumed percentage of retirees choosing the CDHP PPO (i.e., 57.9%). The HRA contribution associated with the CDHP PPO was not assumed to increase.

Appendices

Health care cost trend rates (%)

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are “net” and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is applied to that year’s cost to yield the next year’s projected cost.

Increase Effective July 1,	Medical/ Prescription Drug	Dental	Admin	Part B Reimbursements
2024	8.00	4.00	3.00	7.63
2025	7.75	3.75	3.00	1.00
2026	7.50	3.50	3.00	1.00
2027	7.25	3.25	3.00	1.00
2028	7.00	3.00	3.00	1.00
2029	6.75	3.00	3.00	1.00
2030	6.50	3.00	3.00	1.00
2031	6.25	3.00	3.00	1.00
2032	6.00	3.00	3.00	1.00
2033	5.75	3.00	3.00	1.00
2034	5.50	3.00	3.00	1.00
2035	5.25	3.00	3.00	1.00
2036	5.00	3.00	3.00	1.00
2037	4.75	3.00	3.00	1.00
2038 & Later	4.50	3.00	3.00	1.00

The trend rate assumptions were developed using Segal's internal guidelines, which are established each year using data sources such as the Segal Health Trend Survey, internal client results, trends from other published surveys prepared by the S&P Dow Jones Indices, consulting firms and brokers, and CPI statistics published by the Bureau of Labor Statistics.

Appendices

Retiree contribution increase rate

For retirees who are receiving coverage through a non-Exchange health plan, retiree contributions are modeled using:

1. the overall blended premiums
2. the base explicit subsidy, and
3. the service-based explicit subsidies.

Each of these components was assumed to follow the Medical/Prescription Drug trend.

Administrative expenses

An administrative expense of \$334 per participant per year was added to projected incurred claim costs in developing the benefit obligations.

Plan design

Development of plan liabilities was based on the substantive plan of benefits in effect as described in Appendix C.

Assumption changes since prior valuation:

The valuation-year per capita health care costs were updated. This change decreased the TOL.

The future trend rates on valuation-year per capita health care costs and the plan's Part B reimbursement were updated. This change increased the TOL.

The participation assumptions were updated. This change decreased the TOL.

The discount rate was increased from 3.65% to 3.93%. This change decreased the TOL.

Appendices

Appendix C: Summary of plan provisions

This appendix summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility

Members are not required to be active immediately prior to retirement to be eligible for benefits. Members must be receiving a PERS, LRS, JRS, or RPA pension.

Service Retirement for members with an effective date of membership before January 1, 2010:

- Regular: Age 65 with five years of service, or age 60 with ten years of service, or 30 years of service.
- P&F: Age 65 with 5 years of service, or age 55 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 25 years of Police/Fire service.

Service Retirement for members with an effective date of membership on or after January 1, 2010:

- Regular: Age 65 with five years of service, or age 62 with ten years of service, or 30 years of service.
- P&F: Age 65 with 5 years of service, or age 60 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 30 years of Police/Fire service.

Service Retirement for Regular members with an effective date of membership before July 1, 2015:

- Age 65 with five years of service, or age 62 with ten years of service, or age 55 with 30 years of service, or any age with 33 1/3 years of service.

Early Retirement: Five years of service.

Disability: Five years of service and totally unable to perform current job or any comparable job for which the member is qualified by training and experience, because of injury or illness of a permanent nature, provided the member is in the employ of a participating employer at the time of application for disability retirement.

Appendices

Members hired before January 1, 2010 are eligible to receive a base non-Medicare subsidy, as well as service-based non-Medicare and Medicare Exchange subsidies.

Members hired on or after January 1, 2012 are not eligible for any of the explicit subsidies mentioned above. However, they are eligible for non-Medicare coverage by paying the plan's overall blended premiums.

Members hired on or after January 1, 2010 and before January 1, 2012 must have 15 years of service in order to be eligible for the plan's explicit subsidies, unless they retire through the disability retirement.

Benefit types

Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service. Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of \$195 if retired prior to January 1, 1994, or \$13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994.

Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.

Duration of coverage

Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012.

Appendices

Dependent coverage

Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member \$135.50 for the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65, but are required to pay the full blended premiums. Surviving spouses and children of Police/Fire employees killed in the line of duty are allowed to join or continue the plan, and their full premium is paid by the employer.

Life insurance

Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO or Medicare Exchange is provided a basic life insurance benefit of \$12,500 free of charge. Retirees can purchase additional coverage at their own expense.

Dental contribution

Dental coverage is included with health benefits (no separate dental premium) for participants that have not moved to the Exchange. Dental coverage is available to retirees who are on the Medicare Exchange, but the dental premiums are separate from the medical premiums. The plan year 2024/25 monthly dental premium for State retirees who are enrolled in the Medicare Exchange was \$50.66. Exchange retirees have the option of using their HRA funds towards dental premiums.

Part B reimbursement

Retirees who are over the age of 65 and continue to have health care coverage on the CDHP PPO, LD PPO, EPO, or HMO are required to enroll in Medicare Part B. In addition to the base explicit subsidy and the service-based explicit subsidies, these retirees also received a monthly Part B premium credit/reimbursement of \$135.50 in plan year 2024/25. Spouses and surviving spouses are not eligible for the Part B reimbursement.

Appendices

Retiree contributions

Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2024 through June 30, 2025. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

	CDHP PPO	LD PPO	EPO/ HMO
Retiree	\$263.82	\$293.82	\$389.80
Retiree + Spouse	635.73	695.72	887.69
Surviving Spouse	708.40	747.22	846.32
Base Explicit Subsidy Retiree	444.59	453.41	456.53
Base Explicit Subsidy Spouse	328.28	337.11	340.22

Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium (\$)	Years of Service	Change in Premium (\$)
5	+400.50	13	+80.10
6	+360.45	14	+40.05
7	+320.40	15	0.00
8	+280.35	16	-40.05
9	+240.30	17	-80.10
10	+200.25	18	-120.15
11	+160.20	19	-160.20
12	+120.15	20+	-200.25

Appendices

Plan changes since prior valuation

None.

Appendices

Appendix D: Definition of terms

Definitions of certain terms as they are used in Statement No. 75. The terms may have different meanings in other contexts.

Term	Definition
Actuarially Determined Contribution:	A target or recommended contribution to an OPEB plan for the reporting period based on the most recent measurement available.
Assumptions or actuarial assumptions:	The estimates on which the cost of the Plan is calculated including: a. Investment return — the rate of investment yield that the Plan will earn over the long-term future; b. Mortality rates — the death rates of employees and retirees; life expectancy is based on these rates; c. Retirement rates — the rate or probability of retirement at a given age; d. Turnover rates — the rates at which employees of various ages are expected to leave employment for reasons other than death, disability, or retirement.
Covered payroll:	The payroll of the employees that are provided OPEB benefits
Discount rate:	The single rate of return, that when applied to all projected benefit payments results in an actuarial present value that is the sum of the following: a. the actuarial present value of projected benefit payments projected to be funded by plan assets using a long term rate of return, and b. the actuarial present value of projected benefit payments that are not included in (a) using a yield or index rate for 20 year tax exempt general obligation municipal bonds with an average rating of AA/Aa or higher
Entry age actuarial cost method:	An actuarial cost method where the present value of the projected benefits for an individual is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age
Health care cost trend rates:	The rate of change in per capita health costs over time
Net OPEB Liability:	The Total OPEB Liability less the Plan Fiduciary Net Position
Plan Fiduciary Net Position:	Fair Value of Assets
Real rate of return:	The rate of return on an investment after removing inflation
Service cost:	The amount of contributions required to fund the benefit allocated to the current year of service.
Total OPEB Liability:	The portion of the actuarial present value of projected benefit payments that is attributed to past periods of employee service in conformity with the requirements of Statement No. 75.
Valuation date:	The date at which the actuarial valuation is performed

#5955719v2/16664.010

August 25, 2025

Board of Trustees
State of Nevada Public Employees' Benefits Program
3427 Goni Road, Suite #109
Carson City, NV 89706

**Re: State of Nevada Retiree Health and Life Insurance Plan
Governmental Accounting Standards Board (GASB) Statements 74 and 75 Valuation
measured as of June 30, 2024 for June 30, 2025 Employer Reporting
Addendum Letter – Employer Allocation Exhibits**

Dear Board Members:

Our June 30, 2024 Governmental Accounting Standards Board Statements No. 74 and No. 75 (GASB 74/75) actuarial valuation provides the Net OPEB Liability (NOL) and other disclosures required for the Plan's June 30, 2024 financial reporting. This addendum letter provides the June 30, 2024 results allocated by employer, for use in the employers' June 30, 2025 financial reports. In addition, Appendix A includes an estimate of the "implicit subsidy" for the year ending June 30, 2025, which is needed to calculate the employer's contributions made after the measurement date.

These schedules have been developed based on the assumptions, methods, and results shown in our June 30, 2024 GASB 74/75 report for June 30, 2025 employer reporting. The historical amortization periods can be found in Section 2, Exhibit G of the report. Further details broken down for each employer are found in the attached appendices.

As requested by the Plan's outside auditor, the deferred outflows and inflows related to changes in proportion have been calculated as if the impact of changes in proportion had been amortized over the plan's average expected remaining service lives since the inception of GASB 75. In prior years, the balance sheet impact of changes in proportion were recognized immediately in each participating employer's OPEB expense.

The transition to this new methodology may require the participating employers to restate their beginning of year deferred outflows and inflows related to changes in proportion from zero to the amounts shown in Appendix E. The amounts in Appendix E represent the beginning of year deferred outflows and inflows related to changes in proportion, had the impact of changes in proportion been amortized over the plan's average expected remaining service lives since the inception of GASB 75.

This document has been prepared for the exclusive use and benefit of the State of Nevada PEBP based upon information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This letter should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of the Plan. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

These actuarial calculations were completed under the supervision of Mehdi Riazi, FSA, FCA, EA, MAAA. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Please let us know if you have any questions.

Sincerely,



Richard Ward, FSA, FCA, MAAA
Senior Vice President



Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary

Appendices

Appendix A: Determination of Proportionate Share and Total Employer Contribution as of June 30, 2024

Agency # (1)	Agency (2)	Retiree Trust Contribution Amount (3)	Allocation Percentage (4)	Benefits Not Paid by Retiree Trust (5)	Total Employer Contribution (6) = (3) + (5)	Implicit Subsidy Paid After Measurement Date (7)
101	Board of Medical Examiners	\$106,055	0.1578%	\$27,988	\$134,043	\$20,884
102	Board of Nursing	69,868	0.1039%	18,430	88,298	15,337
103	Board of Pharmacy	77,657	0.1154%	20,470	98,127	14,427
104	Board of Chiropractors	4,234	0.0063%	1,117	5,351	826
105	Board of Dental Examiners	18,609	0.0277%	4,913	23,522	3,614
106	Legislative Counsel Bureau	1,031,943	1.5340%	272,099	1,304,042	246,083
108	Board of Osteopathic Medicine	9,584	0.0142%	2,519	12,103	2,087
109	Board of Massage Therapy	9,764	0.0145%	2,572	12,336	1,835
111	Funeral and Cemetery Board	5,575	0.0083%	1,472	7,047	1,135
113	Public Employee Retirement System	187,862	0.2793%	49,542	237,404	38,728
116	Central Payroll	33,320,339	49.5317%	8,785,870	42,106,209	7,154,120
118	Nevada Department of Transportation	3,354,552	4.9866%	884,517	4,239,069	680,835
128	Board of Accountancy	8,808	0.0131%	2,324	11,132	1,765
129	Board of Cosmetology	38,817	0.0577%	10,235	49,052	8,124
134	Board of Professional Engineers	17,318	0.0257%	4,559	21,877	3,137
139/140	Nevada System of Higher Education	27,937,496	41.5300%	7,366,538	35,304,034	5,581,047
141	Board of Architecture	11,399	0.0169%	2,998	14,397	2,157
146	Board of Examiners for Social Workers	9,247	0.0137%	2,430	11,677	1,695
147	Liquefied Petroleum Gas Board	6,637	0.0099%	1,756	8,393	1,121
148	Board of Optometry	4,469	0.0066%	1,171	5,640	896
149	Board of Veterinary Examiners	7,608	0.0113%	2,004	9,612	1,583
150	Board of Examiners for Alcohol, Drugs, & Gambling	2,903	0.0043%	763	3,666	560

Appendices

Agency # (1)	Agency (2)	Retiree Trust Contribution Amount (3)	Allocation Percentage (4)	Benefits Not Paid by Retiree Trust (5)	Total Employer Contribution (6) = (3) + (5)	Implicit Subsidy Paid After Measurement Date (7)
171	Nevada Physical Therapy Board	8,876	0.0132%	2,341	11,217	1,639
172	Private Investigators Licensing Board	17,265	0.0257%	4,559	21,824	3,488
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	7,707	0.0115%	2,040	9,747	1,359
174	Nevada Applied Behavior Analysis Board	3,642	0.0054%	958	4,600	812
175	State of Nevada - Judicial Board	991,866	1.4744%	261,527	1,253,393	200,561
176	Nevada Board of Psychological Examiners	586	0.0009%	160	746	476
Total		\$67,270,686	100.00%	\$17,737,872	\$85,008,558	\$13,990,331

Notes:

Per GASB 75, employer contributions include trust contributions and benefits paid by the employer with its own assets.

The \$17,737,872 in benefits not paid by the retiree trust equals the difference between \$68,523,402 in plan paid benefit payments and \$50,785,530 in deductions from the retiree trust. This difference is often referred to as an "implicit subsidy". The participating employers finance the implicit subsidy via premiums they pay for active employees.

The amounts in column (5) represent cash payments made on behalf of active employees, that should be reclassified as payments towards retiree healthcare benefits. These "implicit subsidies" are additional employer contributions that help finance the annual retiree benefits.

The allocation percentages in column (4) are used to allocate the amounts in column (5) and are based on the retiree trust contribution amounts in column (3).

The Total Employer Contribution shown above of \$85,008,558 is \$7,335 lower than the \$85,015,893 shown in the GASB 74/75 report due to the difference between the sum of REGI contributions provided by employer and total employer contributions in the plan's financial statements. Under GASB 75, these differences are recognized in the same manner as changes in proportion.

The implicit subsidy paid after the measurement date in column (7) can be added to the REGI contributions made during FYE25 in order to estimate the total deferred outflow for employer contributions after the measurement date. Please note that the amounts in column (7) are estimates of next year's column (5) and will be updated when the audited FYE25 trust deductions are determined.

Appendices

Appendix B: Schedule of Net OPEB Liability and Sensitivity Disclosures as of June 30, 2024

Agency # (1)	Agency (2)	Net OPEB Liability (3.93%) (3)	1% Decrease in Discount Rate (2.93%) (4)	1% Increase in Discount Rate (4.93%) (5)	1% Decrease in Trend Rates (6)	1% Increase in Trend Rates (7)
101	Board of Medical Examiners	\$2,143,221	\$2,349,566	\$1,963,928	\$2,042,378	\$2,258,000
102	Board of Nursing	1,411,159	1,547,021	1,293,106	1,344,760	1,486,731
103	Board of Pharmacy	1,567,351	1,718,251	1,436,231	1,493,603	1,651,287
104	Board of Chiropractors	85,566	93,804	78,408	81,540	90,148
105	Board of Dental Examiners	376,219	412,440	344,745	358,516	396,366
106	Legislative Counsel Bureau	20,834,630	22,840,523	19,091,665	19,854,302	21,950,385
108	Board of Osteopathic Medicine	192,863	211,431	176,729	183,788	203,191
109	Board of Massage Therapy	196,938	215,898	180,462	187,671	207,484
111	Funeral and Cemetery Board	112,730	123,583	103,299	107,425	118,767
113	Public Employee Retirement System	3,793,424	4,158,643	3,476,077	3,614,932	3,996,573
116	Central Payroll	672,734,436	737,503,224	616,455,429	641,080,385	708,761,342
118	Nevada Department of Transportation	67,727,486	74,248,079	62,061,602	64,540,717	71,354,492
128	Board of Accountancy	177,923	195,053	163,038	169,551	187,451
129	Board of Cosmetology	783,675	859,125	718,115	746,801	825,644
134	Board of Professional Engineers	349,055	382,661	319,854	332,631	367,748
139/140	Nevada System of Higher Education	564,056,173	618,361,754	516,868,873	537,515,740	594,263,038
141	Board of Architecture	229,534	251,633	210,332	218,734	241,826
146	Board of Examiners for Social Workers	186,072	203,986	170,506	177,317	196,037
147	Liquefied Petroleum Gas Board	134,461	147,406	123,212	128,134	141,662
148	Board of Optometry	89,641	98,271	82,141	85,423	94,441
149	Board of Veterinary Examiners	153,475	168,252	140,636	146,254	161,694

Appendices

Agency # (1)	Agency (2)	Net OPEB Liability (3.93%) (3)	1% Decrease in Discount Rate (2.93%) (4)	1% Increase in Discount Rate (4.93%) (5)	1% Decrease in Trend Rates (6)	1% Increase in Trend Rates (7)
150	Board of Examiners for Alcohol, Drugs, & Gambling	58,402	64,025	53,516	55,654	61,530
171	Nevada Physical Therapy Board	179,281	196,542	164,283	170,845	188,882
172	Private Investigators Licensing Board	349,055	382,661	319,854	332,631	367,748
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	156,192	171,229	143,125	148,843	164,556
174	Nevada Applied Behavior Analysis Board	73,342	80,403	67,207	69,891	77,270
175	State of Nevada - Judicial Board	20,025,149	21,953,108	18,349,903	19,082,909	21,097,554
176	Nevada Board of Psychological Examiners	12,224	13,401	11,201	11,649	12,878
Total		\$1,358,189,677	\$1,488,951,973	\$1,244,567,477	\$1,294,283,024	\$1,430,924,725

Appendices

Appendix C: Schedule of OPEB Expense by Employer as of June 30, 2024

Agency # (1)	Agency (2)	Proportionate Share of Plan OPEB Expense (3)	Changes in Proportion (4)	Total Employer OPEB Expense (5) = (3) + (4)
101	Board of Medical Examiners	\$54,810	\$74,362	\$129,172
102	Board of Nursing	36,087	10,840	46,927
103	Board of Pharmacy	40,083	78,071	118,154
104	Board of Chiropractors	2,189	-198	1,991
105	Board of Dental Examiners	9,621	22,434	32,055
106	Legislative Counsel Bureau	532,808	1,007,476	1,540,284
108	Board of Osteopathic Medicine	4,932	6,405	11,337
109	Board of Massage Therapy	5,036	-22,575	-17,539
111	Funeral and Cemetery Board	2,882	-1,651	1,231
113	Public Employee Retirement System	97,009	59,598	156,607
116	Central Payroll	17,203,975	-6,735,237	10,468,738
118	Nevada Department of Transportation	1,732,009	-1,564,527	167,482
128	Board of Accountancy	4,550	3,945	8,495
129	Board of Cosmetology	20,040	-24,289	-4,249
134	Board of Professional Engineers	8,926	10,385	19,311
139/140	Nevada System of Higher Education	14,424,723	2,519,123	16,943,846
141	Board of Architecture	5,871	3,861	9,732
146	Board of Examiners for Social Workers	4,758	4,481	9,239
147	Liquefied Petroleum Gas Board	3,440	5,254	8,694
148	Board of Optometry	2,293	-1,157	1,136
149	Board of Veterinary Examiners	3,925	-10,067	-6,142
150	Board of Examiners for Alcohol, Drugs, & Gambling	1,493	-4,965	-3,472
171	Nevada Physical Therapy Board	4,585	48,119	52,704
172	Private Investigators Licensing Board	8,926	92,700	101,626

Appendices

Agency # (1)	Agency (2)	Proportionate Share of Plan OPEB Expense (3)	Changes in Proportion (4)	Total Employer OPEB Expense (5) = (3) + (4)
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	3,994	39,713	43,707
174	Nevada Applied Behavior Analysis Board	1,876	16,408	18,284
175	State of Nevada - Judicial Board	512,107	4,358,834	4,870,941
176	Nevada Board of Psychological Examiners	313	2,657	2,970
Total		\$34,733,261	\$0	\$34,733,261

Appendices

Appendix D: Schedule of Deferred Outflows and Inflows of Resources by Employer as of June 30, 2024

Agency # (1)	Agency (2)	Differences Between Expected and Actual Experience (Outflow) (3)	Change of Assumptions (Outflow) (4)	Changes in Proportion (Outflow) (5)	Total Deferred Outflows of Resources (6) = (3) + (4) + (5)	Differences Between Expected and Actual Experience (Inflow) (7)	Net Difference Between Expected and Actual Investment Earnings on OPEB Plan Investments (Inflow) (8)	Change of Assumptions (Inflow) (9)	Changes in Proportion (Inflow) (10)	Total Deferred Inflows of Resources (11) = (7) + (8) + (9) + (10)
101	Board of Medical Examiners	\$0	\$0	\$110,277	\$110,277	\$27,410	\$552	\$207,980	\$39,221	\$275,163
102	Board of Nursing	0	0	20,517	20,517	18,047	363	136,940	78,287	233,637
103	Board of Pharmacy	0	0	43,829	43,829	20,045	403	152,097	138,837	311,382
104	Board of Chiropractors	0	0	377	377	1,094	22	8,303	5,052	14,471
105	Board of Dental Examiners	0	0	81,892	81,892	4,811	97	36,509	97,657	139,074
106	Legislative Counsel Bureau	0	0	3,437,545	3,437,545	266,452	5,362	2,021,814	0	2,293,628
108	Board of Osteopathic Medicine	0	0	10,635	10,635	2,467	50	18,716	14,961	36,194
109	Board of Massage Therapy	0	0	30,940	30,940	2,519	51	19,111	58,918	80,599
111	Funeral and Cemetery Board	0	0	18,692	18,692	1,442	29	10,939	49,237	61,647
113	Public Employee Retirement System	0	0	224,473	224,473	48,514	976	368,118	164,127	581,735
116	Central Payroll	0	0	0	0	8,603,548	173,136	65,282,858	30,183,557	104,243,099
118	Nevada Department of Transportation	0	0	0	0	866,162	17,430	6,572,347	4,586,333	12,042,272
128	Board of Accountancy	0	0	0	0	2,275	46	17,266	29,412	48,999
129	Board of Cosmetology	0	0	0	0	10,022	202	76,049	87,981	174,254
134	Board of Professional Engineers	0	0	49,312	49,312	4,464	90	33,873	11,336	49,763
139/140	Nevada System of Higher Education	0	0	12,601,995	12,601,995	7,213,670	145,166	54,736,605	0	62,095,441

Appendices

Agency # (1)	Agency (2)	Differences Between Expected and Actual Experience (Outflow) (3)	Change of Assumptions (Outflow) (4)	Changes in Proportion (Outflow) (5)	Total Deferred Outflows of Resources (6) = (3) + (4) + (5)	Differences Between Expected and Actual Experience (Inflow) (7)	Net Difference Between Expected and Actual Investment Earnings on OPEB Plan Investments (Inflow) (8)	Change of Assumptions (Inflow) (9)	Changes in Proportion (Inflow) (10)	Total Deferred Inflows of Resources (11) = (7) + (8) + (9) + (10)
141	Board of Architecture	0	0	10,097	10,097	2,935	59	22,274	13,862	39,130
146	Board of Examiners for Social Workers	0	0	11,038	11,038	2,380	48	18,057	0	20,485
147	Liquefied Petroleum Gas Board	0	0	3,382	3,382	1,720	35	13,048	30,798	45,601
148	Board of Optometry	0	0	377	377	1,146	23	8,699	13,272	23,140
149	Board of Veterinary Examiners	0	0	22,754	22,754	1,963	39	14,893	0	16,895
150	Board of Examiners for Alcohol, Drugs, & Gambling	0	0	0	0	747	15	5,667	7,429	13,858
171	Nevada Physical Therapy Board	0	0	51,402	51,402	2,293	46	17,398	2,527	22,264
172	Private Investigators Licensing Board	0	0	155,552	155,552	4,464	90	33,873	25,265	63,692
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	0	0	76,897	76,897	1,998	40	15,157	0	17,195
174	Nevada Applied Behavior Analysis Board	0	0	52,515	52,515	938	19	7,117	0	8,074
175	State of Nevada - Judicial Board	0	0	18,612,224	18,612,224	256,100	5,154	1,943,262	0	2,204,516
176	Nevada Board of Psychological Examiners	0	0	11,347	11,347	156	3	1,186	0	1,345
Total		\$0	\$0	\$35,638,069	\$35,638,069	\$17,369,782	\$349,546	\$131,800,156	\$35,638,069	\$185,157,553

Appendices

Appendix E: Schedule of June 30, 2023 Deferred Flows Related to Changes in Proportion

Agency # (1)	Agency (2)	Beginning of Year Deferred Outflows Related to Changes in Proportionate Share (3)	Beginning of Year Deferred Inflows Related to Changes in Proportionate Share (4)
101	Board of Medical Examiners	\$222,000	\$28,178
102	Board of Nursing	57,574	7,883
103	Board of Pharmacy	155,608	1,193
104	Board of Chiropractors	1,363	0
105	Board of Dental Examiners	85,054	134,447
106	Legislative Counsel Bureau	1,455,990	187,724
108	Board of Osteopathic Medicine	24,386	9,875
109	Board of Massage Therapy	40,402	22,413
111	Funeral and Cemetery Board	28,573	0
113	Public Employee Retirement System	329,912	7,403
116	Central Payroll	2,400,323	9,330,916
118	Nevada Department of Transportation	85,029	3,084,103
128	Board of Accountancy	12,474	5,220
129	Board of Cosmetology	23,453	82,754
134	Board of Professional Engineers	64,392	2,040
139/140	Nevada System of Higher Education	9,545,487	2,127,061
141	Board of Architecture	17,680	476
146	Board of Examiners for Social Workers	13,089	717
147	Liquefied Petroleum Gas Board	18,943	31,735
148	Board of Optometry	2,466	2,525
149	Board of Veterinary Examiners	6,323	17,012
150	Board of Examiners for Alcohol, Drugs, & Gambling	0	7,731

Appendices

Agency # (1)	Agency (2)	Beginning of Year Deferred Outflows Related to Changes in Proportionate Share (3)	Beginning of Year Deferred Inflows Related to Changes in Proportionate Share (4)
171	Nevada Physical Therapy Board	100,113	0
172	Private Investigators Licensing Board	254,168	0
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	94,827	0
174	Nevada Applied Behavior Analysis Board	51,777	0
175	State of Nevada - Judicial Board	0	0
176	Nevada Board of Psychological Examiners	0	0
Total		\$15,091,406	\$15,091,406

The amounts provided in this appendix represent the beginning of year deferred outflows and inflows related to changes in proportion, had the impact of changes in proportion been amortized over the plan's average expected remaining service lives since the inception of GASB 75. In prior valuation reports, these changes were amortized immediately over one-year periods, so there were no deferred flows related to changes in proportion.

As discussed in the cover letter, the plan's outside auditor's requested a change in methodology to recognize changes in proportion over multi-year periods. As part of the transition (for consistency with the OPEB expense and deferred outflows and inflows provided in Appendix D), the participating employers may choose to restate their beginning of year deferred outflows and inflows related to changes in proportion from zero to the amounts shown in Appendix E.

Appendices

Appendix F: Schedule of Deferred OPEB Amortization by Employer as of June 30, 2024

Agency # (1)	Agency (2)	Net Remaining Deferred Inflows/Outflows (3)	2026 (4)	2027 (5)	2028 (6)	2029 (7)	2030 (8)	Thereafter (9)
101	Board of Medical Examiners	-\$164,886	-\$54,145	-\$29,931	-\$29,840	-39,384	-\$11,586	\$0
102	Board of Nursing	-213,120	-75,789	-42,673	-42,614	-41,104	-10,940	0
103	Board of Pharmacy	-267,553	-79,394	-57,741	-57,676	-57,313	-15,429	0
104	Board of Chiropractors	-14,094	-5,209	-2,803	-2,800	-2,603	-679	0
105	Board of Dental Examiners	-57,182	-2,114	-26,346	-26,330	-3,667	1,275	0
106	Legislative Counsel Bureau	1,143,917	113,901	332,120	332,984	290,583	74,329	0
108	Board of Osteopathic Medicine	-25,559	-13,917	-2,756	-2,748	-4,682	-1,456	0
109	Board of Massage Therapy	-49,659	-17,058	-7,271	-7,263	-13,719	-4,348	0
111	Funeral and Cemetery Board	-42,955	-10,050	-8,638	-8,634	-12,046	-3,587	0
113	Public Employee Retirement System	-357,262	-135,991	-54,340	-54,183	-86,273	-26,475	0
116	Central Payroll	-104,243,099	-43,700,190	-19,517,075	-19,489,168	-17,145,040	-4,391,626	0
118	Nevada Department of Transportation	-12,042,272	-4,811,705	-2,453,968	-2,451,159	-1,876,514	-448,926	0
128	Board of Accountancy	-48,999	-16,250	-10,463	-10,456	-9,399	-2,431	0
129	Board of Cosmetology	-174,254	-87,381	-28,429	-28,397	-24,007	-6,040	0
134	Board of Professional Engineers	-451	-5,534	5,819	5,834	-4,373	-2,197	0
139/140	Nevada System of Higher Education	-49,493,446	-24,409,421	-7,797,788	-7,774,390	-7,512,512	-1,999,335	0
141	Board of Architecture	-29,033	-8,313	-6,111	-6,101	-6,656	-1,852	0
146	Board of Examiners for Social Workers	-9,447	-5,860	-559	-552	-1,848	-628	0

Appendices

Agency # (1)	Agency (2)	Net Remaining Deferred Inflows/Outflows (3)	2026 (4)	2027 (5)	2028 (6)	2029 (7)	2030 (8)	Thereafter (9)
147	Liquefied Petroleum Gas Board	-42,219	-12,410	-11,419	-11,413	-5,926	-1,051	0
148	Board of Optometry	-22,763	-7,481	-4,942	-4,939	-4,303	-1,098	0
149	Board of Veterinary Examiners	5,859	-989	2,123	2,129	2,051	545	0
150	Board of Examiners for Alcohol, Drugs, & Gambling	-13,858	-5,528	-2,877	-2,875	-2,092	-486	0
171	Nevada Physical Therapy Board	29,138	25,476	3,111	3,119	-1,648	-920	0
172	Private Investigators Licensing Board	91,860	73,282	13,203	13,218	-4,761	-3,082	0
173	Board of Examiners for Marriage Family Therapists & Clinical Professional Counselors	59,702	31,180	11,821	11,828	4,418	455	0
174	Nevada Applied Behavior Analysis Board	44,441	12,597	13,102	13,105	5,072	565	0
175	State of Nevada - Judicial Board	16,407,708	3,328,556	3,979,876	3,980,707	4,026,672	1,091,897	0
176	Nevada Board of Psychological Examiners	10,002	2,029	2,426	2,426	2,454	667	0
Total		-\$149,519,484	-\$69,877,708	-\$25,702,529	-\$25,646,188	-\$22,528,620	-\$5,764,439	\$0

8.4

8.4 Discussion on other models or information Board would like to review in November

9.

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



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Stacie Weeks
Director



Theresa Carsten
Executive Officer

AGENDA ITEM

☐

Action Item

☒

Information Only

Date: October 24, 2025

Item Number: 9

Title: Chief Financial Officer Budget Report

Summary

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

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of September 30, 2025, with comparisons to the same period in Fiscal Year 2024. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

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

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

Operational Budget 1338

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

With the change in fiscal staff and integration into the new Nevada Health Authority a new budget tracking system is being implemented to improve the process and provide consistency across the department. Detailed budget projections will be provided once the budget tracking system is fully implemented.

Recommendations

None.

10.

10. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitation. (Theresa Carsten, Executive Officer)
(For Possible Action)

10.1 Contract Overview

10.2 New Contracts

10.3 Contract Amendments

10.4 Status of Current Solicitations



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Stacie Weeks
Director



Theresa Carsten
Executive Officer

AGENDA ITEM

☒ Action Item

☐ Information Only

Date: October 24, 2025
Item Number: 10
Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

10.1 Contract Overview: Active Contract Summary – the contract with Capitol Reporters is currently expired and PEBP staff are working to secure bids for an informal solicitation for court reporting/transcription services. Discussions with purchasing will be held in relation to the possibility of an extension for pharmacy benefit management services, which an update will be reported on during the November board meeting.

PEBP Active Contracts Summary				
Vendor	Service	Contract #	Effective Date	Termination Date
Eide Bailly	Financial Auditor	27703	7/11/2023	12/31/2026
Health Plan of Nevada Inc	Southern Nevada HMO	30493	7/1/2025	6/30/2030
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026
Lifeworks/Telus Health	Benefits Management System	25935	5/10/2022	12/31/2026
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026
*Willis Towers Watson (VIA)	*Medicare Exchange	30613	7/1/2025	6/30/2030
HSABank	HSA/HRA Account Manager	25213	7/1/2022	6/30/2026
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025
Carrum Health	Centers of Excellence	28745	2/12/2024	6/30/2028
Carrum Health	Oncology Concierge	29053	5/14/2024	6/30/2028
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028

No action necessary.

10.2 New Contracts: PEBP does not currently have any new contracts for ratification.

No action necessary.

10.3 Contract Amendments (**for possible action**). PEBP currently has two contracts that expire in approximately eight months. Each vendor has agreed to continue with current pricing if the contracts are extended, and each contract allows for a two-year extension. PEBP staff request approval from the board for amendment to extend each contract:

10.3.1 HSA Bank for extension through 6/30/28.

10.3.2 United Healthcare Insurance for extension of Basic Life Insurance through 6/30/28.

Recommendation:

Recommend approval to extend both contracts.

10.4 Status of Current Solicitations

10.4.1 Benefits Management System -negotiations phase. PEBP staff are working with the Department of Purchasing to execute a final contract.

No action necessary.

11.

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



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Carson City, Nevada 89706
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PEBP.NV.GOV



Stacie Weeks
Director

Theresa Carsten
Executive Officer

AGENDA ITEM

☒ Action Item
☐ Information Only

Date: October 24, 2025
Item Number: 11
Title: Executive Officer Report

SUMMARY

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

REPORT

FOR INFORMATION ONLY:

1. STAFFING UPDATE:

PEBP currently has 34 positions and currently 3 vacancies. The vacant positions are administrative assistant positions within the Member Services Unit, which are responsible for customer service calls and emails from members. PEBP's vacancy rate is currently: 9%.

2. CYBER ATTACK UPDATE:

On August 25, 2025, PEBP was closed due to a statewide government response to a cyberattack. On August 26, 2025, staff came to the office to pick up equipment, meet the new Executive Officer, and provide contact information in case staff were later "called back" to the office. Some staff received administrative leave this day as both internet and phones were not accessible. Essential staff that had laptops were allowed to work from home. Supervisors monitored PEBP portal messages and emails to assist members. On August 27, 2025, staff with access to laptops continued to work from home, while the remainder were out on administrative leave. On August 28, 2025, staff returned to the office as internet and phones were back up. The cyberattack had minimal impact on PEBP, as files were saved to the cloud and accessible through internet access. Another contributing factor for the minimal impact to PEBP is that the system portals used for business processes are hosted by third party vendors who had not been impacted by the statewide outages.

3. PLAN MIGRATION FROM PLAN YEAR 2024 TO 2025 AND 2025 TO 2026

Plan enrollment year over year shows membership moving away from CDHP, EPO, and HMO plans.

	Plan YR 2024	Plan YR 2025		Plan YR 2025	Plan YR 2026	
	June 24	July 24	Difference	June 25	July 25	Difference
CDHP Total Lives	23,861	22,708	-1153	22,991	22,526	-465
LD-PPO Lives	20,108	22,286	2178	23,812	25,181	1,369
EPO Lives	5,562	5,289	-276	5,052	4,621	-431
HMO Lives	6,123	6,036	-87	5,977	5,677	-300
Med Exchange Total Lives	14,673	14,743	70	14,561	14,686	125
Tricare Total Lives	300	302	2	307	314	7
PEBP Total Lives	70,627	71,364	734	72,700	73,005	305

4. RESERVE BALANCES

Reserve	Actuary Amount	Budgeted Amount	Work Program Amount	Deficit
IBNR	57,513,000.00	62,444,001.00	53,670,132.00	-3,842,868
Catastrophic	46,500,000.00	49,490,100.00	42,536,700.00	-3,963,300
HRA				
80%	17,541,532.97	29,198,807.00	25,096,147.00	7,554,614.00
Total Difference				-251,554.00

During previous public comment periods it was asserted that PEBP reserves were short by tens of millions. PEBP staff provide here today an accounting of actuarial amounts communicated by Segal as well as current reserve balances.

Segal estimated the IBNR reserve at 57.5 million for FY 26 and PEBP budgeted 62 million, this was reduced through the final budgeting process. Catastrophic reserves were advised to be budgeted for 46.5 million this year based on 45 days of projected total incurred claims for FY 25. PEBP budgeted 49 million for this reserve account and the final approved budget is 42.5 million.

Finally, the HRA reserve must maintain 80% of the available HRA balances. The remaining balance for FY 25 is 2.4 million and the balance for FY 26 is 19.5 million. 80% of these balances is 17.5 million, PEBP budgeted 29 million, and the allowable budget was 25 million.

5. CARSON TAHOE HOSPITAL/UMR UPDATE

Carson Tahoe and UMR have entered contract negotiations to extend participation in the PEBP network through June 30, 2027. Final contract amendments have not been completed, but both parties will be sending a communication to notify the board of their negotiations and their commitment to PEBP members accessing services in the Carson Valley for the November Board Meeting.

Additionally, during the July board meeting there was public comment made that members had reported being denied services at Carson Tahoe. After the board meeting, PEBP staff reviewed call center logs as well as complaints and appeals report and could not identify one member reporting an incident of this nature. Staff were made aware of an incident where a member was accessing services from Carson Medical Group and Carson Medical Group referenced that they were in network and would be in network after 2025. This statement may navigate patients away from seeking services at Carson Tahoe providers but is not the same thing as Carson Tahoe denying services to PEBP members through 2025. PEBP could not confirm the statement made at July's public comment.

FOR POSSIBLE ACTION:

6. HPN LARGE GROUP MEDICAL LOSS RATIO PREMIUM REBATE (FOR POSSIBLE ACTION)

Attached you will find a memo prepared by Segal to address the premium rebate amounts and the considerations for refunding members.

Recommendation:

PEBP staff recommend a variation from Segal's suggested options, which is refunding the approximate \$79 through a one-time reduction to the premium deductions applied to affected members and advising non-state employers to reduce their employee premiums by the appropriate amount.

Option 1 would require PEBP accounting staff to release refunds by check, which would be a larger administrative burden at this time.

Option 2 would require PEBP staff to reduce premiums by manual adjustments during the monthly payroll cycle for thousands of member premiums, which would negatively impact our accounting staff's workflow as there would be a significant increase in adjustments that would be made manually every month.

If the Board approves our recommendation, then the PEBP accounting staff will need to alternate the number of manual adjustments over several pay periods in Plan Year 27 to apply all the MLR related adjustments for State staff and will notify members which pay period their reduction in premium will be adjusted as a result of the MLR Rebate. It may take up to 6 months to apply all premium reductions by manual adjustment to the payroll deductions.

Memorandum

To: Board of Trustees
Nevada Public Employees' Benefits Program (PEBP)

From: Richard Ward, FSA, FCA, MAAA

Date: October 24, 2025

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

Overview

The Affordable Care Act requires that health insurance issuers provide rebates to policyholders and subscribers in large group health plans when the issuer's Medical Loss Ratio (MLR) is below 85% for the large group market in the state in which the policy is located. Issuers must also send notices concerning the rebate directly to both the policyholder and the individual subscribers.

Rules vary on how the rebates should be handled, based on the type of plan. For example, rules for public sector plans are different from those for private sector plans and church plans. Additionally, the rules do not apply to self-funded plans. Therefore, by definition, the only PEBP group health policy in this consideration is the HMO.

This memo focuses on the applicable provisions and requirements for insured public sector plans and how they relate to PEBP. The decision regarding how to use rebates involves fiduciary considerations; therefore, legal counsel should be consulted before finalizing any decisions regarding how to use the funds.

Provisions for Public Sector Plans

Although non-federal governmental plans are not subject to ERISA, HHS has direct regulatory authority over them. Consequently, HHS issued an interim final rule establishing how these plans can use rebates.¹

HHS has directed that insurers distribute the entire rebate to the group policyholder. The group policyholder is then required to use the portion of the rebate attributable to the percentage of premiums paid by participants for the benefit of participants. For example, if an insurer pays a \$20,000 rebate to a policyholder, and the employees paid 40 percent of the total premium, then the policyholder must use 40 percent of the rebate, or \$8,000, for the benefit of the participants.

¹ 76 Fed. Reg. 76596 (December 7, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31291.pdf>

The participant portion of the rebate must be used in one of the following ways, to be determined by the policyholder:

1. Reduce participants' portion of the annual premium for the subsequent policy year for *all* participants covered under any option offered under the group health policy at the time the rebate is received by the policyholder;
2. Reduce the participants' portion of the annual premium for the subsequent policy year only for those participants covered under the group health option for which the rebate was based at the time the rebate is received by the policyholder; or
3. Provide a cash refund only to participants enrolled in the group health option for which the rebate is based at the time the rebate is received by the policyholder.

At the policyholder's option, the reduction or refund may be divided evenly among the participants, divided based on each subscriber's actual contributions to premium, or apportioned in a manner that reasonably reflects each subscriber's contributions to premium.

For non-federal governmental plans, the interim final regulations specifically require any portion of a rebate that is based on former participants' contributions to be aggregated and used for the benefit of current participants. Therefore, all options available to PEBP require that the rebate be used to benefit those covered at the time the rebate is *received* by the policyholder, not those covered during the period that generated the rebate.

Current Rebate

On September 17, 2025, HPN notified PEBP staff that it would be issuing a rebate of \$891,657.35 for the 2024 benefit plan year (i.e., calendar year 2024) and this would be paid directly to PEBP as the policyholder. The calendar year measurement period differs from PEBP's July-June plan year cycle, but this does not affect how the rebate should be calculated. It does mean that premium reductions would be applied in the July-June 2027 Plan Year, since this is the subsequent policy year after the rebate is received.

The portion to be allocated to reducing member costs is about \$257,000, based on a 28.9% member cost share of the full premium rates in (calendar year) 2024 for the HMO. With approximately 3,250 subscribers HMO option in September 2025, this converts to about \$79 per subscriber.

Final amount will be dependent upon how the refund is used to reduce member costs.

HPN has subsequently sent the required notification to all PEBP members enrolled in the HPN HMO during 2024. This includes current and former PEBP members.

PEBP Options

PEBP is required to use the rebate to reduce costs for subscribers enrolled in the HMO when the rebate is received. This prohibits PEBP from providing a refund to former HMO enrollees, whether currently enrolled in PEBP or not.

PEBP has the discretion to provide the same rebate to all eligible members. With this approach, there are two straightforward options:

1. Provide a cash refund of about \$79.
2. Provide a premium reduction of about \$6.50 per month in PY2027, which is the subsequent policy year after the date the rebate is received.

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.

For Non-State members, the employer collects the employee premium and provides PEBP the full cost for both the employer and the employee. Federal regulations require the rebate reduce costs for the participants. Therefore, PEBP should instruct affect Non-State PEBP employers to reduce their employees' HMO premiums by the appropriate amount.

In Summary

This rebate provides some financial relief for PEBP and members, to amounts of approximately \$630,000 for PEBP and \$260,000 for members. The rebate has been paid to PEBP as the HMO policy holder and the next step is for PEBP to determine how to utilize the member portion of the rebate to reduce member expenses.

cc: Theresa Carsten, PEBP

12.

12. Quarter 4 Vendor Reports (Information/Discussion)

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care Management

12.1.2 Q4 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network

12.1.3 Q4 UnitedHealthcare Basic Life Insurance

12.1.4 Q4 Amplifon Performance Report

12.2 Questions or discussion related to any reports provided (Board)

12.1

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care Management

12.1.2 Q4 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network

12.1.3 Q4 UnitedHealthcare Basic Life Insurance

12.1.4 Q4 Amplifon Performance Report

12.1.1

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care Management



Public Employees' Benefits Program

Quarterly Plan Performance Review

OCM & DCM • 2025-4Q



A UnitedHealthcare Company



Obesity Care Management

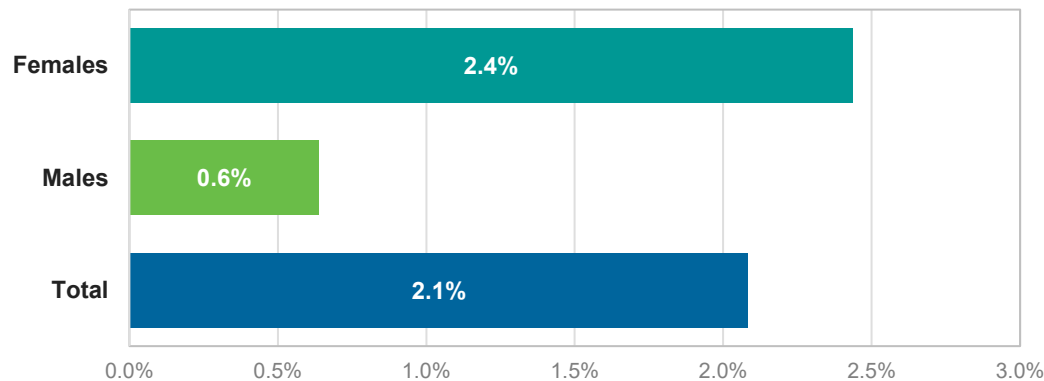
Overview



Weight Management Summary	Females	Males	Total
Members Enrolled in OCM	329	66	395
Average Pounds Lost	5.2	1.6	4.6
Total Pounds Lost	1,697.9	107.8	1,805.7
% Pounds Lost	2.4%	0.6%	2.1%
Average Paid per Member	\$7,528	\$4,276	\$6,985

➤ At \$582.08, Paid PMPM for OCM participants is significantly (-48.3%) lower than non-participants (\$1,126.84)

Average % Pounds Lost



Obesity Care Management participation is for the 2025 Plan Year with activity through 6/30/2025

Claims Date Range (for Avg. Paid per Member): Service Dates 7/1/2024 - 6/30/2025, Paid through 6/30/2025



Obesity Care Management

Financial & Utilization Summary

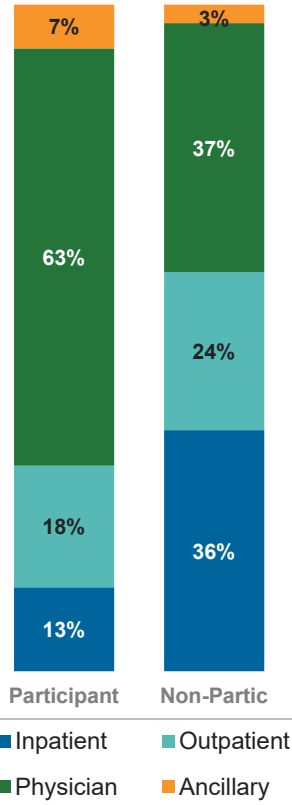


Financial Summary

Financial Measure	Participants	Non-Partic.	Variance
Average Enrollment			
Employees	354	551	-35.8%
Tot. Members	395	630	-37.3%
Emp to Total Ratio	1.1	1.1	-2.4%
Financial Summary			
Allowed	\$3,198,358	\$9,690,598	-67.0%
Plan Paid	\$2,759,046	\$8,518,933	-67.6%
Member Paid (OOP)	\$428,701	\$1,009,322	-57.5%
Paid PEPY*	\$7,794	\$15,461	-49.6%
Paid PMPY*	\$6,985	\$13,522	-48.3%
Paid PEPM	\$649	\$1,288	-49.6%
Paid PMPM	\$582	\$1,127	-48.3%
High-Cost Claimants (Med Paid \$100,000+)			
# of HCCs	3	10	-70.0%
HCCs per 1000	7.6	15.9	-52.2%
Paid per HCC	\$227,861	\$368,664	-38.2%
HCC Paid % of Tot	24.8%	43.3%	-18.5 pts
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	\$882	\$4,889	-82.0%
Outpatient	\$1,274	\$3,208	-60.3%
Physician	\$4,372	\$5,049	-13.4%
Ancillary	\$458	\$376	21.7%

* Annualized

Cost Distribution By Claim Type



Utilization Summary

Utilization Measure	Participants	Non-Partic.	Variance
Inpatient Admissions			
# of Admits	21	69	-69.6%
# of Admit Days	72	515	-86.0%
Paid per Admit	\$18,801	\$46,497	-59.6%
Paid per Admit Day	\$5,484	\$6,230	-12.0%
Admits per 1000	53.2	109.5	-51.5%
Average LOS	3.4	7.5	-54.1%
Emergency Room Visits			
# of ER Visits	76	236	-67.8%
~ % resulting in Admit	10.5%	10.6%	-0.1 pts
ER Visits per Patient	1.3	1.7	-20.9%
ER Visits per 1000	192.4	374.6	-48.6%
Paid per ER Visit	\$3,114	\$3,733	-16.6%
Urgent Care Visits			
# of UC Visits	209	356	-41.3%
UC Visits per Patient	1.8	1.8	0.5%
UC Visits per 1000	529.1	565.1	-6.4%
Paid per UC Visit	\$105	\$108	-2.7%
Office Visits			
Off Visits per Patient	17.0	8.9	90.4%
Paid per Office Visit	\$118	\$92	28.7%
Office Visits Paid PMPY	\$2,000	\$809	147.0%
Services			
Radiology Svcs per 1000	5,341.8	6,395.2	-16.5%
Radiology Paid PMPY	\$558	\$795	-29.8%
Lab Services per 1000	16,458.2	22,533.3	-27.0%
Labs Paid PMPY	\$419	\$608	-31.1%

Non-participants are defined as members identified with a morbid obesity condition in the prior 12 months (7/1/2024 - 6/30/2025), but who are not enrolled in the Obesity Care Management program

Claims Date Range: Service Dates 7/1/2024 - 6/30/2025, Paid through 6/30/2025



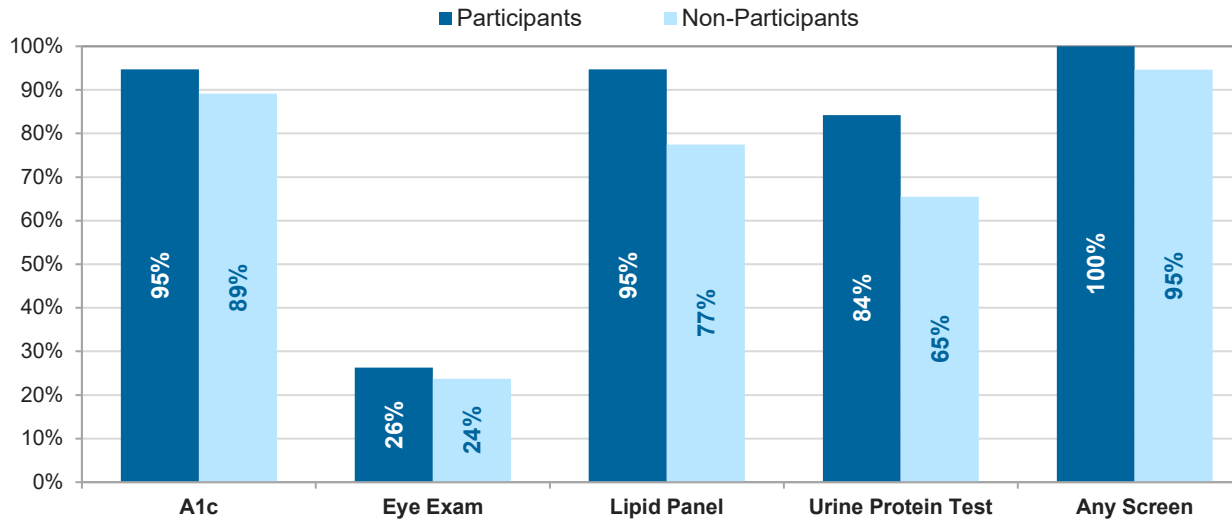
Diabetes Care Management

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	19	18	94.7%	3,306	2,948	89.2%	5.6
Eye Exam	19	5	26.3%	3,306	784	23.7%	2.6
Lipid Panel	19	18	94.7%	3,306	2,560	77.4%	17.3
Urine Protein Test	19	16	84.2%	3,306	2,165	65.5%	18.7
Any Diabetes Screen	19	19	100.0%	3,306	3,129	94.6%	5.4

- 84.2% of DCM participants had an office visit for Diabetes, while 74.2% of non-participants had a visit
- 26.3% of DCM participants received all four screenings, while 14.1% of non-participants did



Diabetes Care Management participation is for the 2025 Plan Year with activity through 6/30/2025

Non-participants are defined as members identified with diabetes in the prior 12 months (7/1/2024 - 6/30/2025), but who are not enrolled in the Diabetes Care Management program

Screening Date Range: Service Dates 7/1/2024 - 6/30/2025, Paid through 6/30/2025



Diabetes Care Management

Financial & Utilization Summary

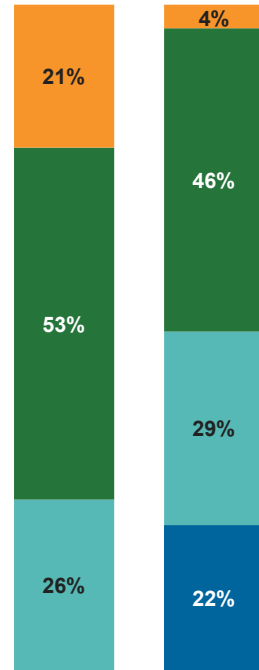


Financial Summary

Financial Measure	Participants	Non-Partic.	Variance
Average Enrollment			
Employees	11	2,649	-99.6%
Tot. Members	19	3,306	-99.4%
Emp to Total Ratio	1.7	1.2	38.4%
Financial Summary			
Allowed	\$61,602	\$40,702,304	-99.8%
Plan Paid	\$36,134	\$28,149,593	-99.9%
Member Paid (OOP)	\$25,467	\$4,785,327	-99.5%
Paid PEPY*	\$3,285	\$10,626	-69.1%
Paid PMPY*	\$1,902	\$8,515	-77.7%
Paid PEPM	\$274	\$886	-69.1%
Paid PMPM	\$158	\$710	-77.7%
High-Cost Claimants (Med Paid \$100,000+)			
# of HCCs	0	45	-100.0%
HCCs per 1000	0.0	13.6	-100.0%
Paid per HCC	\$0	\$199,732	-
HCC Paid % of Tot	0.0%	31.9%	-31.9 pts
Cost Distribution by Claim Type (Paid PMPY*)			
Inpatient	\$0	\$1,867	-100.0%
Outpatient	\$490	\$2,471	-80.2%
Physician	\$1,004	\$3,875	-74.1%
Ancillary	\$408	\$303	34.9%

* Annualized

Cost Distribution By Claim Type



Participant Non-Partic

■ Inpatient ■ Outpatient
■ Physician ■ Ancillary

Utilization Summary

Utilization Measure	Participants	Non-Partic.	Variance
Inpatient Admissions			
# of Admits	0	309	-100.0%
# of Admit Days	0	1,312	-100.0%
Paid per Admit	\$0	\$23,789	-
Paid per Admit Day	\$0	\$5,603	-
Admits per 1000	0.0	93.5	-100.0%
Average LOS	0.0	4.2	-
Emergency Room Visits			
# of ER Visits	2	963	-99.8%
~ % resulting in Admit	0.0%	23.1%	-23.1 pts
ER Visits per Patient	1.0	1.6	-38.5%
ER Visits per 1000	105.3	291.3	-63.9%
Paid per ER Visit	\$1,978	\$3,129	-36.8%
Urgent Care Visits			
# of UC Visits	1	1,321	-99.9%
UC Visits per Patient	1.0	1.7	-39.6%
UC Visits per 1000	52.6	399.6	-86.8%
Paid per UC Visit	\$0	\$97	-100.0%
Office Visits			
Off Visits per Patient	3.8	7.8	-51.0%
Paid per Office Visit	\$63	\$90	-29.3%
Office Visits Paid PMPY	\$244	\$688	-64.6%
Services			
Radiology Svcs per 1000	1,789.5	6,752.9	-73.5%
Radiology Paid PMPY	\$189	\$644	-70.6%
Lab Services per 1000	15,315.8	19,887.2	-23.0%
Labs Paid PMPY	\$296	\$447	-33.8%

Non-participants are defined as members identified with diabetes in the prior 12 months (7/1/2024 - 6/30/2025), but who are not enrolled in the Diabetes Care Management program

Claims Date Range: Service Dates 7/1/2024 - 6/30/2025, Paid through 6/30/2025

12.1.2

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care
Management

**12.1.2 Q4 Sierra Healthcare Options and United
Healthcare Plus Network – PPO Network**

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	98.90%	
Q2 Results	97.52%	
Q3 Results	97.01%	
Q4 Results	98.48%	

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%	99.77%
Q3 Results	99.50%	99.50%
Q4 Results	99.50%	99.50%

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

12.1.3

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care Management

12.1.2 Q4 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network

12.1.3 Q4 UnitedHealthcare Basic Life Insurance

370074 State of Nevada Public Employees' Benefits Program

Life Performance Guarantees FY 2025 Q4 – 04/01/2025 – 06/30/2025)

Service	Metric	Measurement	How Measured	Fee at Risk	Results Details	Guarantee Achieved?
Claim Processing	Life Insurance - Complete Life Claim Decision	A. Basic Life Claim Determination 97% of claims processed within 10 days of receipt of complete information	Claim Turn Around Reports	.3% of quarterly Basic Life Insurance Premium	100%	Yes
	Life Insurance - Timeliness of Claim Payments	A. Timeliness of Claim Payment 97% of claims approved and payment issued, or claims denied, and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Quarterly claim decision report	.3% of quarterly Basic Life Insurance Premium	100%	Yes
	Life Insurance - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of quarterly Basic Life Insurance Premium	100%	Yes
Claim Customer Service	Average Speed of Answer	80% of Calls will be answered in less than 30 seconds	Call Center Statistics	.3% of quarterly Basic Life Insurance Premium	82.53% calls answered with in 24 seconds	Yes
	Abandonment Rate	Less than 5% of calls will be abandoned	Call Center Statistics	.3% of quarterly Basic Life Insurance Premium	.0.95%	Yes

12.1.4

12.1 Receipt of quarterly vendor reports for the period ending July 31, 2025:

12.1.1 Q4 UMR – Obesity and Diabetes Care Management

12.1.2 Q4 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network

12.1.3 Q4 UnitedHealthcare Basic Life Insurance

12.1.4 Q4 Amplifon Performance Report



Performance Report

Nevada Public Employees' Benefit Program
April 1st through June 30th, 2025

Amplifon Updates



AMPLIFON CONTINUES GROWING RAPIDLY

We now work with 50+ health and insurance partners. In just 24 months, we've doubled our Medicare Advantage business, doubled our Medicare Supplement business, and doubled our commercial client business



CONCIERGE-LEVEL SERVICE EXCELLENCE

Amplifon continues to focus on exceptional member service through our focus on education and engagement, our hearing-dedicated Patient Care Advocates, and enhancements to our member journey via virtual tools



A FOCUS ON NETWORK ACCESS

Amplifon continues to expand our network and will soon exceed 6,000 nationwide locations. We remain the only hearing health administrator with Miracle-Ear® locations in network

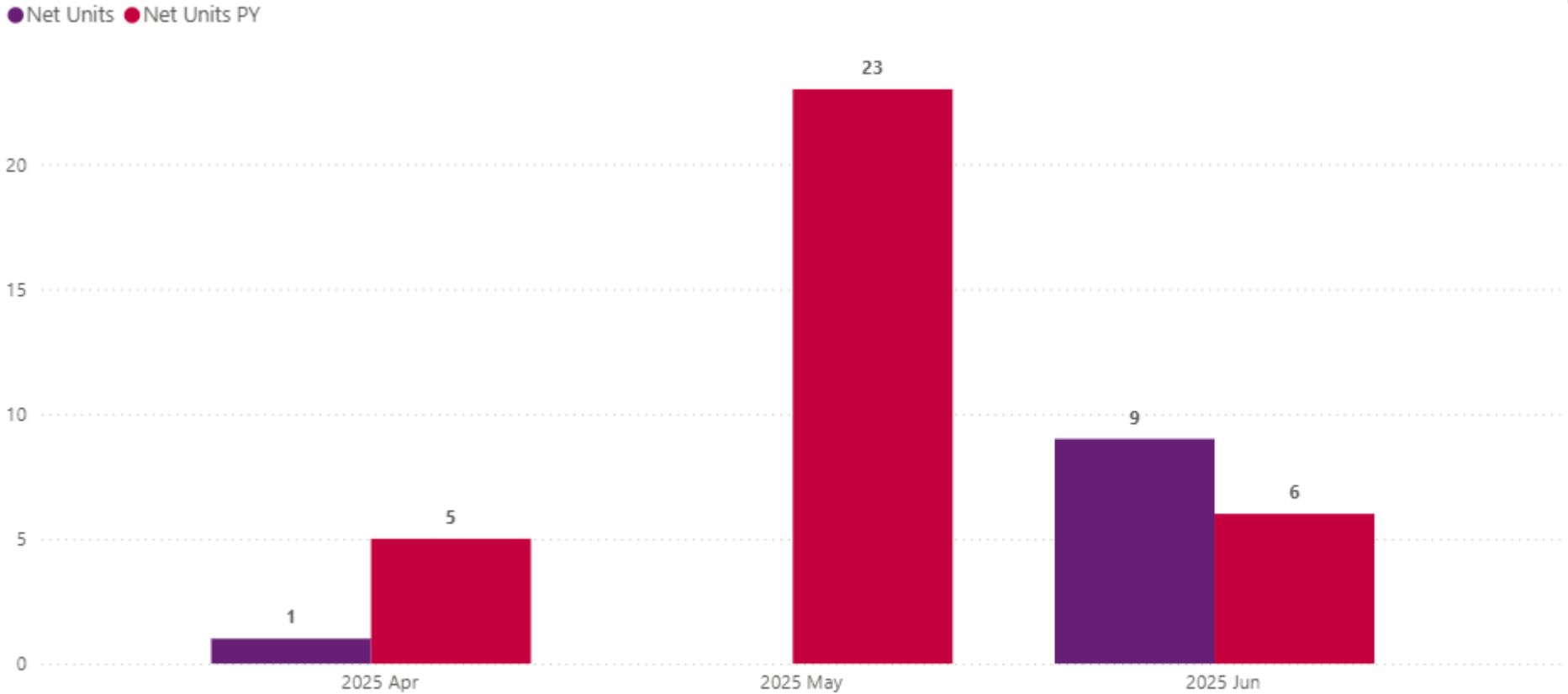


UNIFORM PROVIDER REIMBURSEMENT

Amplifon continues to be the only hearing health administrator with a universal provider reimbursement focused on quality of care vs. a graded reimbursement that rewards providers for selling more expensive HAs

Hearing Aid Purchases

NET UNITS BY MONTH: CURRENT YEAR VS PRIOR YEAR



MEMBERS SERVED

6		
19	-68.42%	
PY	%YOY	

HEARING AIDS DISPENSED

10		
34	-70.59%	
PY	%YOY	

RETURN RATE

(Blank)		
(Blank)	(Blank)	
PY	%YOY	

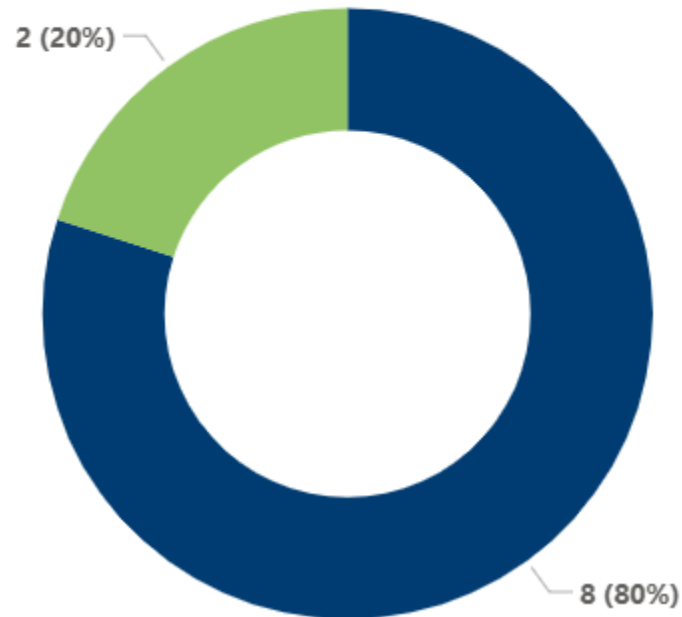
? Why do members return hearing aids?

Typically, members return hearing aids due to issues with comfort. For example, a member may feel they want an invisible in-the-ear-canal model but realize it's uncomfortable. They may request to return their hearing aids and switch to an over-the-ear model.

Hearing Aids Dispensed by Manufacturer

HEARING AIDS DISPENSED BY MANUFACTURER

● Starkey ● OTICON



What do providers think?

In a recent Amplifon survey, 90% of providers indicated they prefer having the option to dispense the hearing aid brand and model best suited for the members' lifestyle, technology and hearing needs.

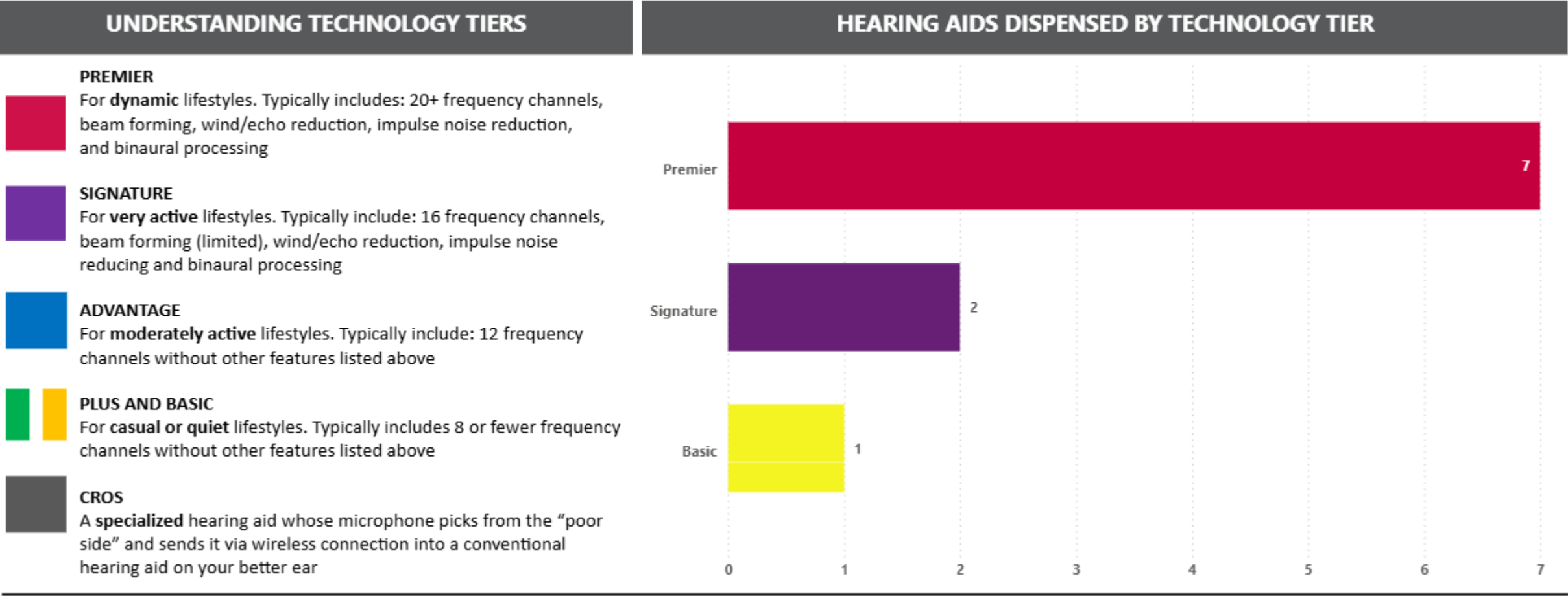
THE IMPORTANCE OF CHOICE

Since Amplifon is the only major hearing administrator not owned by a manufacturer, our program is designed to provide your members substantial member choice.

Why is choice of hearing aids important?

- Most providers do not offer all manufacturers. Most only offer 1 to 2 brands of hearing aids
- For members who may already wear hearing aids, they often prefer not to switch manufacturers because they are comfortable with their existing brand
- Some models by manufacturers may be better suited for different lifestyle, technology and hearing healthcare needs

Hearing Aids Dispensed by Technology Tier



100%

Percent of Your Members Purchased Rechargeable Hearing Aids
What’s the primary difference between disposable and rechargeable hearing aid batteries? Rechargeable hearing aids eliminate the time, stress, and cost of dealing with disposable batteries. Take note: two digital hearing aids eat up an average of 300 (or more!) batteries in a 3-year span.

Savings Analysis

\$290

=

TOTAL SAVINGS YEAR TO DATE
We're on our way to another successful year. Think of the impact you're making on your members quality of life!

		HAs PURCHASED	AVR MSRP	AVR MBR COST	TOTAL SAVINGS
	Premier	7	\$1,142	\$2,195	(\$7,370)
	Signature	2	\$5,460	\$1,895	\$7,130
	Basic	1	\$2,025	\$1,495	\$530

Average MSRP Per Aid

\$2,094

\$6,789 -69.2%

PY %YOY

Average Cost Per Aid

\$2,065

\$2,092 -1.29%

PY %YOY

Total Cost of Aids Purchased

\$21K

\$71.13K -70.97%

PY %YOY

Average Cost Per Purchase

\$3,679

\$3,791 -2.95%

PY %YOY

Network Access

Member Utilization: Top Counties

COUNTY	STATE	UTILIZATION YTD	PRIOR YEAR
CARSON CITY	NV	6	8

Member Utilization: Top Providers

PROVIDER	UTILIZATION YTD	PRIOR YEAR
Hearing Care Of Carson City Ltd	2	4
Sierra Nevada Hearing Aid Center	4	4

The Importance of a Uniform Provider Reimbursement Schedule

Rewarding providers with larger dispensing fees (right) leads to unnecessary upselling and greater expense.

FACT: Amplifon is the only hearing health administrator with a universal provider reimbursement rate.

FOCUS: QUALITY OF CARE	Amplifon		Competitors		FOCUS: MAXIMIZING PROVIDER ROI
	Premier	\$\$	Premier	\$\$\$\$\$	
	Signature	\$\$	Signature	\$\$\$\$ ↑	
	Advance	\$\$	Advance	\$\$\$ ↑	
	Plus	\$\$	Plus	\$ ↑	
	Basic	\$\$	Basic	\$ ↑	



Thank you!

12.2

12.2 Questions or discussion related to any reports provided
(Board)

13.

13. Public Comment.

14.

14. Adjournment.