STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

ACCREDITED
CORE
Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AMENDED MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	March 28, 2019 9:00 a.m.
Place of Meeting:	The Richard H. Bryan Building 901 South Stewart Street, Suite 1002 Carson City, Nevada 89701
Video Conferencing:	Nevada State Business Center 3300 West Sahara Avenue, Tahoe Room, Suite 430 Las Vegas, Nevada 89102
Streaming Website:	www.pebp.state.nv.us

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. Persons making 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. Persons unable to attend the meeting and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Laura Landry 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or llandry@peb.state.nv.us at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

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

4. Consent Agenda (Deonne Contine, 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.

   4.1 Approval of Action Minutes from the January 24, 2019 PEBP Board Meeting.

   4.2 Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2018 – December 31, 2018.

   4.3 Acceptance of Health Claim Auditors' annual audit findings for Express Scripts, Inc. (ESI) for the PEBP Plan Year 2018 (July 1, 2017 – June 30, 2018).

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

      4.4.1 Hometown Health Case/Utilization Management report

      4.4.2 HealthSCOPE Obesity Care Management Program enrollment & utilization

      4.4.3 The Standard Basic Life and Long Term Disability data & performance report

      4.4.4 The Standard Voluntary Life and Short Term Disability data & performance report

      4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

   4.5 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2018.

      4.5.1 Budget Report

      4.5.2 Utilization Report

   4.6 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2019 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

5. Discussion and possible action regarding an update to PEBP's Voluntary Benefit Platform implementation, to include an update by the Nevada Division of Insurance on vendor compliance with insurance law requirements to offer voluntary benefits in Nevada. (Laura Rich, Operations Officer) (**For Possible Action**)

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

   6.1 Amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor to coordinate payroll deductions for voluntary benefits;

6.2 Amend the HealthSCOPE Benefits Third Party Administration (TPA) contract to reduce TPA collection of fees, subrogation recoveries, and provider refunds;

6.3 Amend the Express Scripts, Inc. Pharmacy Benefits Manager contract to reduce administrative fees and implement greater drug discounts and guaranteed drug rebates;

6.4 Extend and amend the Extend Health (Willis Towers Watson) Medicare Exchange contract to provide services for an additional 5 years through 2025 and eliminate administration fees beginning July 1, 2019.

(Cari Eaton, Chief Financial Officer) (**For Possible Action**)

7. Discussion and possible action regarding changes to Plan Year 2020 Consumer Driven Health Plan (CDHP) plan design to include: reducing deductibles and out-of-pocket maximums; increasing dental benefit maximums; and eliminating annual vision exam copays. (Damon Haycock, Executive Officer) (**For Possible Action**)
8. Discussion regarding future Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plan in-state network strategies for improving access and choice to healthcare providers. (Damon Haycock, Executive Officer) (Information/Discussion)
9. Discussion and possible action to include approving Plan Year 2020 (July 1, 2019 – June 30, 2020) rates for State and Non-State employees, retirees, and their dependents for the Statewide Consumer Driven Health Plan (CDHP); southern Nevada Health Maintenance Organization (HMO) Plan; and the northern and rural Nevada PEBP Premier (Exclusive Provider Organization - EPO) Plan. (Damon Haycock, Executive Officer) **(For Possible Action)**.
10. Approval of the proposed changes to the CDHP and EPO Master Plan Documents for Plan Year 2020 (July 1, 2019 – June 30, 2020) for medical, dental, life, and long term disability benefits, for enrollment and eligibility rules, and for privacy and security requirements, to reflect previously approved plan design modifications, changes in legislative or regulatory requirements, and technical corrections or updates. (Nancy Spinelli, Quality Control Officer) **(For Possible Action)**
11. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)
12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bills

    * Senate Bills

    * Bill Draft Requests

    (Damon Haycock, Executive Officer) **(For Possible Action)**

***Due to time constraints inherent in the legislative process, a list of specific bill or bill draft requests, if applicable, on which PEBP staff will seek direction from the Board during this meeting will be posted on the PEBP website and at the locations where the agenda is normally posted on Monday, March 25, 2019.**

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 www.pebp.state.nv.us/board.htm (under the Board Meeting date referenced above).
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. The Board reserves the right to limit Internet broadcasting during portions of the meeting that need to be confidential or closed.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Laura Landry 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 are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Laura Landry 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 at the following locations: NEVADA STATE LIBRARY & ARCHIVE, 100 N. Stewart St, Carson City; BLASDEL BUILDING, 209 East Musser Street, Carson City; PUBLIC EMPLOYEES' BENEFITS PROGRAM, 901 South Stewart Street, Suite 1001, Carson City; THE GRANT SAWYER STATE OFFICE BUILDING, 555 East Washington Avenue, Las Vegas; THE LEGISLATIVE BUILDING, 401 South Carson Street, Carson City, and on the PEBP website at www.pebp.state.nv.us, also posted to the public notice website for meetings at www.leg.state.nv.us/App/Notice and 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. (Brandee Mooneyhan, Deputy Attorney General)
(Information/Discussion)

4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

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4.1.

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   4.1 Approval of Action Minutes from the January 24, 2019 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Richard H. Bryan Building
901 South Stewart Street, Suite 1002
Carson City, Nevada 89701
Video conferenced to:
Nevada State Business Center 3300 West Sahara Avenue,
Tahoe Room, Suite 430
Las Vegas, Nevada 89102

ACTION MINUTES (Subject to Board Approval)
January 24, 2019

MEMBERS PRESENT IN CARSON CITY:	Mr. Patrick Cates, Board Chair Mr. Don Bailey, Vice Chair Ms. Linda Fox, Member Ms. Leah Lamborn, Member Mr. John Packham, Member Mr. Tom Verducci, Member Ms. Christine Zack, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Mr. Damon Haycock, Executive Officer Ms. Celestena Glover, Chief Financial Officer Ms. Cari Eaton, Financial Analyst Ms. Laura Rich, Operations Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Laura Landry, Executive Assistant
MEMBERS EXCUSED:	Ms. Jennifer Bonilla, Member

1. Open Meeting: Roll Call
   Chair Patrick Cates opened the meeting at 9:05 a.m.

2. Public Comment

   Public Comment in Carson City:

   - Doug Unger - Chair, Faculty Senate University of Nevada, Las Vegas
   - Kent Ervin – Nevada Faculty Alliance
   - Barbara Richardson – Commissioner of the Nevada Division of Insurance

   Public Comment in Las Vegas:

   - Bruce Borgos – Morneau Shepell

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)
4. Presentation on Ethics in Government. (Judy Prutzman, Associate Counsel, Nevada Commission on Ethics) (Information/Discussion)
5. Presentation on the Open Meeting Law. (Brandee Mooneyhan, Deputy Attorney General, Nevada Attorney General's Office) (Information/Discussion)
6. Consent Agenda (Patrick Cates, 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 November 29, 2018 PEBP Board Meeting.

   6.2. For possible action to receive quarterly vendor reports for timeframe July 1, 2018 – September 30, 2018:

   6.2.1. HealthSCOPE Benefits – Obesity Care Management Program

   6.2.2. Hometown Health Providers – Utilization and Large Case Management

   6.2.3. The Standard Insurance – Basic Life and Long Term Disability Insurance

   6.2.4. Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

   6.2.5. Hometown Health Providers and Sierra Healthcare Options – PPO Network

   6.3 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending September 30, 2018.

   6.3.1 Budget Report

   6.3.2 Utilization Report

   6.4 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance.

BOARD ACTION ON ITEM 6 -
MOTION: Motion to accept item 6, all of the consent items.
BY: Member Tom Verducci
SECOND: Member Christine Zack
VOTE: Unanimous; the motion carried.

7. Presentation on self-funded claims trend experience and projections of the composite rate trend for Plan Year 2019 (July 1, 2018 – June 30, 2019). (Stephanie Messier, Aon Hewitt) (Information/Discussion)

8. Presentation on PEBP's Fiscal Year 2020/2021 Governor Recommends Budget. (Celestena Glover, Chief Financial Officer) (Information/Discussion)

9. Presentation on PEBP's 2018 Member Satisfaction Survey. (Damon Haycock, Executive Officer) (Information/Discussion)

10. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)

11. Discussion and possible action regarding additional proposed plan design changes for Plan Year 2020 / 2021 (July 1, 2019 – June 30, 2021), including but not limited to the following:

    - Possible increases and requirements to CDHP HSA/HRA enhanced employer contributions;
    - Funding Medicare exchange participant HRA administration fees and life insurance premiums;
    - Additional benefit design inclusions/exclusions/alterations to meet projected budget needs.

    (Damon Haycock, Executive Officer) (**All Items for Possible Action**)

Member Tom Verducci requested an agenda item on the March Board meeting to discuss additional plan design opportunities as discussed by public comment and the actuarial analysis to back it up.

BOARD ACTION ON ITEM 11 -
MOTION: Motion to approve agenda item 11 with the additional request for PEBP staff to prepare the actuarial analysis with the four items that NFA brought forward.
BY: Member John Packham
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried.

12. Discussion and possible action to approve a 4-year contract (through 2023) with American Health Holdings for Utilization Management / Large Case Management services for PEBP members on the CDHP and EPO plans. Pursuant to NRS 287.04345(4), the PEBP Board may close a portion of this item to review the results of the evaluation of proposals for the contract; no action will be taken during any closed portion of the session. (Damon Haycock, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 12 -

MOTION: Motion to approve item 12 and ratify the evaluation committee's recommendation as read.

BY: Member Don Bailey

SECOND: Member Leah Lamborn

VOTE: Unanimous; the motion carried.

13. Discussion and possible action to evaluate the performance of Damon Haycock, PEBP's Executive Officer. (Patrick Cates, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 13 -

No action taken.

14. 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.

Public Comment in Carson City:

- Marlene Lockard - Retired Public Employees of Nevada (RPEN)
- Priscilla Maloney - Representative of AFSCME retirees
- Terri Laird – Executive Director of RPEN

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

15. Adjournment

Chair Cates adjourned the meeting at 11:53 a.m.

4.2.

4. Consent Agenda (Deonne Contine, 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.

   4.2 Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2018 – December 31, 2018.

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2019, Quarter Two
October, November and December 2018

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
January 2019

TABLE OF CONTENTS

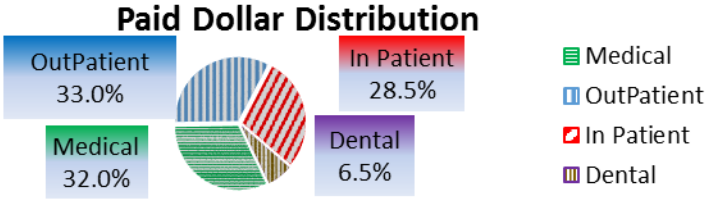
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,066,079.69
Total Paid Value of random selection: $ 279,936.41



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	99.6%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.9%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.7%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	21 sec. 1.40% 97.18%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Previous Findings

1)HTH Repricing as Non PPO for Excluded Services

Multiple contractual agreements utilized for discount rates, etc. and repriced by HTH for PEBP claims contain language, in which, the provider is considered a PPO vendor, however, displays services that they are not authorized to provide and are excluded for payment(s) if rendered under the HTH contract. Audit detected where HTH was repricing these exclusions as NON PPO versus "Excluded" or at $0 allowable(s) causing HSB to apply NON PPO benefits and pricing versus denial as excluded. This audit finds the issue solved, however, will be specifically focus audited in the future.

2) **Letters of Authorizations**

HTH contracting department may have some excluded services within their contracts that could be covered under "blanket" Letter of Authorizations (LOAs) that the claims repricing personnel are not provided. This audit finds the issue solved, however, will be specifically focus audited in the future.

3) HTH authorizations for Diplomat Pharmacy

Numerous EPO plan claims with authorizations provided to PEBP participants by HTH for large dollar prescription drug claims to be purchased through Diplomat Pharmacy (a network pharmacy), however, are to be purchased through PEBP's Specialty Drug vendor, Accredo to receive the negotiated PEBP rates. This audit finds the issue solved, however, will be specifically focus audited in the future.

4) End Stage Renal Disease

Previous detected an issue concerning errors with the payment of participant claims with diagnosis (DX) of End Stage Renal Disease (ESRD) where claims were found to be Medicare eligible and requesting in excess of $450,000 in overpayments. HCA has conducted follow-up focus audits and verified that the majority of these overpayments have been collected. HCA recommends that PEBP consider language within the Plan Specific Plan Document (SPD) that addresses the enrollment of participants Medicare eligible with an ESRD DX.

Overpayments

The quarterly audit includes a review of the causes, volume and HealthSCOPE's policies and procedures for identification and collection of overpayments. This quarter, the identified overpayment dollar volume remains at one of the highest levels in the PEBP's history with HealthSCOPE as its medical claims administrator. A major cause of overpayments is a result of the claims sent for collections due to network pricing adjustments from both major networks within the PEBP Statewide Network. It is important to note, that of the most current identified overpayments for Plan Year 2019 (to date), 51.9% of the identified overpayment volume was found to be caused by external sources that are <u>not</u> a cause of the HealthSCOPE adjudication processes.

Repricing by Hometown Health

The audit detected a trend in which the allowables repriced by Hometown Health and provided to HSB for adjudication of PPO claims are incorrect. Examples of this audit include a claim repriced as "NON PPO" causing HSB to apply Usual & Customary (U&C) rates at $11,576.87. HCA requested the claim to be repriced again, of which, was repriced as the allowable at $596.14. Another example is hospital claims with surgical services where the surgical add-on allowable is not applied as per contract agreement.

Pre-certification Penalty

HCA has two observations concerning penalties for authorizations not obtained by the PEBP plan participant(s).

1) The current Master Plan Document (MPD), section Failure to Follow Required UM Procedures states "If you do not follow the required prior authorization review process described in this section, benefits payable for the services you failed to receive a prior authorization will be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both in-network and out-of-network (when allowed due to exception) covered expenses. When adjudicating multiple claims related to a participant that does not obtain the required prior authorization for services rendered in a hospital, HSB applies the 50% penalty only to the facility bill as per instructions obtained previously. HCA requests verification of this issue from PEBP for future adjudications.

2) The audit revealed a situation where a PEBP member obtained an authorization for a hospital stay beyond the allowable in-patient days for a difficult baby delivery. The mother called the PEBP Utilization Management (UM) firm and obtained the authorization for extended days with diagnosis' that included obstruction, failed induction and complications of labor with the cord around the baby's neck, etc. Unfortunately, HSB contacted the UM firm and told that no authorization was obtained so the baby's billing was penalized in excess of $17,000. Typically, under this situation, the UM firm would follow up with mother and baby for possible case management. HCA has inquired with the UM firm (through HSB) on their policies concerning these circumstances.

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 16.

Pre-authorization penalty applied in error; Supporting ref. nos. 033 and 168

Incorrect rate due to re-pricer; Supporting reference nos. 044 and 508

Charge/claim denied in error; Supporting reference nos. 112 and **441**

Incorrect rate; Supporting reference nos. 502 and 510

Claim adjusted and additional payment made in error; Supporting ref. no. **094**

Claim not paid after requested information received; Supporting ref. no. 173

Preventive services paid as medical; Supporting reference no. 208

ASC facility co-pay not applied; Supporting reference no. 223

Bilateral surgical reduction not applied; Supporting reference no. 423

Claim paid after retroactive termination; Supporting reference no. 430

Deductible applied in error; Supporting reference no. 467

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 16.

Pre-certification penalty applied only to facility charges;
Supporting reference no. 033

Claim awaiting client's colonoscopy benefit clarification, now received;
Supporting reference no. 195

Overpayments for after termination claims not requested for 90 days;
Supporting reference no. 430

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In January 2019, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 21 January 2019.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from December 2017 to December 2018 and were processed by HealthSCOPE from 01 October 2018 through 31 December 2018 (PEBP's Second Quarter Plan Year 2019). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 385,590.32	$ 89,584.61	32.0%	334
Outpt. Hospital	$ 312,951.96	$ 92,476.68	33.0%	62
Inpt. Hospital	$ 325,431.31	$ 79,840.67	28.5%	5
Dental	$ 42,106.10	$ 18,034.45	6.5%	99
TOTAL	**$1,066,079.69**	**$ 279,936.41**	**100%**	**500**

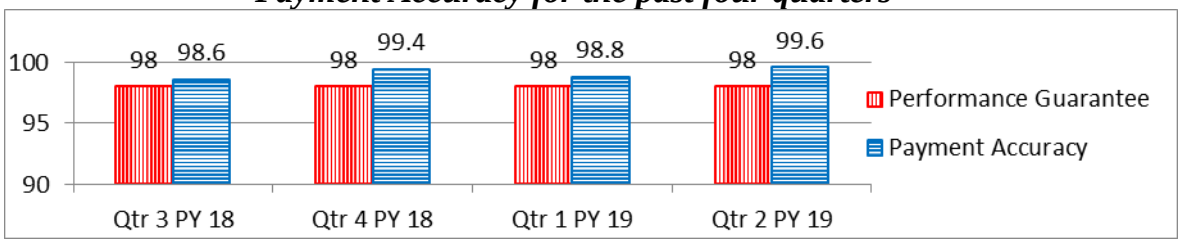
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 99.6%.

Number of claims:	500
Number of claims paid incorrectly:	2
Percentage of claims paid incorrectly:	0.4%
Number of claims paid correctly:	498
Percentage of claims paid correctly:	99.6%

Payment Accuracy for the past four quarters



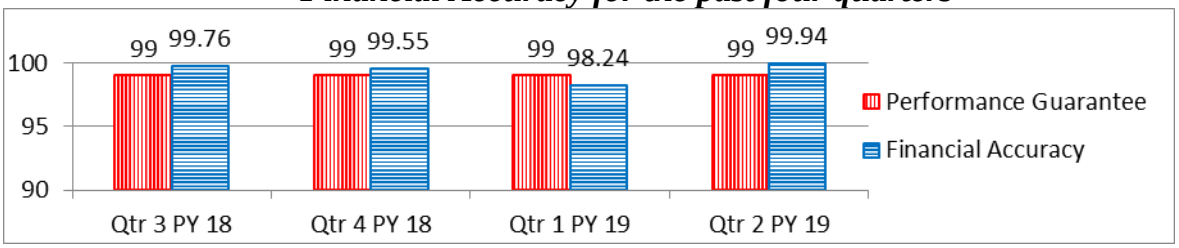
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.9%. This audit reflected thirty-six and one tenth percent (36.1%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 279,936.41
Amount of paid dollars remitted incorrectly	$ 156.41
Percentage of Dollars paid incorrectly	0.06%
Paid Dollars of claims paid correctly	$ 279,780.00
Percentage of Dollars Paid correctly	99.94%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

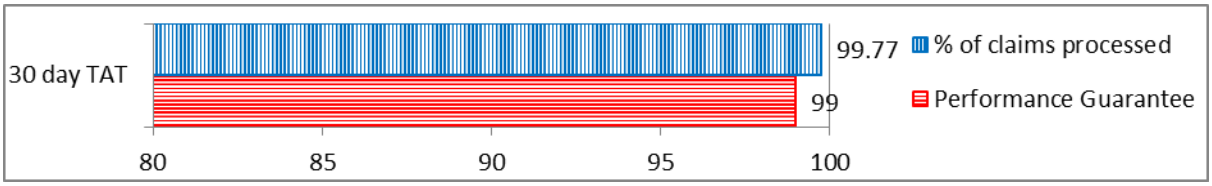
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	**99.6%**	**99.9%**	**5.6 days**	**:21.0**	**1.40%**	**97.18%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.77% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 5.6 days.

Turnaround Time Measurements



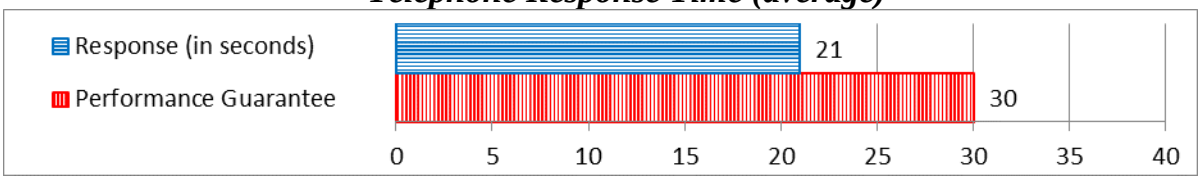
The turnaround time, measured only from the random selected claims, for Medical claims was 13.2 calendar days, Out Patient Hospital claims was 14.3 calendar days, In Patient Hospital claims was 16.4 calendar days and Dental claims was 1.5 calendar days.

During the audit period of 01 October 2018 to 31 December 2018, HealthSCOPE had received 1,428 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 8.5 hours.

Customer Service Satisfaction

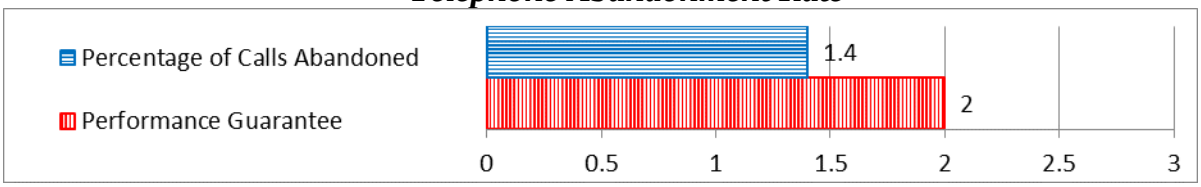
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2019, which revealed the average incoming answer speed to be 21.0 seconds (0:21.0). The telephone response time was 25 seconds for October 2018, 28 seconds for November 2018 and 10 seconds for December 2018.

Telephone Response Time (average)



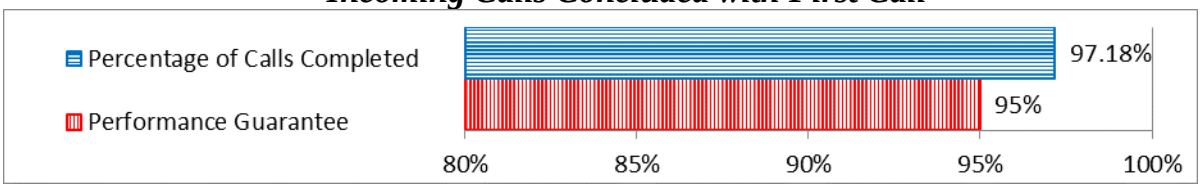
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2019, which revealed the abandoned calls ratio to be 1.40%. The telephone abandonment rate was 1.49% for October 2018, 1.82% for November 2018 and 0.84% for December 2018.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2019, which revealed that HealthSCOPE documented 97.18% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

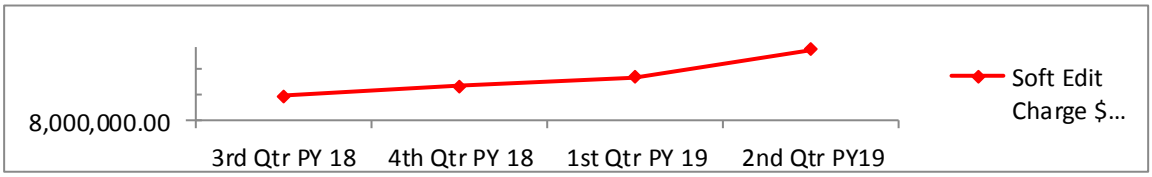
HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is HCA's opinion that these amounts are the result of HealthSCOPE conducting due diligence and resolution of the issues and trends including those previously detected in previous audits. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 5,558 claims representing $ 36,168,714.98.



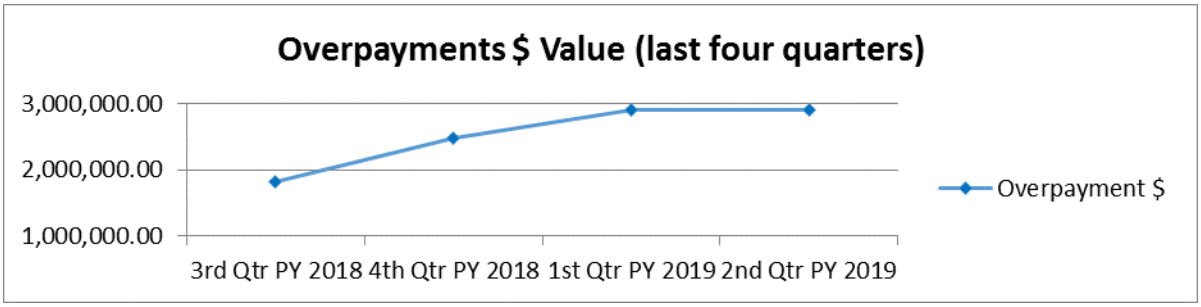
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	**5,558**	**$36,168,714.98**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $2,898,529.39 (a decrease of $5,615.15). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 139,276.05
- Fiscal Year 2013	$ 253,248.27
- Fiscal Year 2014	$ 126,496.85
- Fiscal Year 2015	$ 263,468.23
- Fiscal Year 2016	$ 334,115.62
- Fiscal Year 2017	$ 329,057.38
- Fiscal Year 2018	$ 878,783.41
- Fiscal Year 2019	$ 574,083.58
TOTAL	$2,898,529.39



Of the 1,466 most current (Plan Year 2019) identified outstanding overpayments (HSB only), 51.9% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current (PY19) overpayments (by claim count) are listed by reason as follows:

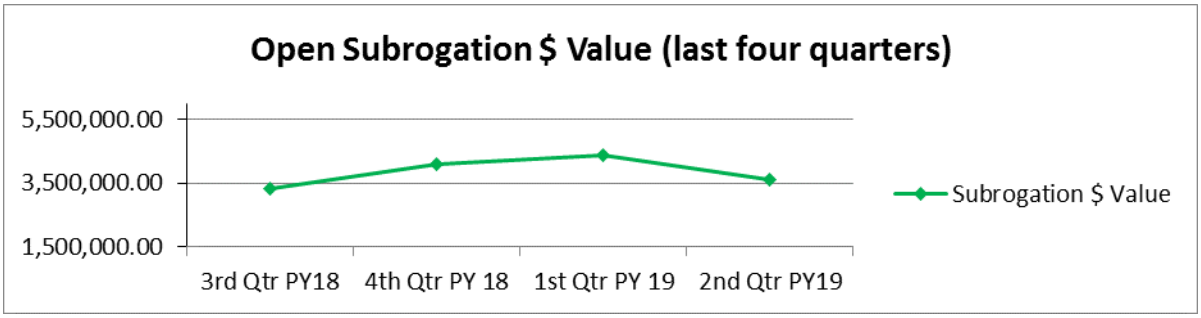
18.91%	Subrogation error
16.38%	Retro termination
15.22%	Provider caused, rebilled, charges billed in error, corrected EOB
12.01%	No COB on file
7.71%	SHO Pricing Correction
7.30%	Incorrect Benefit Applied
7.30%	Incorrect Rate Applied
5.94%	Corrected HTH Network Pricing
2.12%	Duplicate
1.98%	COB incorrectly calculated or not applied
0.89%	Previous Information Received
0.82%	Industrial and/or possible Workers Compensation claim
0.75%	Service not covered
0.61%	Processed under the incorrect provider
0.34%	Processed under incorrect patient
0.27%	Adjusted after medical review
0.27%	Incorrect assignment applied
0.27%	Paid NON PPO as PPO
0.20%	Eligibility
0.20%	Stop Payment
0.14%	Paid PPO provider as NON PPO
0.14%	Pre-Certification
0.07%	Pharmacy claim deductible/Co-Insurance error
0.07%	Entry Error
0.07%	Benefit Clarification

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $3,609,305.16; a decrease of $758,475.69 from the previous quarter.

Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $104,920.97. After contingency fees were paid, PEBP received $78,690.73.



HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected thirty-four (35) active members and twenty-three (23) dependents for a total of 58 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $80,301,609.56.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, **CHANGE**, 2 individuals deleted and 2 added for a total of 3 individuals;
- Funding Supervisor;
- Claims Administration Manager; **CHANGED**
- Claims Administration Supervisor; **CHANGE**, one deleted for a total of 1 individual;
- Claims Analysts, **CHANGE**, 2 individuals added for a total of 14 individuals;
- Eligibility Director;
- Eligibility Supervisor; **CHANGED**
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager; **CHANGED**
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

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HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 033 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Facility bill (audited claim) had PA penalty applied
Claim xxxxxx surg & -26 modifier services applied penalty (93451.26 & 93463)
Claim xxxxxx (93306.26) chg 428.00, allow 282.48 paid at 80%
Should this claim have also applied PA penalty of 50%?
HSB response: Precert penalties only assessed on facility. Please see attached. No error.
HCA Note: Per attached 2012 email from PEBP the pre-cert penalty to apply to the facility only.

Ref. No. 044 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

70th percentile U&C applied:

51785.26	chg 2547.00	allow 850.00
95861.26	1090.00	1090.00
95929.26	1795.00	1795.00
95937.26	1133.00	1133.00
95938.26	2709.00	2708.87
95941	4000.00	4000.00 – 2 units
	13,274.00	11,576.87
		2,167.03 coins
		9,409.84 paid

Claim xxxxxx:

51785.TC	chg 2947.00	allow 307.40
95861.TC	1090.00	152.24
95292.TC	1795.00	229.56
95937.TC	1133.00	79.02
95938.TC	2709.00	496.56
95940	3000.00	321.84
	12,674.00	1,586.62

Audited claim paid as non-PPO. TC provider same address paid as PPO. Can we verify if audited claim provider is non-PPO?

HSB response: Claim originally processed as Non-Par per HTH. Upon resubmission to HTH claim was returned as Par. Please see explanation attached from HTH.

HCA Note: HTH repriced claim at $596.14. Claim is overpaid $8,932.93. Per attached HTH states: "We have a hold code G1 which was setup as a warning for the examiner to review and make sure the correct provider was linked to the claim, at some point the status was updated on the hold code and was changed to deny, I believe this was a system issue that we corrected."

Ref. No. 094 Medical HSB claim no.

Overpayment - $56.41

Provider billed as: 58300 chg 455.00
58301-51 364.00

Claim paid as: 58300 allow 72.15 x 50% = 36.08 paid 36.08
58301 112.82 112.82

Claim adjusted under xxxxxx on 12/12/18 to pay as:

58300	allow 72.15	pd 72.15
58301	112.82	112.82
		184.97
		148.90 previously paid
		36.07 additional payment

Shouldn't claim have been adjusted as:

58300	allow 72.15	pd 72.15
58301-51	112.82 x 50% = 56.41	56.41
		128.56

Appears there should have been an overpayment versus additional payment made.

HSB response: 1) Agree original claim pd incorrectly. Orig pymt $148.90 Correct pymt s/b $128.56 = OP $20.34 2) Adj claim pd add'l money incorrectly. OP $56.41 ($20.34 + $36.07 = $56.41)

Ref. No. 112 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

91110.26	chg 350.00	allow 141.43
91110.TC	1050.00	588.64
	1400.00	730.07

Original paid claim on 12/13/17. Denied 91110.TC as "the maximum allowable per day has been met"

Claim was appealed & adjusted on 10/11/18 allowing payment of TC on audited claim.

HSB response: Original claim xxxxxx denied 91110-TC in error. Provider billed TC & 26 modifier and both were allowed under xxxxxx when corrected. No error.

Ref. No. 168 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim is for newborn I/P stay 7/6-7/12/18. Claim pd as follows:
Denied orig on 9/4/18
Paid on 10/11/18 – repriced at 34,166.48
17,083.26 PA penalty
17,083.22 paid
Mother's file reflects that C-section services were rendered.
Admitted on 7/5/18, contact date on 7/7/18, apr dch dt on 7/10/18,
Days approved: 5
Since mother obtained auth for her stay and her DXs reflected 1) obstructed labor, 2) Failed medical induction of labor and 3) Labor/ delivery complicated by cord around neck, wouldn't the UM firm have investigated/inquired about the baby and conducted concurrent & retrospective reviews for this condition?
Please forward to UM firm for response.
HSB response: Submitted to HTH/UM recon.
HTH response: All of the information in this request, except the attachment, is related to the member's mother. Auth 01-070718-900-26 is also for the mother. There is not an auth for the baby. We will need clinical records in order to proceed with auth. In answer to your question re: Yes, if the UM nurse thinks the member will require additional services, they refer the member to Case Management.

Ref. No. 173 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx DOS 8/3/18 same provider, same services as audited clm
EOB stated that denied for physician's orders, etc. Since this data has been received & claims after have been paid, should this claim have been paid also?
HSB response: Medical records linked to claim xxxxxx, DOS 8/3/18 and should have been sent to Medical Mgmt/UM and not denied.

Ref. No. 195 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim is facility bill for routine colonoscopy
Claim xxxxxx is for same DOS, surgeon's bill for routine colonoscopy
Provider is PPO
45380 chg 1398.00, billed/rec'd on 10/27/18. Memos on 11/12/18 stating system allowing as wellness. Please explain why this claim was not paid & still not paid.
HSB response: We have been waiting for client directive for colonoscopies on EPO & CDHP plans. Change form now submitted/received from client and pended claims are being worked.

Ref. No. 208 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
58670 chg 2048 allow/pd 500.11 DX – Z302 encounter for sterilization
Claim xxxxxx same DOS for anesthesia w/same DX being paid at 80%
00840 chg 1400 allow 780.00 pd 624.00
Shouldn't this have also paid at 100%?
HSB response: Yes anesthesia claim xxxxxx should pay at 100%
UP $156.00

Ref. No. 223 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
66984 chg 2105 allow/pd 858.65 (cataract surgery)
Per MPD for EPO plan shouldn't $350 copay have been applied?
(Note: Claim xxxxxx same DOS for anesthesia a/pd 413.00 and claim xxxxxx for surgery center a/pd 1011.61 – no copay applied on either claim)
HSB response: No - $350 copay for ASC should be assessed on facility claim Txxxxxx

Ref. No. 423 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
58661.50 chg 3185.00
Orig claim allowed 895.13 per HTH repricing on 11/8/18
Claim adjusted on 12/7/18 to allow modifier -50 and allow 1342.70
HSB response: Original claim paid w/o applying bilateral surgery pricing. Claim adjusted to allow bilateral $895.13 x 150% = 1342.70. Claim is correct.

Ref. No. 430 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Termed 8/1/18
Multiple claims with total paid $2,267.04 paid after termination date
1) Please advise when HSB was notified of termination
2) Have refunds been requested?
HSB response: 1) Notice received 10-8-18. Non pay of COBRA.
2) Claims are in line to be denied and overpayments requested. Our standard is to hold for 90 days in case coverage is reinstated.

Ref. No. 441 Medical HSB claim no.

Underpayment - $100.00
97110 chg 134.36, 97140 chg 62.10, G0283 chg 30.48
Claim denied for physician's order for therapy
Claims xxxxxx (Ref #384) for DOS 10/31/18, xxxxxx for DOS 10/17/18 and xxxxxx DOS 10/10/18 for same services as audited claim have been paid. Should audited claim have also been paid?
HSB response: Claim xxxxxx should have been paid. $100.00 UP

Ref. No. 467 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
87086 chg 139.00 allow 7.35
Orig claim applied 7.35 to deductible on 11/27/18
Adjusted claim paid 7.35 on 12/14/18 as claim is for EPO member
HSB response: Txxxxxx – December 2018 we received a report of hospital lab claims that had applied to deductible/copay in error. Claims have been corrected.

Ref. No. 502 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Rev 174 x 49, 3456/day = 169,344.00
173 x 16, 3456/day = 55,296.00
636, $656,993.80 = paid $0
DRG 4 add-on = 7,405.00
Per contract: d) Orphan drugs & Therapy Agents/Drugs Rev 256, 636* Bone Products & Bone Marrow Products, Gendyne Kits are 60% disc from billed charges
Are the rev 636 drugs to be allowed at 40% of BC?
HSB response: Yes per our understanding of agreement allowable is 40% of billed. No error.

Ref. No. 508 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
DRG 040
Rev 128, 17 days x 2510 = 42,670.00 (rehab)
128 6 days x 2510 = 15,060.00 (rehab)
360 surg add-on = 2,816.00
636, 8843.00 x 40% = 3,537.20
64,083.20
DRG = 040 = surgical DRG, periph/cranial nerv
Since DRG 040, shouldn't surgical add-on be applied?
HSB response: Please see attached. HTH has advised we were provided Incorrect pricing. We will have claim corrected. UP $2816.00.

Ref. No. 510 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim allowed at 74,717.75
Rev 123, 22 days x 2837.00 = 62,414.00
278, 25,209.38 x 40% = 10,083.75
360, surg add-on = 2,220.00
636, 5,109.62 x 40% = 2,043.85
76,761.60

1) Per contract shouldn't rev 636 be allowed at 60% discount from billed charges?
2) Should allowable be $76,761.60 versus $74,717.75?
HSB response: 1) Per attached, provider must submit request to SHO for Consideration regarding specific codes. 2) Yes.

HealthSCOPE BENEFITS

27 Corporate Hill
Little Rock, AR 72205

January 31, 2019

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results October 1, 2018 – December 31, 2018

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the second quarter of Plan Year 2019. The audit included 500 claims with paid amounts totaling $279,936.41.

HealthSCOPE Benefits is extremely pleased to have met all performance guarantees for this audit period. We strive to have the highest possible quality, and we continue to review quality improvement opportunities within our organization, as well as with our vendors.

We are pleased to report the financial savings we are able to provide on the PEBP account. We saved PEBP an additional $1,608,874 through non-network negotiations, subrogation and transplant savings in the second quarter of Plan Year 2019.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President & Co-CEO

4.3.

4. Consent Agenda (Deonne Contine, 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.

   4.3 Acceptance of Health Claim Auditors' annual audit findings for Express Scripts, Inc. (ESI) for the PEBP Plan Year 2018 (July 1, 2017 – June 30, 2018).

REDACTED VERSION

COMPLIANCE WITH ESI AGREEMENT

Prescription Benefit Manager Audit Report

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Plan Year 2018 (July 2017 – June 2018)

Conducted on

Express Scripts, Inc.

Submitted By:

Health Claim Auditors, Inc.

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INTRODUCTION

In September and October 2018, Health Claim Auditors, Inc. (HCA) performed a Prescription Drug Audit of Express Scripts, Inc. (ESI) on behalf of The State of Nevada Public Employees' Benefits Program (PEBP). ESI is a contracted vendor that provided administration of the PEBP's Benefit Plan for prescription drug claims as per terms within PEBP RFP 3220.

The audit was performed to assure PEBP that ESI is doing a proficient job of controlling prescription costs while paying claims accurately within a reasonable period of time and in compliance with the contract for services.

The prescription claims audited were processed by ESI from 01 July 2017 to 30 June 2018 (PEBP Plan Year 2018). HCA reviewed 100% of the prescription drug claims processed during this time period.

The preliminary report of audit results was electronically delivered to ESI representatives on 13 November 2018 for their review and comments. ESI responses, received on 11 January 2019 (within the 60 days allowed by agreement), have been inserted within this report and are displayed in ***Bold and Italicized*** type for easy detection.

Please note*:* Certain contract discount data contained within this report is considered proprietary and thereby has been redacted in this report for confidentiality purposes to be in compliance with the ESI agreement. This version of the report is in compliance with all ESI requests for confidentiality redactions. The audit measured the actual values of specific negotiated rates for discounting, dispensing fees, rebates and all performance guarantees, however, are displayed within this report as xx.x% or $xx.xx.

The detail claims data received for this audit reflected the Average Wholesale Pricing (AWP) for name brand and generic claims dispensed by retail and mail order pharmacies.

EXECUTIVE SUMMARY-

Summary of Findings for Contracted/Guaranteed Performance Measurements
Audit Period: PEBP Plan Year 2018 (01 July 2017 through 30 June 2018)

The table below provides an overview of the audit findings for contracted services with performance standards and financial guarantee indicators. Details of each category can be found within the Executive Summary and Report Details sections of this report.

Perf. Category	Detail Category	Under/Over Perform. Pass/Fail
Discounts	Retail Name Brand 1-83 days	*Over Performance
	Retail Name Brand 84-90 days	*Over Performance
	Retail Generic	*Under Performance
	Mail Order Name Brand	Pass
	Mail Order Generic	*Under Performance
	ESI Pharmacy Specialty Drugs	*Over Performance
	Aggregate of all Categories	***Over Performance**
Dispensing Fees	Retail Name Brand 1-83 days	*Over Performance
	Retail Name Brand 84-90 days	*Under Performance
	Retail Generic 1-83 days	*Over Performance
	Retail Generic 84-90 days	*Under Performance
	Mail Order Name Brand	Pass
	Mail Order Generic	Pass
	Specialty Drugs	Pass
	Aggregate of all Categories	***Over Performance**
Manuf. Rebates	$xx.xx Ret. NB 1-83 dys/$xx.xx Ret NB 84-90 dys/$xx.xx per MO NB/$xx.xx NB Specialty	**Not determined**
	Timely remittance to PEBP	**Not determined**
Admin. Fees	$xx.xx per employee per month (PEPM)	Pass
Customer Service	Telephone Response within xx seconds	Pass
	Abandonment Rate less than xx.x%	Pass
	Network Pharmacy xx% within 5 mi.	Pass
	xx% or greater First Call Resolution	Pass
	Mail clms shipped in x dys (no intrvntn)	Pass
	Mail clms shipped in x dys (w/intrvntn)	Pass
	Survey, xx% at "satisfactory" or better	Pass
Adjdctn Accuracy	xx% of Retail claims with no errors	Pass
	xx% of Mail Order claims with no errors	Pass
Reporting	Monthly, quarter and annual in xx days	Pass
Disclosures	All new subcontractors	No exceptions noted
	All movement of data storage	No exceptions noted
Claim Transfer	xx.xx% daily data file transfer to TPA	Pass
Eligibility Data	xx% extracts available next bus. Day	Pass

* Per Agreement, specific types of claims were excluded from the performance guarantee calculations.

Summary of Findings for <u>NON Contracted/Guaranteed Performance Measurements</u>
Audit Period: PEBP Plan Year 2018 (01 July 2017 through 30 June 2018)

The table below provides an overview of the audit findings for services that do not include performance standards and financial guarantees. The data has been provided for informational purposes only. Details can be found within the Executive Summary and Report Details sections.

Category, Plan Year 2018	Detail Category	Note
Generic Distributions	Percentage of Generic claims to all claims	Exceeds industry
Specific Pricing	Zero Balance Pricing	Pass
Claim Adjudication	Days Supply Limits	Pass

Other findings

- PEBP should be congratulated for the XX+% distribution of Generic Drug utilization of all Retail and Mail Order claims. This distribution is among the highest in the nation and drives an overall lower cost to PEBP participants and the PEBP plan;
- It is recommended that PEBP review the Possible Drug Exceptions for verification and confirmation with ESI for plan exclusion;
- The ESI adjudication system edits and DUR edits tested were found to follow proper protocol and practices in areas to include, but not limited to scheduled drugs, dosage limitations, days supply, step therapy, generic substitutions, etc.;

Executive Summary/Conclusions/Recommendations

ESI was found to provide and apply numerous services as PEBP's Prescription Benefit Manager that met and/or exceeded the contracted guarantees and vendor responses remitted within the processes for The State of Nevada Purchasing Division Request For Proposal (RFP) No. 3220.

ESI was found to be in compliance with all performance guaranteed metric measureable areas for the audited period within The State of Nevada PEBP/ESI Agreement with the exceptions of Retail Generic and Mail Order Generic aggregate discount rates plus Retail Name Brand and Retail Generic dispensing fees that were found to be an underperformance of the guarantees, however, no penalties can be applied as the overall fees acquired by PEBP for the aggregate of these categories were found to be an overperformance when measured to the guarantee.

It is HCA's unbiased opinion that ESI has performed to all negotiated guaranteed within the Agreement and no penalties should be applied for PEBP's Plan Year 2018 period.
ESI Response – ESI notes the quarterly rebate reports are attached for HCA's review. ESI also notes the reconciliation for pricing guarantees will be completed by March 01, 2019 (240 days from end of plan year). The guarantees will be requested and provided within two weeks of the completion date.

AUDIT SUMMARY

This report consists of HCA's findings and observations concerning the system edit capabilities, procedures, contract compliance and savings provided by Express Scripts, Inc. (ESI). Areas that have performance standards listed in the PEBP contract are listed first.

AUDIT CRITERIA

SELECTION PROCESS

One hundred percent (100%) of claims provided by ESI within the detailed claim report were audited for appropriate discount rates and compliance with PEBP's contract for services. The audit included, but was not limited to compliance with the following categories within the contract for services in force at the time of the adjudication:

1) Retail drug dispensing fee;
2) Mail order brand name and generic drug dispensing fees;
3) Manufacturer rebates;
4) Customer Service;
5) Drug Utilization Review (DUR) policies and procedures;
6) Claim processing and procedures;
7) Eligibility (both internal and compliance with PEBP's Medical Plan Administrator);
8) Accumulator data (both internal and compliance with PEBP's Plan Administrator);
9) Quality assurance and internal audits and training;
10) Security access;
11) Report capabilities;
12) Savings;
13) Administration Fees.

The individual prescription costs audited were calculated from the PEBP current detailed claims listings as supplied by ESI. Confidential data was collected and utilized to formulate this report.

AUDIT RESULTS– Period: 01 July 17 through 30 June 18, Performance Standards Apply

***Important Note:** Due to the issues experienced by PEBP with previous PBM services, the Average Wholesale Pricing (AWP) displayed within the detail claims report received from ESI for Name Brand drug claims was checked against a 2009 pre-class action lawsuit accounting format. It has been confirmed that the AWP supplied is in compliance with the current negotiated agreement between PEBP and ESI.

As per the Agreement, AWPs were was audited and calculated utilizing the database supplied by Medi-Span for the allowables as of the date of service. Per Agreement, specific types of claims were excluded from the performance guarantee calculations as displayed in each category results.

Transparency
Per Agreement, PEBP and ESI have negotiated metric measurements minimums for each category, i.e. discounts, fees, etc. PEBP and ESI have also entered into pass-through arrangements where PEBP pays ESI the actual ingredient cost and dispensing fee amount paid by ESI for the particular claim when the claim is adjudicated to the pharmacy.

HCA Findings: HCA has reviewed reconciliation reports to ensure ESI is providing PEBP the transparency portion of the Agreement as described above and concludes that ESI is in compliance with the Agreement.

Retail Claims Discount Rate

Retail Name Brand Claims

Per the agreement, the discount rate for Retail Pharmacy Name Brand Drugs is to be an aggregate of xx.x% from 100% AWP (Average Wholesale Price) for 1-83 days supply.

HCA Findings: The aggregate discount rate for this category was calculated to be AWP – xx.x% for the audited period and in compliance of the contract agreement. The aggregate paid by PEBP reflects an overperformance by an estimated $255,944 as compared with the performance guarantee.

Per the agreement, the discount rate for Retail Pharmacy Name Brand Drugs is to be an aggregate of xx.x% from 100% AWP (Average Wholesale Price) for 84-90 days supply.

HCA Findings: The aggregate discount rate for this category was calculated to be AWP – xx.x% for the audited period and in compliance of the contract agreement. The aggregate paid by PEBP reflects an overperformance by an estimated $72,491 as compared with the performance guarantee.

Retail Generic Claims

Per the agreement, the discount rate for Retail Pharmacy Generic Drugs is to be an aggregate of xx.x% from 100% AWP.

HCA Findings: The aggregate discount rate of this category for the entire audited period was found to be AWP – xx.x% for the audited period, below the contract agreement and not in compliance of the contract agreement. The aggregate paid by PEBP reflects an underperformance by an estimated $225,426 as compared with the performance guarantee.

Mail Order Claims Discount Rate

Mail Order Name Brand Claims

Per the agreement, the discount rate for the Mail Order Program Name Brand Drugs is to be xx.x% from 100% AWP.

HCA Findings: Aggregate discount rate for this category was calculated to be AWP – xx.x% for the audited period, within the agreement and in compliance of the contract agreement. The aggregate paid by PEBP reflects an equal value as compared with the performance guarantee.

Mail Order Generic Claims

The discount rate for Mail Order Program Generic Drugs is to be xx.x% from 100% AWP.

HCA Findings: HCA found the AWP discount for Mail Order Generic claims to be AWP – xx.x% for the audited period, in compliance with the contract. The aggregate paid by PEBP reflects an underperformance by an estimated $97,016 as compared with the performance guarantee.

Specialty Claims Discount Rate

Per Agreement (Performance Standards and Guarantees) a separate pricing category for Specialty Medications is to be applied.

Per agreement, the discount rate for Express Scripts Specialty Pharmacy Drugs, displayed in the agreement as "ESI Specialty Pharmacy Fills Only" is to be reimbursed as per the Exclusive Specialty Pharmacy Price List and guaranteed an aggregate discount of xx.x% from 100% AWP.

HCA Findings: The aggregate discount rate of this category for the entire audited period was found to be AWP – xx.x% for the audited period, below the contract agreement and not in compliance of the agreement. The aggregate paid by PEBP reflects an overperformance by an estimated $28,648.76 as compared with the performance guarantee.

Aggregate Claims Discount Rate

Per the Agreement supplied, HCA did not recognize language regarding that overperformances may be used to offset discount rate underperformances, however, PEBP has stated that the intent was to combine the discount categories for an aggregate measurement.

HCA Findings:

Claim Type Category	Over/(Under) $ Performance
Retail Name Brand 1-83 days	$255,944
Retail Name Brand 84-90 days	$72,491
Retail Generics	($225,426)
Mail Order Name Brand	$0
Mail Order Generics	($97,016)
Specialty Drugs (ESI Pharmacy	$28,648
TOTAL	$122,641

Retail Claims Dispensing Fees

Name Brand Claims

Per the Agreement, the dispensing fee during the audited period is to be an aggregate of $x.xx for 1-83 days supply of Retail Name Brand prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, below the guaranteed level. The aggregate paid by PEBP reflects an overperformance by an estimated $11,112 as compared with the guarantee.

Per the Agreement, the dispensing fee during the audited period is to be an aggregate of $x.xx for 84-90 days supply of Retail Name Brand prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, above the guaranteed level. The aggregate paid by PEBP reflects an underperformance by an estimated $83 as compared with the guarantee.

Generic Brand Claims

Per the Agreement, the dispensing fee for the audited period is to be an aggregate of $x.xx for 1-83 days supply of Retail Generic prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, within the agreement guarantee. The aggregate paid by PEBP reflects an overperformance by an estimated $24,619 as compared with the guarantee.

Per the Agreement, the dispensing fee for the audited period is to be an aggregate of $x.xx for 84-90 days supply of Retail Generic prescriptions.

HCA Findings: The dispensing fees ranged from $x.xx to $x.xx with an aggregate average dispensing fee of $x.xx, within the agreement guarantee. The aggregate paid by PEBP reflects an underperformance by an estimated $907 as compared with the guarantee.

Mail Order Brand Name Dispensing Fees

Name Brand and Generic Claims

The dispensing fee for Mail Order Name Brand and Generic prescriptions is to be $x.xx.

HCA Findings: The average dispensing fee was found to be $x.xx in compliance with the agreement.

Specialty Drug Dispensing Fees

The dispensing fee for all Specialty Drug claims is to $x.xx.

HCA Findings: The average dispensing fee was found to be $x.xx in compliance with the agreement.

Aggregate Claims Dispensing Fees

Per Agreement, all dispensing fee guarantees will be reconciled annually against actual results. Overperformance may be used to offset discount rate underperformance.

HCA Findings: Claim Type Category Over/Under ($) Performance

Retail Name Brand 1-83 days	$11,112
Retail Name Brand 84-90 days	($83)
Retail Generics 1-83 days	$24,619
Retail Generics 84-90 days	($907)
Mail Order	$0
Specialty Drugs	$0
TOTAL	$34,741

HCA finds the actual aggregate dispensing fee paid by PEBP for all categories is $152,544 less than the aggregate guaranteed rate.

Processing Accuracy

Per agreement, xx.x% of all claims (Retail and Mail Order) are to be paid with no errors. Errors are displayed as the incorrect drug, form, strength or wrong patient.

HCA Findings: Reports for this issue was reviewed by HCA and found to be xx.x% for retail and xx.x% for mail order claims during the audited period.

Mail Order Processing Time

Per agreement, clean claims (without intervention) are to be shipped within xx business days of receipt and claims requiring intervention are to be shipped within xx business days for each quarter year period.

HCA Findings: All claims paid within this audited period were in compliance with this portion of the agreement with claims without intervention being shipped in an average of x.x days and claims with intervention shipped in an average of x.x days.

Manufacturer Rebates

The contract for services with PEBP is to collect, report and pay manufacturer rebates on a quarterly basis and payments will be made within 90 calendar days after the last calendar day of the quarter in which such rebates are received. As per Agreement, ESI agreed to provide PEBP the greater of a flat guarantee of $xx.xx per net 1-83 day supply retail name brand paid claim, $xx.xx per net 84-90 day supply retail name brand paid claim, $xx.xx per net mail order name brand paid claim and $xx.xx per specialty drug claim dispensed exclusively through ESI Specialty Pharmacy or the yield of manufacturer rebates collected for PEBP claims by ESI.

There are typically at least four (4) types of payments pertinent to manufacturer rebates; (access, administration cost, base and market share). PEBP is paid an estimation of rebates by quarter and the actual amount is calculated as the rebates are received. ESI reported manufacturer rebate reimbursement payments made to PEBP in the following amounts and require PEBP verification of receipt:

Period	Total Paid to PEBP
Quarter 1	$x,xxx,xxx.xx
Quarter 2	$x,xxx,xxx.xx
Quarter 3	$x,xxx,xxx.xx
Quarter 4	$x,xxx,xxx.xx
TOTAL	$x,xxx,xxx.xx

HCA findings: HCA requested the appropriate reports regarding the calculations and payments to PEBP for PEBP's Plan Year 2018. HCA received the following ESI response on 21 January 2019:
ESI comment: As a reminder the pricing and rebate true ups will not be complete and available for request until March 1st. The reports will likely take a few weeks and then ESI will forward to HCA.
HCA note: HCA will conduct the audit on this category upon receipt of data from ESI.

Please note: Per reports received for final calculations of PEBP PY17 guarantees, ESI reported the Percent Share Calculation of $xx.xx and payments to PEBP of $xx.xx. HCA requests verification from PEBP that the $xx.xx balance was collected.

Customer Service

A. Per the contract for services, the telephone response time is to be an average of xxxx seconds (x:xx) or less.

HCA Findings: HCA obtained the data for this issue and found the telephone response time range per quarter to have a range of xx.x seconds (x:xx.x) to xx.x seconds (x:xx.x) for an aggregate average of xx.x seconds (x:xx.x) over-performing the benchmark level guaranteed within the agreement.

B. Per the contract for services, the telephone abandonment rate is to be less than xxxx percent (xx.x%) of all calls.

HCA Findings: HCA obtained the data for this issue and finds that the abandonment telephone rate ranged from xx.x% to xx.x% for each quarter year measurement, within the guarantee level.

C. Per the contract for services, xx.x% or greater of the incoming telephone calls from participants are to be resolved within the first call received.

HCA Findings: HCA obtained the data for this issue and finds that the first call resolution equaled xx.x% for the year measurement, within the guarantee level.

D. Per the contract for services, xx% of PEBP PPO Plan Participants must have a network pharmacy within five (5) miles of their residence.

HCA Findings: HCA requested a report that reflects the percentage of this issue. The report reflected that xx.x% of PEBP participants had at least one (1) Network Pharmacy within 5 miles of their residence for each of the quarter year periods.

E. Per Agreement, an annual Program Satisfaction Survey is to be conducted of PEBP plan participants who have used the pharmacy benefit. xxxx percent (xx%) or more of participants must provide a "satisfactory" level of services they received or a penalty can be assessed.

HCA Findings: Per the Customer Satisfaction Survey results, ESI met the guaranteed metric measurement of xx.x% with xx% satisfied members surveyed.

Subcontractor Disclosures

Per Agreement supplied to HCA, is requesting that ESI supply a statement confirming if there are any exceptions of ESI notifying PEBP and receive approval a minimum of xx days prior to any subcontractor commencing work utilizing PEBP information or data.
ESI Response: ESI initially provided Nevada PEBP with a list of approved subcontractors, which Nevada PEBP approved. The ESI Account Team sends all changes occurring throughout the year to Nevada PEBP. The process has been in place for one year.

Data Storage Change Disclosures

Per Agreement, ESI must disclose to PEBP all physical locations of PEBP data storage. HCA is requesting that ESI supply a statement confirming if there are any exceptions of ESI notifying PEBP for movement of any data storage xxxx (xx) days prior to a subcontractor vendor of ESI.
ESI Response: ESI initially provided Nevada PEBP with a list of approved data storage facilities which Nevada PEBP approved. The ESI Account Team sends all changes occurring throughout the year to Nevada PEBP. The process has been in place for one year.

Eligibility Accumulators/Data Transfer delivered to PEBP Third Party Administrator

Per Agreement, ESI must make available xx.x% of full electronic claim accumulator extracts by 12:00AM CST on the next business day.

HCA Findings: Report received and reviewed for this category reflect that ESI met the guarantee for each quarter and is in compliance with the guarantee.

Per Agreement, a daily operational data file must be transferred, retrieved and processed by the predetermined time with no incorrect content.

HCA Findings: Report received and reviewed for this category reflect that ESI met the guarantee for each quarter and is in compliance with the guarantee.

AUDIT RESULTS – Period of 01 July 2016 through 30 June 2017
Performance standards do not apply

1. **Distributions**

Based on audit results, calculations for the distribution of Name Brand versus Generics and Retail versus Mail Order were measured for the audited period. Please note that Specialty Drugs and Compound Drug claims are not included within the number of claims and ingredient cost of claim distributions. The results are as follows:

Number of Claims

Retail - Brand, 12.9% of total retail claims;
Generic, 87.1% of total retail claims;
Total, 94.2% of all claims.
Mail Order - Brand, 11.4% of total mail order claims;
Generic, 88.6% of total mail order claims;
Total, 5.8% of all claims.
Name Brand Prescriptions, 12.8% of all claims.
Generic Prescriptions, 87.2% of all claims.

Ingredient Cost of Claims

Retail - Brand, 63.3% of total retail claims;
Generic, 36.7% of total retail claims;
Total, 94.2% of all claims.
Mail Order - Brand, 61.9% of total mail order claims;
Generic, 38.1% of total mail order claims;
Total, 5.8% of all claims.
Name Brand Prescriptions, 79.2% of all claims.
Generic Prescriptions, 20.8% of all claims.

Specialty Drugs

Distribution by claims number volume, 0.85% of all claims;
Distribution by Ingredient Cost, 45.1% of all claims.

2. **Days Supply**
The audited period was reviewed for claims that exceed the Day Supply maximum levels as per the PEBP PPO benefit plan. The claim detail reports were audited for retail claims that exceeded 30 day supply and mail order claims that exceeded 90 day supply that did not reflect a Prior Authorization or a maintenance drug prescription.

HCA Findings: The audit detected no exceptions within all categories.

3. **Administration Fees**
The audit reviewed the administration fees billed to PEBP for claim processing services during the audited period as compared with the PEBP Agreement. Per Agreement, PEBP will pay an administrative fee of $x.xx per employee per month (PEPM) for the period of PEBP's Plan Year 2018.

HCA Findings: Calculations for each month reflect that the correct method of "each employee" was applied at the agreed to PEPM value. PEBP paid a total of $xx.xx with an average of xx.x member fees per month. The report received reflected the PEPM Administrative Fee for the month of July 2017 combined with August 2018 and billed on 15 August 2018.

The audit reviewed the fees billed to PEBP for appeal services during the audited period as compared with the PEBP Agreement. Per Agreement, PEBP will pay a fee of $xx.xx for initial Administrative level one appeals and initial determinations.

HCA Findings: xxx level two appeal services were provided to PEBP for a total fee of $xx.xx for the audited period. HCA determined that these charges are in compliance with the Agreement.

The audit reviewed the fees billed to PEBP for AUM services during the audited period as compared with the PEBP Agreement.

HCA Findings: The audit reflects that PEBP paid a fee of $xx.xx PEPM for the PEBP Plan Year 2018 period for a total fee paid of $xx.xx.

4. **Drug Utilization Review**
This audit and previous audits have detected claims with extensive utilization (dispensing in every month of the audited period or excessive multiple prescriptions within the same time period) with scheduled drugs. HCA was supplied protocols and cases with said drugs where case management and the appropriate interventions were found to be applied and utilized.

HCA also previously requested documentation regarding sample cases in which the patients are utilizing drugs in which step therapy or alternate over the counter drugs should be used before prescriptions of said drugs are to be charged to the RX plan. Review of these reports reflects that ESI was found to have the correct system edits in place and properly reviewed each case for Drug Utilization Review and possible case management.

5. Possible Drug Benefit Exceptions

The audit revealed drugs paid within claims of the audited period, which could be considered exclusions of the PEBP PPO benefit plan. These possible drug exclusions should be verified by PEBP. Drugs audited for exclusions included but were not limited to: Fertility Agents (injectable and oral), sexual dysfunction (quantity greater than allowed), self injectables, diagnostic/biologicals, blood products, growth hormones without PA, hemophiliac factors, immunization, OTC, nutritional supplements, anorexiants, cosmetic, hair growth/replacement, infertility, and investigational drugs. ESI provided a report reflecting the following drugs dispensed through the PEBP benefit plan as permitted, however, they should be presented to PEBP for verification of possible exceptions that could be considered outside the PEBP benefits:

-Adapalene, over age 26 to age 59 without Prior authorization (cosmetic);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Adapalene during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Botox, over age 26 to age 67 without Prior authorization (cosmetic);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Botox during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Minocycline, over age 26 to age 50 without Prior Authorization, (cosmetic);
ESI Response: Claims are correct. Per Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset, a step therapy rule applies for oral Tetracycline. Please note this rule applies to brand drugs only. In addition, per the step therapy supplemental file included in Attachment R, the drug in question is a 1st line generic alternative. A prior authorization is not required for the drug in question.

-Tetracycline, over age 26 to age 64 without Prior Authorization, (cosmetic);
ESI Response: Claims are correct. Per Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset, a step therapy rule applies for oral Tetracycline. Please note this rule applies to brand drugs only. In addition, per the step therapy supplemental file included in Attachment R, the drug in question is a 1st line generic alternative. A prior authorization is not required for the drug in question.

-Tazorac, over age 26 to age 38 without Prior Authorization, (cosmetic);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Tazorac during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Tazarotene, over age 26 to age 52 without Prior Authorization, (cosmetic);
ESI response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Tazarotene during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Minoxidil, without a Prior Authorization, (hair);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Minoxidil during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Viagra, quantity over 8 per month without Prior Authorization, (impotence);
ESI Response: Claims are correct. Per Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset, select erectile dysfunctional drugs are to be dispensed at a max quantity of 8 units in 30 days or 24 units in 90 days. As the claims in question adjudicated for less than or equal to a quantity of 24 in a rolling 90 days, the quantity limit rule was not exceeded and a prior authorization was not required.

-Phentermine, without Prior Authorization, (weight loss);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Phentermine during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Diethylpropion, without Prior Authorization, (weight loss);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Diethylpropion during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Xenial, without Prior Authorization, (weight loss);
ESI Response: Claims are correct. ESI notes Nevada PEBP did not elect to exclude or require a Prior Authorization for Xenial during the audit period. The drug in question is not included in Attachment R - BIT Report with Clinical Rules and Detail Tab provided to HCA during the audit onset. A prior authorization is not required for the drug in question.

-Estradiol Valerate, without a Prior Authorization, (hormone therapy).
ESI Response: Claim is correct. ESI notes the Nevada PEBP is set up with a Quantity duration rule TWICE-WEEKLY ESTRADIOL PATCHES TO BE DISP AT MAX OF 8 PATCHES IN 21 DAYS OR 24 PATCHES IN 63 DAYS and was not effective until 11/17/17. ESI also notes the date of service for the claim in question was 10/17/17.

HCA supplied a file containing samples of possible drug benefit exception claims for each of the drug as described above for ESI research and response. These sample claims can be found within file: St.NV.PEBP.RX.Possible Drug Exceptions.PY2018.ENCRYPTED.

REPORT DETAILS

I. SYSTEM CAPABILITIES

A. Drug Utilization Review (DUR)

ESI has the capability for the pharmacist to utilize a screen indicating specific patient information regarding known allergies and/or possible drug reactions. ESI Clinical Personnel will conduct a retroactive DUR review if necessary.

ESI does generate reports to determine prescribing and dispensing patterns for patients and pharmacies. ESI currently does not provide Current DUR Savings or Retrospective DUR reports monthly for PEBP; however, the ESI clinical pharmacist does provide physicians with reporting to encourage increased generic and formulary prescribing.

B. Diagnosis Sensitive Prescription Drugs.

The ESI system does not currently have the capability to edit specific prescriptions by comparing the diagnosis with other clinical data to determine appropriate dispensing.
HCA Recommendation: ESI should explore the capability of obtaining patient diagnosis information for certain medications to evaluate appropriate dispensing.
ESI Response: ESI Account Team has proposed, and Nevada PEBP is considering, RationalMed. Through this program, ESI would onboard medical data and diagnosis codes to our system. ESI would then use that data to help drive decisions through clinical rules as well as run the RationalMed program which is a health and safety program that reviews where there may be a disease indication and medication conflict. This data would also be available for ESI Therapeutic Resource Pharmacists to review when they are filling prescriptions for Nevada PEBP members or having counseling conversations with members.

C. Adverse/Potential Chemical Reaction.

The ESI system will edit if the prescriptions being dispensed would have an adverse reaction or potential chemical reaction when taken together.

D. Duplicate Claim Submissions.

The system edits for duplicate claims submitted either on-line or by paper. Three types of duplicate edits exist on the ESI system. These edits are for a True Ingredient Duplicate, which is when both claims have the exact same NDC number, a Therapeutic Duplicate and a "Refill Too Soon" Duplicate.

The ESI system will edit when multiple drugs are prescribed which would have the same therapeutic effect and if similar prescriptions are received from multiple providers concurrently.

E. Frequency/Dosage.

The ESI system will edit if a prescription is purchased prior to the time the original drug dispensed will be depleted (refill too soon). This edit is client specific. For PEBP participants, this edit will not allow the refill until seventy five percent (75%) of the retail prescription and sixty five percent (65%) of the dispensed mail order prescription usage time has expired.

The system is capable to edit if a prescription being dispensed indicates long term usage for a drug that is normally prescribed on a short term basis. The system is capable and will edit for failure to refill a prescription at the appropriate time.

F. Federal Legend Drug Requirement.

The system will edit to assure that the Federal Legend Drug Requirement is met utilizing the NDC (National Drug Code) number.

G. Appropriate Drugs.

The ESI system does contain edits to assure that drugs prescribed are appropriate for a patient's age or gender.

The ESI system does edit for prescriptions that may cause harm during pregnancy or lactation.

Drugs with possible uses for possible cosmetic or experimental conditions which are not allowed under the PEBP PPO benefit plan are flagged and denied or researched before payment is made.

H. Correct Pricing.

ESI utilizes automated pricing to assure that the charge is appropriate for the drug being billed.

I. Formulary Alternatives and Generic Substitution.

Currently, the ESI system does edit at the time of sale to show a formulary alternative or a generic substitution.

J. Ineligible Prescriptions.

ESI systematically denies specific types of drugs that the client advises them are ineligible by utilizing NDC and GPI, third party exception codes and Route of Administration.

K. Suspended Physician.

The ESI system has the capability for denial of a claim when a drug is prescribed by a physician with a suspended or restricted license.

L. Case Management and Subrogation.

ESI does have the ability to edit or identify prescriptions that may require Third Party Liability (Subrogation). These edits will be used only if the TPA contacts ESI to advise them of a subrogation situation.

ESI edits all prescriptions to identify drugs utilized for potential Case Management intervention. This information is communicated during a monthly meeting with Case Management personnel.

ESI was found to have the correct system edits in place and properly reviewed each case for Drug Utilization Review and possible case management.

II. CLAIM PROCESSING AND PROCEDURES

A. Electronic Claims Submission.

ESI currently does have a program which has the capability to receive electronic requests for prescriptions from physicians. ESI relies mostly on communications by, e-prescribing, forms, fax and sometimes E-Mail currently.

B. Overpayment Procedures.

If an overpayment is detected, ESI will subtract overpayments from future payments and credit the client when utilizing the retail and mail order programs.

C. Turnaround Time for Client Billing.

ESI remits payment to pharmacies on a weekly basis. ESI will provide PEBP with invoices for retail and home delivery drugs on a xxxx time basis.

D. Pended Claim Procedures.

Claims are not pended for additional information; claims are denied and processed when complete information is obtained.

E. Compound Drug Reimbursement.

ESI stated reimbursement for compound drugs is calculated using submitted price of the main ingredient for the compound. Compound drugs over xxxx xxxx dollars filled at retail and xxxx xxxx dollars filled through the mail order program require prior authorization.

F. Paper Claim Reimbursement.

Per ESI each client has the option of how paper claims are reimbursed. Under the PEBP agreement, employees are reimbursed at the contracted amount less applicable copayments and/or coinsurance for in network paper claims submitted.

The PEBP plan is currently set-up to reimburse participants at the contracted amount less applicable copayments and/or coinsurance for in network and out of network paper claims.

Per agreement, ESI charges $xx.xx for each paper claim processed.

G. Mail Order Program.

The mail order program is integrated with the retail drug program. The system does not have the capability to pay the difference between the retail and mail order pricing when the mail order program is not utilized. This is pertinent for those plans which require subsequent refilled prescriptions be filled through the mail order program.

H. Filing Limitation.

The ESI system utilizes a filing limitation of 12 months for paper claims and thirty (30) days for pharmacies to resubmit a claim.

I. Specialty Drugs/Home Infusion

Many home infusion billings are adjudicated through the medical claims paying system. ESI has a wholly-owned subsidiaries, Accredo and CuraScript SP Pharmacy which are utilized for specialty drugs. These companies provide specialty pharmacy and related services for patients with certain complex and chronic health conditions. The focus of the specialty pharmacy is on infused, injectable, and oral drugs that:

- Are used recurrently to treat chronic and life-threatening diseases
- Are expensive
- Are difficult to administer
- May cause adverse reactions
- Require temperature control or other specialized handling
- May have restrictions as determined by the FDA

Accredo locations have been continuously accredited by The Joint Commission Home Care Accreditation Program since 2003. Beginning in 2011, Accredo pursued and received URAC Specialty Pharmacy Accreditation. The major Accredo locations in Warrendale PA, Corona CA, Greensboro NC, Orlando FL, Indianapolis IN, Memphis and Nashville TN are currently accredited by URAC.

III. ELIGIBILITY

Eligibility files are maintained on-line at ESI. Communication of eligibility for PEBP participants to ESI is determined by the eligibility listing received daily from PEBP. This includes changes, additions, terminations, dependent eligibility, and disabled dependent status. Eligibility information is loaded onto the ESI system within 24 hours of receipt. PEBP does have the option to have access to ESI's system so that manual eligibility can be entered; however, ESI stated that they have declined this option.

The ESI system has the ability to handle multiple eligibility periods for its members. Claims are processed by date of service to assure accurate processing without regard of benefit or eligibility changes. A pharmacist cannot add or change eligibility information.

The ID card is currently issued by PEBP's third party administrator, HealthSCOPE Benefits.

ESI relies on the information from PEBP to edit for an overage dependent. The ESI system shows dependents as either covered or not covered. ESI can provide claims data for participants who have terminated retrospectively.

ESI does have the capability for card to card COB determination through the RX system. ESI stated that currently PEBP is not using this feature.

ESI will deny any claim for Subrogation if they are notified of such by the TPA.

ESI is not specifically notified of PEBP participants who elect benefits under COBRA rulings under the eligibility file from the TPA. These elected participants are included as active within the regular eligibility listing.

IV. CUSTOMER SERVICE

A. Customer Service Availability

ESI Customer Service Representatives are available seven (7) days a week. In addition, an ESI Registered Pharmacist is available for questions twenty-four (24) hours a day, seven (7) days a week. The telephone number for ESI is included on all prescriptions cards issued to the employees.

Benefit and specific client information is documented on-line. Telephone conversations are recorded. Customer Services Representatives are not able to make claim adjustments. Representatives are audited by phone monitoring and quality control.

Per the contract for services, the telephone response time is to be an average of xxxx seconds (x:xx) or less. HCA obtained the data for this issue and found the aggregate average telephone response time to be in compliance with the guarantee for PEBP plan year 2018.

Per the contract for services, the telephone abandonment rate is to be less than xxxx percent (xx%) of all calls. HCA obtained the data for this issue and finds that the abandonment telephone rate ranged from xx.x% to xx.x% for each quarter year measurement and found to be within the annual guarantee level.

B. Network Pharmacy Availability

Per the contract for services, xx% of PEBP PPO Plan Participants must have a network pharmacy within five (5) miles of their residence. HCA requested a report that reflects this issue percentage and in response, received the Accessibility Summary Report from ESI. This report reflected that xx.x% of PEBP participants had at least one (1) Network Pharmacy within 5 miles of their residence.

C. Customer Satisfaction Report

Per Agreement, an annual Program Satisfaction Survey is to be conducted of PEBP plan participants who have used the pharmacy benefit. xxxx percent (xx%) or more of participants must provide a "satisfactory" level of services they received or a penalty can be assessed.

Per the Customer Satisfaction Survey results received from ESI, ESI did not meet the guaranteed metric measurement of xx% satisfied members surveyed. ESI supplied a report that displayed the results of the survey scorecard experienced by PEBP members to be at xx% for overall satisfaction during the audited period.

V. QUALITY ASSURANCE AND INTERNAL AUDITS/TRAINING

A. Quality Assurance Programs

Quality Assurance Programs exist for Benefit Administration, Eligibility and Pharmacy Services. Each department has its own procedures, checks and standards.

B. Internal Audit for Fraudulent/Abuse Claims

ESI does conduct internal audits for possible fraudulent drug abuse related claims. ESI issues monthly reports which display potential risk claims and presents them to a committee of Registered Nurses and Doctors for determination of possible action.

C. On-site/ Internal Desk Audit of Vendors.

ESI does perform on-site auditing of vendors. ESI audited xx.x% of the pharmacies that submitted at least 250 claims, onsite and desk, for the time period 7/1/17-6/30/18.

D. Appropriate Care.

The ESI claims system edits for appropriate diagnosis, age and gender as well as edits on quantity and dollar limits. If ESI receives a complaint from a participant regarding the quality of service provided by a pharmacy, the ESI Provider Relations Department will contact the pharmacy/pharmacist for immediate resolution.

E. Employee Self-Audit.

ESI does not send EOB letters with a listing of prescriptions to PEBP participants in order to perform a self-audit. PEBP participants are able to view their EOB through the ESI website for self-audits.

F. Preapproval Programs.

ESI offers a preapproval program to predetermine appropriateness and medical necessity of specific prescription drugs.

G. Disease Management Programs.

ESI does offer Patient Care Management Programs to patients, physicians and pharmacists in the areas of Diabetic, etc.

H. Physician Assistance.

Pre-certification is generally provided by ESI Clinical Pharmacists. ESI's Medical Director is also available to assist as necessary.

ESI does have educational programs for physicians and pharmacists for potential drug substitutions.

I. Participant Assistance.

ESI does offer educational materials to PEBP participants with chronic diagnosis(es) through the Disease Management program. ESI stated that PEBP groups allow them to disseminate information regarding the Diabetes Sense program, but does not have any mandatory programs in place.

ESI does notify associates when a mail order prescription is shipped and filled with a name brand drug that a generic drug is available.

J. Internal Audit/Training.

ESI does have an Internal Audit Department. Newly hired ESI employees are required to complete a formal training program. The duration of the training varies by the department employing the new hire. Additional/continued training needs are identified by internal audits, Quality Assurance or a customer/client complaint.

VI. SECURITY ACCESS

Security logs are created and monitored by ESI. Passwords are utilized by ESI employees and client personnel and must be updated. Client can access on line eligibility via internet.

VII. REPORT CAPABILITIES

A. Possible Fraud and Drug Abuse.

ESI does have the capability to provide possible fraud and drug abuse reports by pharmacy and physician.

B. Percentage of Generic Drugs Dispensed.

ESI provides monthly reports to PEBP groups that will allow them to monitor the percentage of generic drugs dispensed.

C. Formulary Alternatives.

ESI has the capability to produce detailed reports regarding the percentage of brand name prescriptions filled with a formulary alternative. ESI stated that they currently provide Formulary Utilization Reports for PEBP groups at no additional cost.

D. Stop-Loss Accumulators.

ESI can communicate information to the TPA of stop-loss (if or when it may be appropriate) on a monthly basis. Since PEBP does not include stop-loss coverage this process is not required.

E. Prescribing Patterns of Individual Physicians.

ESI does have the capability to produce reports detailing prescribing patterns of physicians.

F. Large Numbers of Prescriptions per Patient.

ESI does have the capability to provide information to PEBP regarding participants who incur a large number of prescription claims.

G. Current and Retrospective Drug Utilization Review.

ESI does not generate reports to determine prescribing and dispensing patterns for patients and pharmacies. ESI currently does not provide Current DUR Savings or Retrospective DUR reports monthly for PEBP groups.

ESI's clinical pharmacist meets with the top prescribing physicians to provide benchmarking and encourages increased generic dispensing as well as use of OTC products.

ESI does provide retrospective DUR services. These services include:

- Therapeutic Duplication Review of same therapeutic class used concomitantly.
- Drug-Drug Interactions Review of drugs including any new drug interactions identified through review of clinical trials or warnings released by the FDA.
- High Prescription Utilization Review of all covered individuals.
- ESI reviews claims that are over a set dollar amount dispensed through retail and mail pharmacies.
- Narcotic/Controlled Substance Overutilization/Abuse Review of covered individuals who are utilizing multiple controlled substances and multiple physicians/pharmacies.
- Concurrent evaluations of medications with a potential for overuse.

H. Benefit Description Report

ESI has a summary plan description for each individual client. PEBP's summary plan description is utilized to adjudicate claims per the PEBP PPO benefit plan.

VIII. SAVINGS

A. Average savings from Average Wholesale Price (AWP).

A contract was obtained between ESI and PEBP as sponsor which reflects the discount available to PEBP groups when using the Prescription Benefit Manager (PBM) program for name brand and generic drugs dispensed at retail and the discount available when utilizing the mail order program. The agreement relevant to the name brand discounting for this audited period was to be calculated and reported in post lawsuit effect Average Wholesale Pricing (AWP) values. HCA's audit conformed that name brand prescriptions, both retail and mail order are in compliance with terms negotiated within the agreement.

Savings percentages were calculated excluding the dispensing fee and any administrative cost.

The discount rates were audited against the following criteria for PEBP as described within the Prescription Drug Program Services Agreement Attachment (Negotiated Items) and supplied to HCA:

Drug Type	Discount	Disp. Fee
Retail Name Brand 1-83 days	AWP–xx.x%	$x.xx
Retail Name Brand 84-90 days	AWP – xx.x%	$x.xx
Retail Generics	Lower of MAC, U & C, NON-MAC, SS AWP – xx.x%	$x.xx 1 – 83 days $x.xx 84 – 90 days
Mail Order Name Brand	AWP-xx.x%	$x.xx
Mail Order Generics	AWP-xx.x%	$x.xx
ESI Pharmacy Specialty Drugs	AWP – xx.x%	$x.xx

B. Usual/Reasonable versus Discount Price.

Pharmacies enter the Usual/Reasonable amount and the discounted price for each prescription into their computer database. These amounts are systematically compared and the lower amount is paid. To assure ESI that their clients will pay the lowest cost available, the retail amounts submitted by the pharmacies are audited for accuracy.

C. Generic Pricing and Carrier Ability to Encourage Generic Prescriptions.

Typically, the copayments contained in a benefit plan encourage participants to utilize generic drugs. The application of these copayments (when applicable) is systematic. ESI does have the capability to entice the retailer to fill prescriptions with a generic drug by contracting reimbursement of higher dispensing fees. Retail pharmacists will receive an edit if a generic equivalent is available.

ESI does have capability to charge the member the difference between the cost of the brand and generic drug if a prescription is filled with a brand name drug solely at the patient's request (DAW 2).

In other words, if a generic equivalent for a prescribed brand name drug is available (multisource) but the patient request the brand name drug, the member pays the difference of the generic allowable and the brand name allowable rate.

ESI will reimburse the retailer the cost of the generic equivalent when a prescription is filled with the brand name drug due to the pharmacists choosing to dispense the brand name drug (DAW3). Provider contract does dictate reimbursement utilized for a DAW 3; however, ESI will reimburse the pharmacy at the generic pricing in this situation.

ESI will reimburse the retailer the cost of the generic equivalent when a prescription is filled with the brand name drug if a pharmacy is utilizing a (DAW 4) generic not in stock. The pharmacy is reimbursed at the generic pricing in this situation.

When the mail order program is utilized, the prescription is always filled with the generic equivalent unless prohibited by law.

ESI offers educational programs for physicians, pharmacists and patients for potential substitution of brand name with generic drugs.

D. Formulary Alternative

This section is for review of the ESI formulary program. When a generic drug is not available, there may be more than one (1) brand name drug to treat a condition.

Formulary programs provide a list of recommended brand name drugs for physicians and pharmacists to utilize when prescribing and dispensing medications. It is an alternative tool for controlling rising drug costs while maintaining patient care.

The brand name drugs listed are a preferred list of drugs that have been selected based on their ability to meet a patient's needs at a lower cost. The Formulary maintained by ESI contains xx% of generic drugs and xxx single source brand drugs. Lists of these drugs are printed and distributed yearly and are available for review via the internet.

The Formulary Committee is composed of clinical pharmacists and a Clinical Director and the Review Committee is composed of physicians and Pharm Ds. Formulary medications are selected based on safety, efficiency, therapeutic merit, current standard of practice and cost. Changes are made as deemed necessary to remain responsive to the needs of patients and clients. Formulary educational materials are sent to physicians, pharmacies and patients.

ESI does have the capability to apply an employee rebate program for those employees who switch and utilize alternate drugs.

IX. COPAYMENTS

A. Copayments

HCA was supplied Benefit Summary for PEBP. The following copayments were - reflected in these summaries. The annual medical deductible does apply to dispensed prescription drug claims and is coordinated with the PEBP Medical Third Party Administrator.

- **In-network Retail:**
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Brand Non-Preferred –Not covered - 100% Copay

- **Mail Order**
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Brand Non-Preferred –Not covered - 100% Copay
  Out-of-network Provider – Not covered

- **Specialty Medications**
  Name Brand and Generic – 20% Co-Insurance after Deductible
  Out-of-network Provider – Not covered

The audit detected no copayment exceptions within the categories of Retail Name Brand, Retail Generics, Mail Order Name Brand and Mail Order Generics.

4.4.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

   - 4.4.1 Hometown Health Case/Utilization Management report
   - 4.4.2 HealthSCOPE Obesity Care Management Program enrollment & utilization
   - 4.4.3 The Standard Basic Life and Long Term Disability data & performance report
   - 4.4.4 The Standard Voluntary Life and Short Term Disability data & performance report
   - 4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

4.4.1.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

      4.4.1 Hometown Health Case/Utilization Management report

Hometown Health

Quarterly Update for CDHP PPO PLAN Q2 FY 2019 (10/01/2018 - 12/31/2018)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q2 2019, 645 clients were identified through prior authorization and referral processes for screening by staff. Of those, 118 members met preliminary criteria for enrollment into the Case Management (CM) program and 91 accepted, representing 77.1% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 10/01/2018 to12/31/2018	645	118	91	77.1%
Previous Quarters 07/01/2018 to 09/30/2018	696	91	64	70.3%
Screened Plan Year 2019 07/01/2018 to 12/31/2018	1341	209	155	74.2%

For the current quarter, of the 645 clients screened:

- 502 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 91 cases were actually managed in the post-discharge setting.

- 118 members met preliminary criteria for enrollment into CM. 91 members elected to participate in the CM program. 27 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 91 new cases, 143 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 234 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $800,731 for the second quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the second quarter of Plan Year 2019, 645 unique members were screened for possible case management intervention. Of the 645, 118 members met preliminary criteria for enrollment into CM and 91members (77.1%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 10/01/2018 to 12/31/2018	Year to Date 7/1/2018 to 12/31/2018
CM Trigger List	645	1341
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**645**	**1341**

Case Type – Summary Report

	Quarterly 10/01/2018 to 12/31/2018					Year to Date 07/01/2018 to 12/31/2018				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	10	26	16		**52**	18	54	52		**124**
LCM	66	98	48		**212**	116	189	119		**424**
BH/CHEM	13	5	11		**29**	17	18	39		**74**
Transplant	2	14	26		**42**	4	32	99		**135**
Other										
Totals	**91**	**143**	**101**	**0**	**335**	**155**	**293**	**309**	**0**	**757**
Total Open Cases	**234**									

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases

10/01/2018 to 12/31/2018						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active			$ 202,400		$ 202,400
LCM	Active		$ 169,280			$ 169,280
LCM	Active			$ 68,600		$ 68,600
LCM	Active			$ 51,000		$ 51,000
LCM	Closed			$ 44,000		$ 44,000
LCM	Active			$ 40,600		$ 40,600
LCM	Active		$ 34,960			$ 34,960
LCM	Active			$ 28,800		$ 28,800
LCM	Active			$ 27,200		$ 27,200
LCM	Closed			$ 27,200		$ 27,200
LCM	Closed			$ 19,600		$ 19,600
LCM	Active			$ 16,000		$ 16,000
LCM	Active			$ 13,600		$ 13,600
LCM	Active			$ 9,600		$ 9,600
LCM	Active		$ 4,050	$ 4,800		$ 8,850

Case Management – Saving Detail for Open & Closed Cases (Continued)

10/01/2018 to 12/31/2018						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BHCM	Active			$ 25,200		$ 25,200
LCM	Active			$ 23,200		$ 23,200
LCM	Active			$ 8,000		$ 8,000
LCM	Active		$ 7,400			$ 7,400
LCM	Active			$ 5,550		$ 5,550
BH/CHEM	Active			$ 5,220		$ 5,220
LCM	Active			$ 4,200		$ 4,200
BH/CHEM	Active			$ 3,400		$ 3,400
LCM	Active			$ 2,800		$ 2,800
LCM	Active		$ 2,075			$ 2,075
LCM	Active			$ 396		$ 396
Quarterly Savings by Type			$217,765	$582,966		
Total Quarterly Savings Q2 2019						$800,731
Q1 + Q2 2019 Savings						$1,871,409
Year To Date ROI						$1,871,409

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the second quarter, the PEBP population was 42,957 (average monthly lives for the quarter). Second quarter data shows 502 member admissions and 474 member discharges. Discharges for the second quarter were 10.96 members per thousand lives managed. Discharges annualized were 43.80 members per thousand lives managed. Bed days for the second quarter were 67.20 members per thousand lives managed. Bed days annualized were 268.60 members per thousand lives managed. The average length of stay was 6.13 days.

Inpatient Authorization and Denials:

The data show 502 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 361 (76%), Mother and Newborn 54 (11%), Mental Health 36 (8%), NICU 8 (2%), Skilled Nursing 8 (2%), and Rehab 7 (1%) of total discharges.

Quarter/Year	General Med/Surg	Mother & Newborn	Mental Health	NICU	Skilled Nursing	Rehab
2Q 2019	361 76%	54 11%	36 8%	8 2%	8 2%	7 1%

Second quarter data shows 2 admission denials for a total of 9 denial days. Both of the 2 admit(s) with 9 day(s) were "*DENIED NOT COVERED BY PLAN* ".

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 361, with a total of 1,430 authorized days and an average LOS of 3.96 days. Bed days of 33.10 per thousand lives managed for the quarter *(annualized 132.31 per thousand),* and 8.34 members discharged per thousand of lives managed for the quarter *(annualized 33.35 per thousand).*

- **Mother & Newborn** discharges were 54, with a total of 142 authorized days and an average LOS of 2.63 days. Bed days of 3.29 per thousand lives managed for the quarter *(annualized 13.16 per thousand)* and 1.25 members were discharged per thousand lives managed for the quarter *(annualized 4.99 per thousand).*

- **Mental Health** discharges were 36, with a total of 224 authorized days and an average LOS of 6.22 days. Bed days of 5.16 per thousand lives managed for the quarter *(annualized 20.65 per thousand)* and 0.83 members were discharged per thousand lives managed for the quarter *(annualized 3.32 per thousand).*

- **Skilled Nursing** discharges were 8, with a total of 180 authorized days and an average LOS of 22.50 days. Bed days of 6.27 per thousand lives managed for the quarter *(annualized 25.05 per thousand)* and 0.28 members were discharged per thousand lives managed for the quarter *(annualized 1.11 per thousand).*

- **NICU** discharges were 8, with a total of 153 authorized days and an average LOS of 19.13 days. Bed days of 3.54 per thousand lives managed for the quarter *(annualized 14.15 per thousand)* and 0.19 members were discharged per thousand lives managed for the quarter *(annualized 0.74 per thousand).*

- **Rehab** discharges were 7, with a total of 177 authorized days and an average LOS of 25.29 days. Bed days of 4.09 per thousand lives managed for the quarter *(annualized 16.35 per thousand)* and 0.16 members were discharged per thousand lives managed for the quarter *(annualized 0.64 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
Second quarter discharges show 32.5% of the members discharged fall in the age bracket of 50-64. Overall women make-up 55.49% of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Outpatient Surgical Services, Durable Medical Equipment, Medical Office Visits, Infusion Services (equipment and supplies), Ambulatory Services, Mental health and Substance Abuse (Partial Hospital), Outpatient Mental Health Services, Medical Transportation, Dialysis Services, Wound Care Services, Outpatient Transplant Services, Prenatal Care, Home Health)***:**

Second quarter outpatient utilization consisted of 1,572 requests for services authorized. Authorizations for services are as follows: Outpatient Surgical Services composed 64.76% of total requests. Medical Office Services requests composed 15.27% of total requests. Durable Medical Equipment composed 10.24% of total requests. Infusion Services composed 3.24% and Ambulatory Services composed 2.86% of total request. The remaining requests composed 3.63% of total requests and include: Mental health and Substance Abuse (Partial Hospital), Outpatient Mental Health Services, Medical Transportation, Dialysis Services, Outpatient Rehabilitative Therapy Services, Home Health, Cardiac Rehabilitation Services, Medical Pharmaceutical, Output Substance Abuse, Outpatient Transplant Services, Prenatal Care (1.46%, 0.70%, 0.51%, 0.32%, 0.19%, 0.13%, 0.06%, 0.06%, 0.06%, and 0.06% respectively).

There were 18 outpatient requests for services denied during this quarter of FY 2019. The requests included 2 for ***Medical Office Services,*** 2 for ***Outpatient Surgical Services, and*** 1 for ***Infusion Services, Equipment & Supplies*** were denied as "Not Covered by Plan". 2 for ***Durable Medical Equipment (DME),*** 2 for ***Outpatient Surgical Services,*** 1 for ***Medical Office Services,*** 1 for ***Ambulatory Services,*** *and* 1 for ***Outpatient Mental Health Services*** were "Denied Not Medically Necessary". 2 for ***Ambulatory Services*** and 1 for ***Medical Office Services*** were denied as "Experimental Services EXC***".*** 1 for ***Medical Office Services*** was denied as "Authorization Insufficient Medical Information". Lastly 2 requests for ***Ambulatory Services*** were denied due to unknown reasons.

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018			
Average Population	**42,957**	Quarterly Discharges Per Thousand	**10.96**
Total Discharges	**474**	Quarterly Bed Days Per Thousand	**67.2**
Days Approved	**2,306**		
Total Reviews Performed			
Admissions	**474**		
Concurrent	**263**		
Retrospective	**211**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018 Admissions	Total	General Med/Surg	Mother & Newborn	Mental Health	NICU	Skilled Nusing	Rehab	
# of Discharges	474	361	54	36	8	8	7	
Quarterly Discharges per 1000	11.05	8.34	1.25	0.83	0.19	0.28	0.16	

Total Denied Denials	Surgical	Medical	Detox	Obstetrical	Rehab	Skiilled Nursing	Observation	Total
Total Number of Denied Requests	1	1	0	0	0	0	0	2
Denied, Not Medically Necessary	0	0	0	0	0	0	0	0
Denied, Not Covered by Plan	1	1	0	0	0	0	0	2
Denied, Member Exceeds Max Limits	0	0	0	0	0	0	0	0

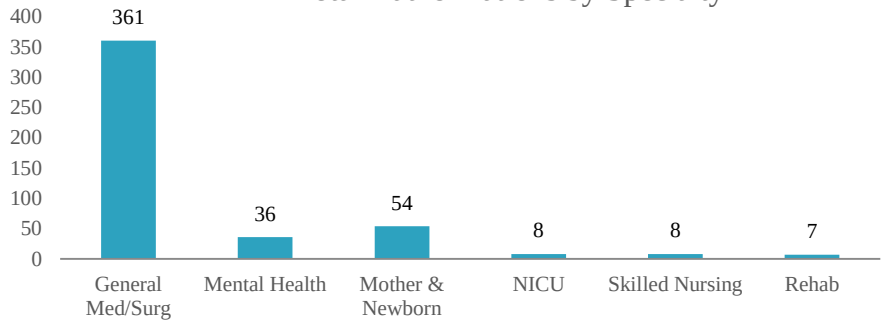
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

Inpatient Discharge Information

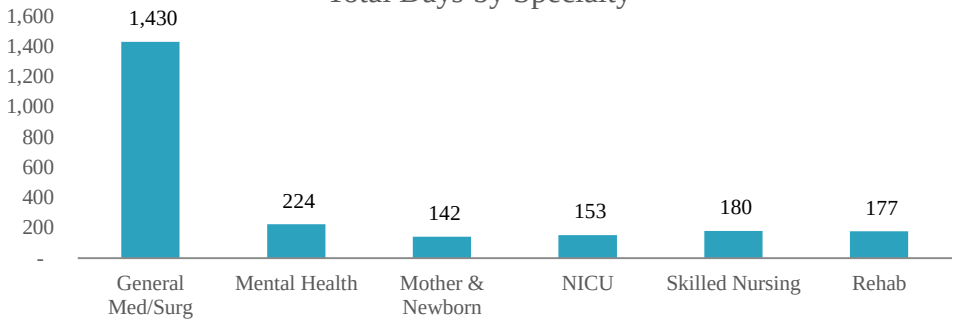
2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	361	1,430	3.96	33.10	8.34
Mother & Newborn	54	142	2.63	3.29	1.25
Mental Health	36	224	6.22	5.16	0.83
NICU	8	153	19.13	3.54	0.19
Skilled Nursing	8	180	22.50	6.27	0.28
Rehab	7	177	25.29	4.09	0.16

*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 17 through 18 of this report.

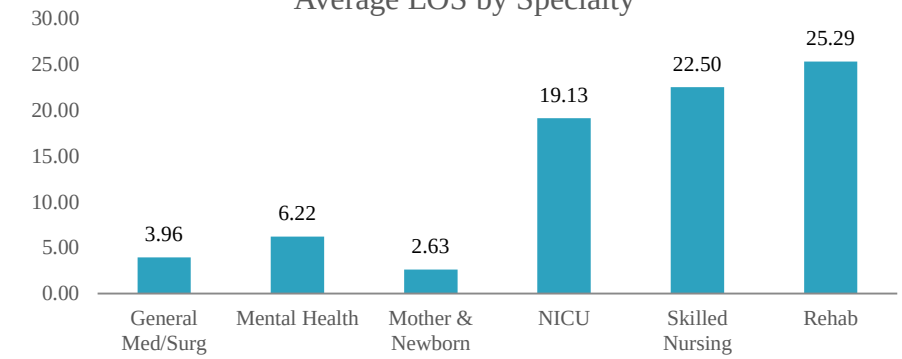
Total Authorizations by Specialty



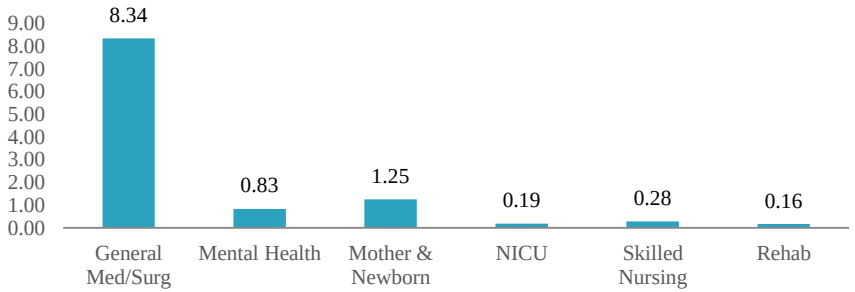
Total Days by Specialty



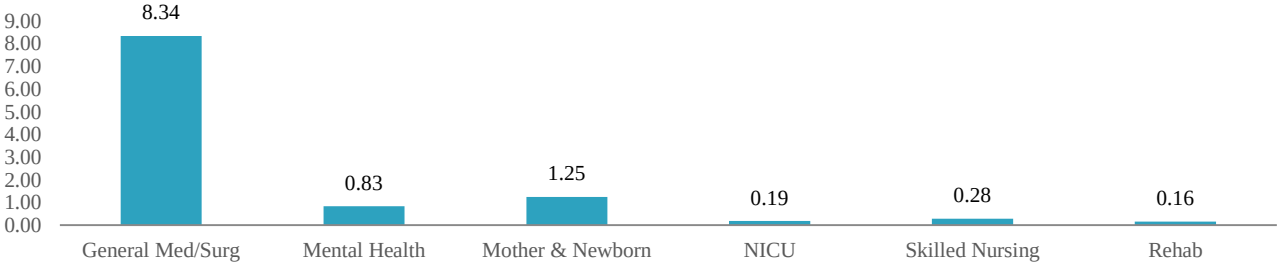
Average LOS by Specialty



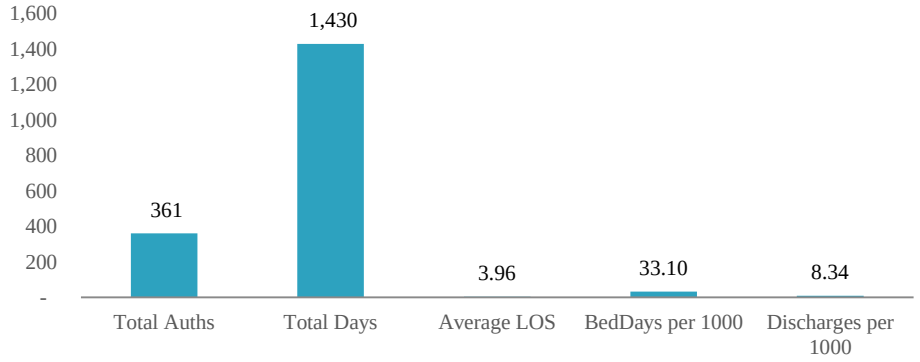
Discharges per Thousand



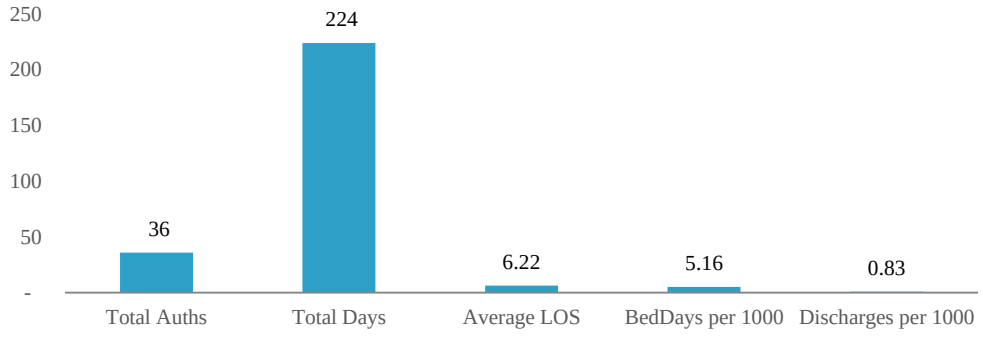
Discharges per Thousand



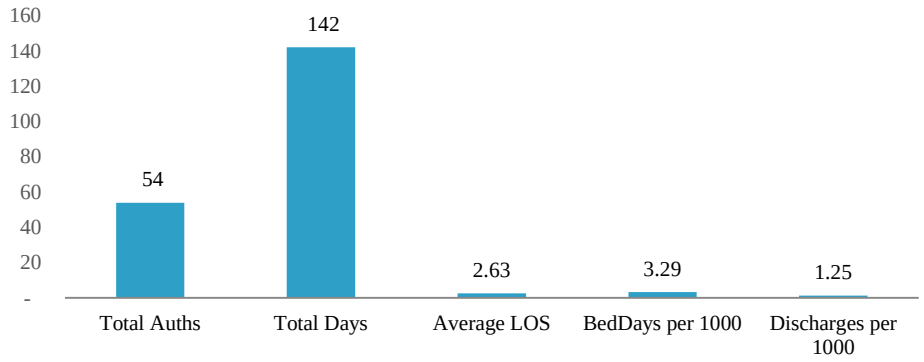
General Med/Surg



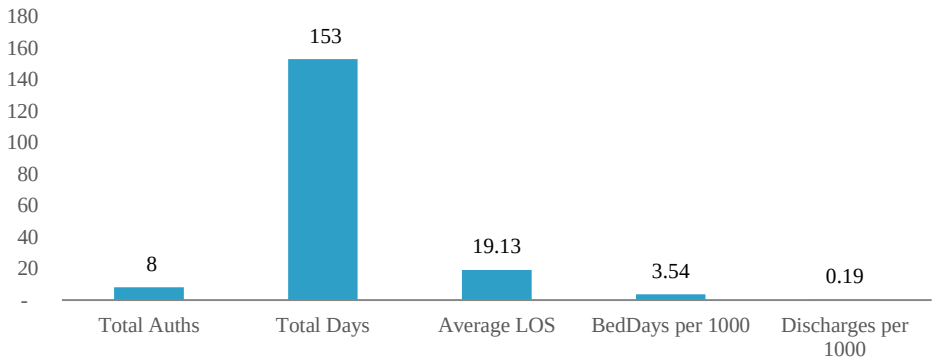
Mental Health

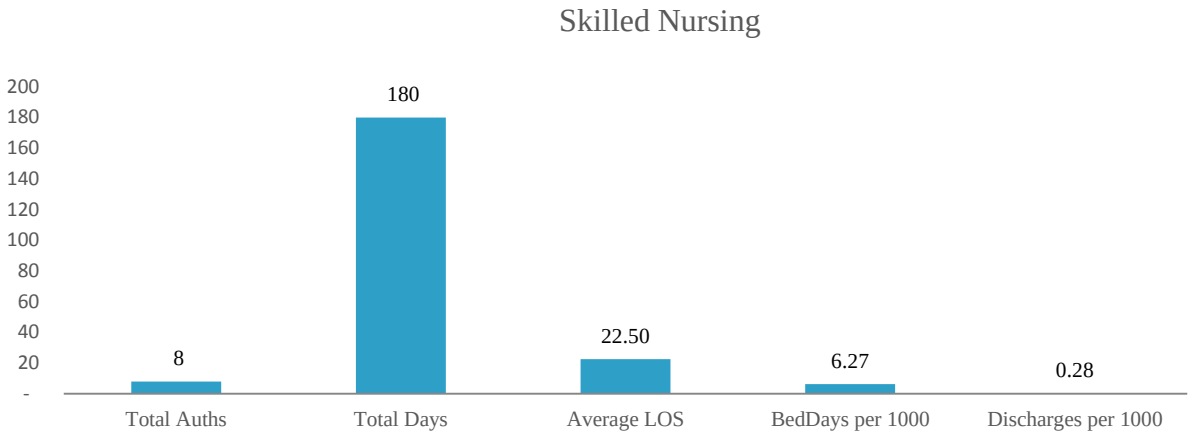


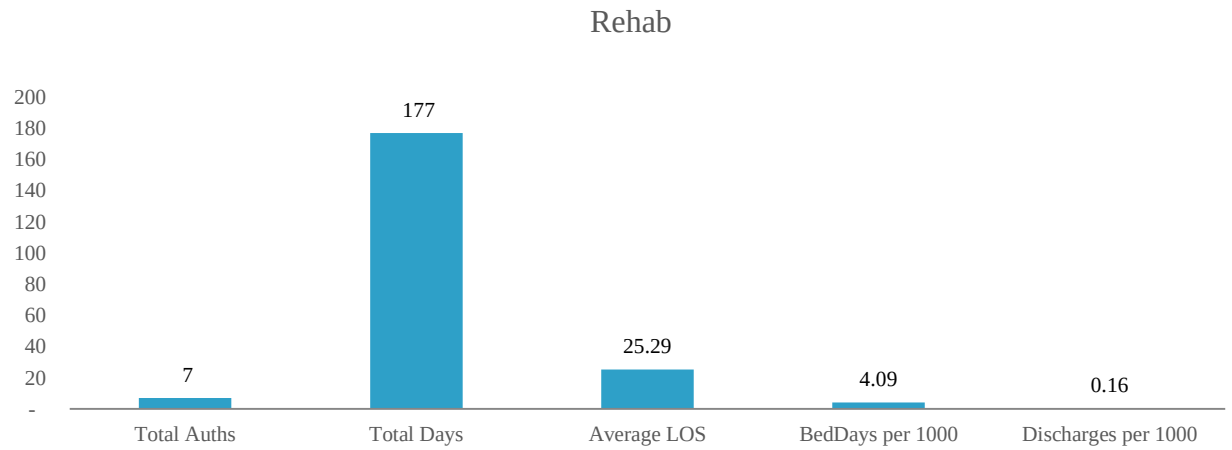
Mother & Newborn



NICU

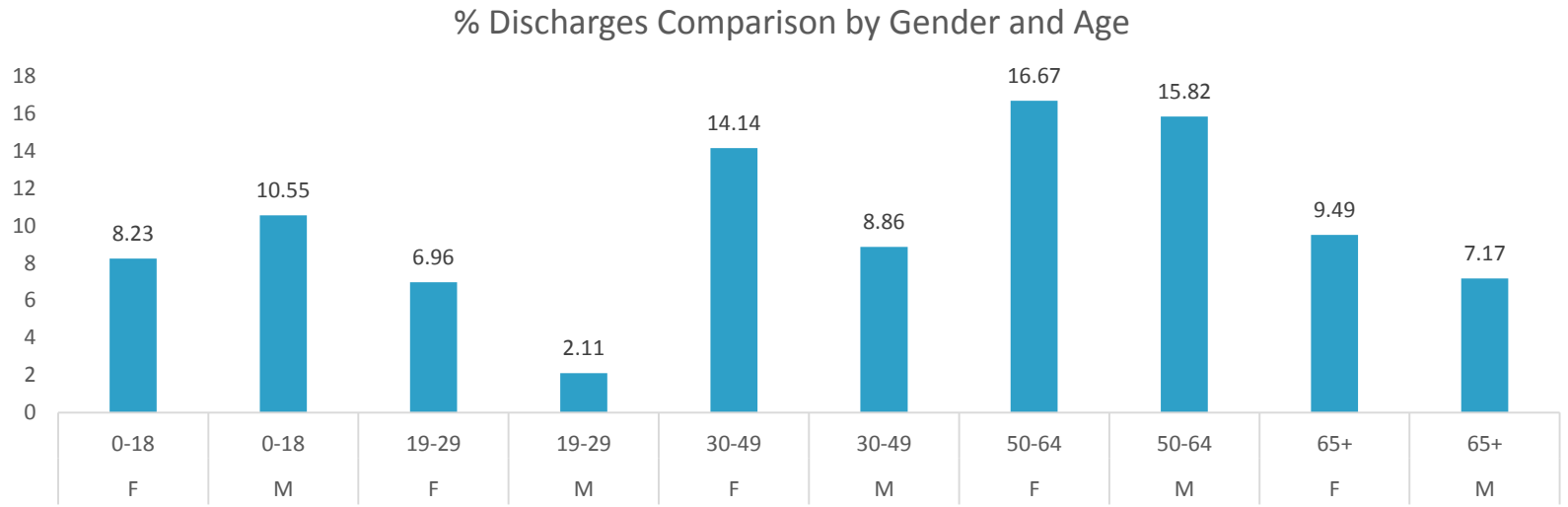



Skilled Nursing
200
180
160
140
120
100
80
60
40
20
-
8
180
22.50
6.27
0.28
Total Auths
Total Days
Average LOS
BedDays per 1000
Discharges per 1000


Rehab
200
180
160
140
120
100
80
60
40
20
-
7
177
25.29
4.09
0.16
Total Auths
Total Days
Average LOS
BedDays per 1000
Discharges per 1000

Age & Gender Distribution

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018 Age Categories	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female	39	33	67	79	45	263
Male	50	10	42	75	34	211
Total	**89**	**43**	**109**	**154**	**79**	**474**
Total (%)	**20**	**9**	**23**	**32**	**17**	**100**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018 Authorizations	
OUTPATIENT SURGICAL SERVICES	1018
MEDICAL OFFICE SERVICES	240
DURABLE MEDICAL EQUIPMENT	161
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	51
AMBULATORY SERVICES	45
MENTAL HEALTH & SUBSTANCE ABUSE PARTIAL	23
OUTPATIENT MENTAL HEALTH SERVICES	11
MEDICAL TRANSPORTATION SERVICES	8
DIALYSIS SERVICES	5
OUTPATIENT REHABILITATIVE THERAPY SERVICES	3
HOME HEALTH SERVICES	2
CARDIAC REHABILITATION SERVICES	1
MEDICAL PHARMACEUTICAL SERVICES	1
OUTPATIENT SUBSTANCE ABUSE SERVICES	1
OUTPATIENT TRANSPLANT SERVICES	1
PRENATAL CARE SERVICES	1
Totals	**1572**

Denials	Ambulatory Services	Outpatient	Medical Office Services	Infusion Services, Equipment & Supplies	DME	Prenatal Care	Mental Health & Substance Abuse	Total
Denied, Not Medically Necessary	1	2	1	0	2	0	1	7
Denied, Not Covered by Plan	0	2	2	1	0	0	0	5
Denied Authorization Insufficient Medical Information	0	0	1	0	0	0	0	1
NULL	2	0	0	0	0	0	0	2
Denied Experimental SVCS EXC	2	0	1	0	0	0	0	3
Total Number of Denied Requests	**1**	**4**	**4**	**1**	**2**	**0**	**1**	**18**

Appendix A

Medical Discharges by Facility and Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
ADVANCED HEALTH CAREOF RENO	1	24	SNF	24.00
AKUA BEHAVIORAL HEALTH	1	6	Mental Health	6.00
ALEXIAN BROTHERS BEHAVIOR HEALTH HO	1	6	Mental Health	6.00
ANSON GENERAL HOSPITAL	1	2	Acute	2.00
BANNER BAYWOOD MEDICAL CENTER	1	3	Acute	3.00
BANNER CHURCHILL COMMUNITY HOSPITAL	1	3	Acute	3.00
BORGESS MEDICAL CENTER	1	17	Mental Health	17.00
CAREMERIDIAN-CARMENBLVD	1	11	SNF	11.00
CARSON TAHOE BEHAVIORAL HLTH SVCS	1	3	Acute	3.00
CARSON TAHOE BEHAVIORAL HLTH SVCS	2	11	Mental Health	5.50
CARSON TAHOE REGIONAL MEDICAL CTR	44	129	Acute	2.93
CARSON TAHOE REGIONAL MEDICAL CTR	2	12	Mental Health	6.00
CARSON TAHOE SIERRASURGERY	4	6	Acute	1.50
CARSON VALLEY MEDICAL CENTER	2	2	Acute	1.00
CENTENNIAL HILLS HOSPITAL MED CTR	21	66	Acute	3.14
CONSULATE HEALTH CARE OF VERO BEACH	1	52	SNF	52.00
CONTINUECARE HOSP OFCARSON TAHOE	1	21	Acute	21.00
DESERT PARKWAY BEHAVIORAL HEALTH	1	1	Acute	1.00
DESERT PARKWAY BEHAVIORAL HEALTH	4	31	Mental Health	7.75
DESERT SPRINGS HOSPITAL	5	37	Acute	7.40
DIAMOND HOUSE DETOX	2	14	Mental Health	7.00
DIGNITY ST ROSE CRAIG RANCH	1	3	Acute	3.00
DIXIE REGIONAL MED CENTER	6	82	Acute	13.67
ENCINO HOSPITAL MEDICAL CTR	1	5	Mental Health	5.00
ENCOMPASS HEALTH REHAB HOSP OF LV	1	20	Rehab	20.00
GROVER C DILS MEDICAL CENTER	2	11	Acute	5.50
GROVER C DILS MEDICAL CENTER	1	23	SNF	23.00
HARMONY RIDGE RECOVERY	1	8	Mental Health	8.00
HARTFORD HOSPITAL	1	34	Acute	34.00
HENDERSON HOSPITAL	8	15	Acute	1.88
HIGHLAND MANOR OF ELKO	1	40	SNF	40.00
KINDRED HOSPITAL LASVEGAS FLAMINGO	1	45	SNF	45.00
LEGACY EMANUEL HOSPITAL PHYS	1	18	Rehab	18.00
LIFE CARE CENTER OFRENO	1	12	SNF	12.00

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
LUTHERAN MEDICAL CENTER	1	3	Acute	3.00
MAYO CLINIC HOSPITAL	1	8	Acute	8.00
MERCY MEDICAL CENTERREDDING	1	1	Acute	1.00
MOUNTAIN VIEW HOSPITAL	20	86	Acute	4.30
NORTH HAWAII COMM HOSPITAL	1	5	Acute	5.00
NORTH VISTA HOSPITAL	1	1	Acute	1.00
NORTHEASTERN NEV R/H	7	16	Acute	2.29
NORTHERN NV MEDICAL	3	9	Acute	3.00
OREGON HEALTH SCIENCES UNIV	1	3	Acute	3.00
PALOMAR MEDICAL CENTER	1	3	Acute	3.00
RENO BEHAVIORAL HEALTHCARE HOSP	3	12	Mental Health	4.00
RENOWN REGIONAL MEDICAL CENTER	117	425	Acute	3.63
RENOWN REHAB HOSPITAL	1	34	Rehab	34.00
RENOWN SOUTH MEADOWS	12	37	Acute	3.08
RONALD REAGAN UCLA MEDICAL CENTER	1	14	Acute	14.00
ROSEWOOD REHABILITATION CENTER	1	29	SNF	29.00
SEVEN HILLS BEHAVIORAL INSTITUTE	3	17	Mental Health	5.67
SHRINERS HOSPITALS FOR CHILDREN	1	1	Acute	1.00
SOUTHERN HILLS HOSPITAL	6	15	Acute	2.50
SPRING MOUNTAIN TREATMENT CENTER	9	52	Mental Health	5.78
SPRING VALLEY HOSPITAL MEDICAL CTR	6	19	Acute	3.17
SPRING VALLEY HOSPITAL MEDICAL CTR	1	5	Mental Health	5.00
ST JOHN'S HOSPITAL AND HEALTH CENTE	1	1	Acute	1.00
ST JOSEPH MEDICALCENTER	1	8	Acute	8.00
ST LUKES HOSPITAL	1	2	Acute	2.00
ST MARYS REGIONAL MED CTR	4	30	Acute	7.50
ST ROSE DOMINICAN HOSPITAL - DELIMA	1	9	Acute	9.00
ST ROSE DOMINICAN SAN MARTIN CAMPUS	9	19	Acute	2.11
ST ROSE DOMINICAN SIENA	31	112	Acute	3.61
STANFORD MEDICAL CENTER	5	17	Acute	3.40
SUMMERLIN HOSPITAL MEDICAL CENTER	34	155	Acute	4.56
SUMMERLIN HOSPITAL MEDICAL CENTER	2	27	Rehab	13.50
SUNRISE HOSPITAL & MEDICAL CTR	13	37	Acute	2.85

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
SUNRISE HOSPITAL & MEDICAL CTR	2	44	Rehab	22.00
THE DESERT HOPE TREATMENT CENTER	2	9	Mental Health	4.50
TUCSON MEDICAL CENTER	1	8	Acute	8.00
U OF U HOSPITAL CLINICS	8	31	Acute	3.88
U OF U HOSPITAL CLINICS	1	6	Mental Health	6.00
U OF U HUNTSMAN CANCER INSTITUTE	1	3	Acute	3.00
UC DAVIS MEDICAL CENTER	1	1	Acute	1.00
UNIVERSITY MEDICAL CENTER-LV	12	74	Acute	6.17
UTMD ANDERSON CANCERCENTER	1	9	Acute	9.00
VA SIERRA NV HEALTH	2	6	Acute	3.00
VA SOUTHERN NEVADA	1	3	Acute	3.00
VALLEY HOSPITAL MEDICAL CENTER	7	14	Acute	2.00
VALLEY VIEW HOSPITAL	1	1	Acute	1.00
VIRGINIA MASON MEDICAL CENTER	1	1	Acute	1.00
WEST HILLS HOSPITAL-NV	2	13	Mental Health	6.50
WEST VALLEY MEDICALCENTER	1	5	Acute	5.00
WILLIAM BEE RIRIE HOSPITAL	5	7	Acute	1.40
WILLIAMSON MEDICAL CENTER	1	3	Acute	3.00

Performance Standards & Guarantees – Self Reported

2nd Quarter Plan Year 2019 10/01/2018 – 12/31/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's Fourth party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's First party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

Hometown Health

Quarterly Update for PREMIER EPO PLAN Q2 FY 2019 (10/01/2018 - 12/31/2018)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q2 2019, 209 clients were identified through prior authorization and referral processes for screening by staff. Of those, 55 members met preliminary criteria for enrollment into the Case Management (CM) program and 49 accepted, representing 89.1% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 10/01/2018 to 12/31/2018	209	55	49	89.1%
Previous Quarters 7/01/2018 to 9/30/2018	222	54	39	72.2%
Screened Plan Year 2019 07/01/2018 to 12/31/2019	431	109	88	80.7%

For the current quarter, of the 209 clients screened:

- 169 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 49 cases were actually managed in the post-discharge setting.

- 55 members met preliminary criteria for enrollment into CM. 49 members elected to participate in the CM program. 6 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 49 new cases, 28 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 77 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $244,610 for the second quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the second quarter of Plan Year 2019, 209 unique members were screened for possible case management intervention. Of the 209, 55 members met preliminary criteria for enrollment into CM and 49 members (89.1%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 09/01/2018 to 12/31/2018	Year to Date 7/1/2018 to 09/30/2018
CM Trigger List	209	431
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**209**	**431**

Case Type – Summary Report

	Quarterly 09/01/2018 to 12/31/2018					Year to Date 07/01/2018 to 12/31/2018				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	4	8	4		**16**	12	16	4		**32**
LCM	35	11	19	0	**65**	61	72	19	17	**169**
BH/CHEM	9	6	3		**18**	11	8	3		**22**
Transplant	1	3	9		**13**	4	4	9		**17**
Other										
Totals	**49**	**28**	**35**	**0**	**112**	**88**	**100**	**35**	**17**	**240**
Total Open Cases	**77**									

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases

09/01/2018 to 12/31/2018						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active		$ 83,040			$ 83,040
LCM	Active		$ 28,350	$ 12,600		$ 40,950
LCM	Active		$ 28,350	$ 11,200		$ 39,550
LCM	Active		$ 37,000			$ 37,000
LCM	Active		$ 33,300			$ 33,300
LCM	Active		$ 6,800			$ 6,800
BH/CHEM	Active		$ 2,970			$ 2,970
BH/CHEM	Active		$ 1,000			$ 1,000
Quarterly Savings by Type			$220,810	$23,800		
Total Quarterly Savings Q2 2019						$244,610
Q1 + Q2 2018 Savings						$322,550
Year To Date ROI						$322,550

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the second quarter, the PEBP population was 8,544 (average monthly lives for the quarter). second quarter data shows 169 member admissions and 162 member discharges. Discharges for the second quarter were 18.80 members per thousand lives managed. Discharges annualized were 75.15 members per thousand lives managed. Bed days for the second quarter were 92.78 members per thousand lives managed. Bed days annualized were 370.86 members per thousand lives managed. The average length of stay was 4.99 days.

Inpatient Authorization and Denials:

The data show 169 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 118 (72.84%), Mother and Newborn 20 (12.35%), Mental Health 13 (8.02%), Skilled Nursing 5 (3.09%), NICU 3 (1.85%), and Rehab 3 (1.85%) of total discharges.

Quarter/Year	General Med/Surg	Mother & Newborn	Mental Health	Skilled Nursing	NICU	Rehab
2Q 2019	118 72.84%	20 12.35%	13 8.02%	5 3.09%	3 1.85%	3 1.85%

second quarter data shows 7 admission denials for a total of 72 denial days. 4 admit(s) with 56 day(s) were "*DENIED SERVICE OUT OF PLAN* ", 3 admit with 16 day was *"DENIED NOT COVERED BY PLAN".*

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 118, with a total of 482 authorized days and an average LOS of 4.08 days. Bed days of 55.92 per thousand lives managed for the quarter *(annualized 223.52 per thousand)*, and 13.70 members discharged per thousand of lives managed for the quarter *(annualized 54.77 per thousand).*

- **Mother & Newborn** discharges were 20, with a total of 44 authorized days and an average LOS of 2.20 days. Bed days of 5.09 per thousand lives managed for the quarter *(annualized 20.35 per thousand)* and 2.32 members were discharged per thousand lives managed for the quarter *(annualized 9.26 per thousand).*

- **Mental Health** discharges were 13, with a total of 87 authorized days and an average LOS of 6.69 days. Bed days of 10.07 per thousand lives managed for the quarter *(annualized 40.25 per thousand)* and 1.51 members were discharged per thousand lives managed for the quarter *(annualized 6.03 per thousand).*

- **Skilled Nursing** discharges were 5, with a total of 42 authorized days and an average LOS of 8.40 days. Bed days of 4.87 per thousand lives managed for the quarter *(annualized 19.45 per thousand)* and 0.58 members were discharged per thousand lives managed for the quarter *(annualized 2.31 per thousand).*

- **NICU** discharges were 3, with a total of 56 authorized days and an average LOS of 18.67 days. Bed days of 9.94 per thousand lives managed for the quarter *(annualized 39.73 per thousand)* and 0.52 members were discharged per thousand lives managed for the quarter *(annualized 2.09 per thousand).*

- **Rehab** discharges were 3, with a total of 40 authorized days and an average LOS of 13.33 days. Bed days of 6.90 per thousand lives managed for the quarter *(annualized 27.56 per thousand)* and 0.52 members were discharged per thousand lives managed for the quarter *(annualized 2.07 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
second quarter discharges show 40.7% of the members discharged fall in the age bracket of 50-64. Overall women make-up 59.88% of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Medical Office Visits, Outpatient Surgery, Durable Medical Equipment, Ambulatory Services, Infusion, Rehabilitation, Home Health, Medical Transportation, Outpatient Mental Health, Prenatal Care, Wound Care Services, Transplant, Hospice)***:**

second quarter outpatient utilization consisted of 1,036 requests for services authorized. Authorizations for services are as follows: Medical Office Services composed 33.59% of total requests. Outpatient Surgical Services composed 29.83% of total requests. Durable Medical Equipment requests composed 25.48% of total requests. Infusion Services composed 2.61% of total requests. Home Health Services 2.32%. Outpatient Rehabilitative Therapy Services composed 2.32% of total requests. Ambulatory Services composed 1.54% of total requests. . The remaining requests composed 2.32% of total requests and include: Outpatient Mental Health Services, Medical Transportation Services, Medical Health & Substance Abuse Partial Hospital, Cardiac Rehabilitation, Hospice Services, Prenatal Care Services, Wound Care Services, Outpatient Transplant Services, and Dialysis Services (0.87%, 0.29%, 0.29%, 0.19%, 0.19%, 0.19%, 0.10%, 0.10%, and 0.10% respectively).

There were 22 outpatient requests for services denied during this quarter of FY 2019. The requests included 6 for ***Medical Office Services,*** 2 for ***Durable Medical Equipment (DME),*** and 1 for ***Ambulatory Services*** were denied as "Not Covered by Plan". 2 for ***Durable Medical Equipment (DME)*** were denied as "Denied Not Medically Necessary". 5 for ***Medical Office Services,*** 4 for ***Outpatient Surgical Services,*** 1 for ***Ambulatory Services,*** and 1 for ***Durable Medical Equipment (DME)*** were "Denied Service out of Plan".

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018			
Average Population	**8,544**	Quarterly Discharges Per Thousand	**19.15**
Total Discharges	**162**	Quarterly Bed Days Per Thousand	**92.78**
Days Approved	**751**		
Total Reviews Performed			
Admissions	**169**		
Concurrent	**110**		
Retrospective	**59**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018							
Admissions	**Total**	**General Med/Surg**	**Mother & Newborn**	**Mental Health**	**Skilled Nursing**	**NICU**	**Rehab**
# of Discharges	162	118	20	13	5	3	3
Quarterly Discharges per 1000	18.80	13.70	2.32	1.51	0.58	0.52	.52

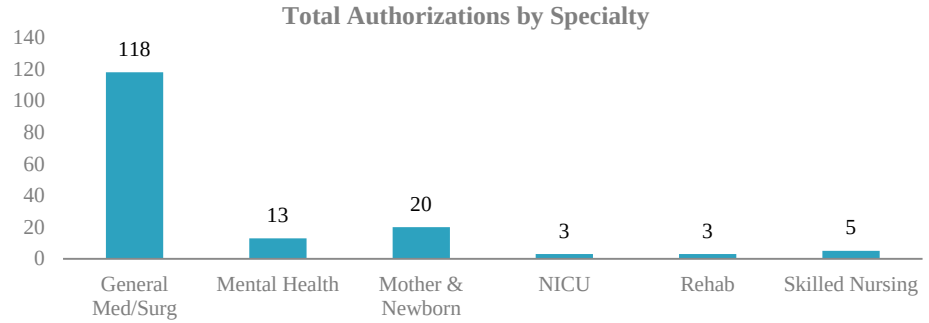
Total Denied								
Denials	**Surgical**	**Medical**	**Detox**	**Obstetrical**	**Rehab**	**Skiilled Nursing Facility**	**Observation**	**Total**
Total Number of Denied Requests	**1**	**0**	**0**	**1**	**2**	**0**	**0**	**4**
Denied, Not Medically Necessary	0	0	0	0	1	0	0	1
Denied, Not Covered by Plan	0	1	0	1	0	0	1	1
Denied, Service Out Of Plan	1	0	0	0	1	0	0	2

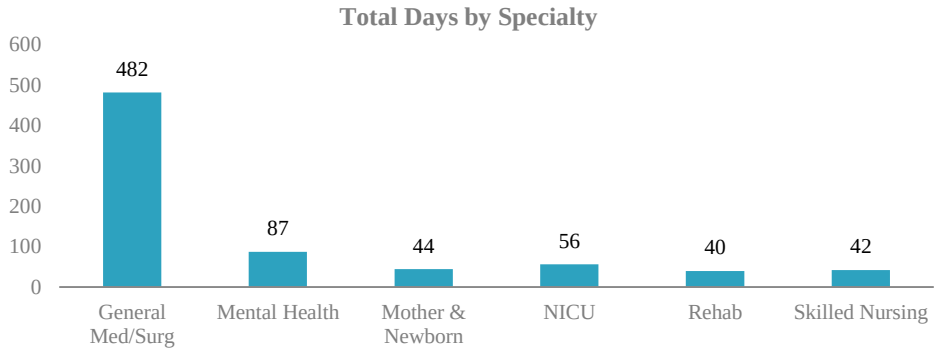
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

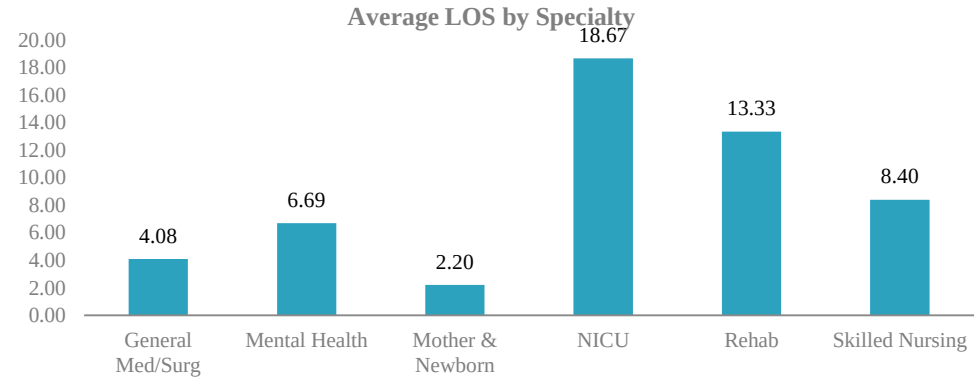
Inpatient Discharge Information

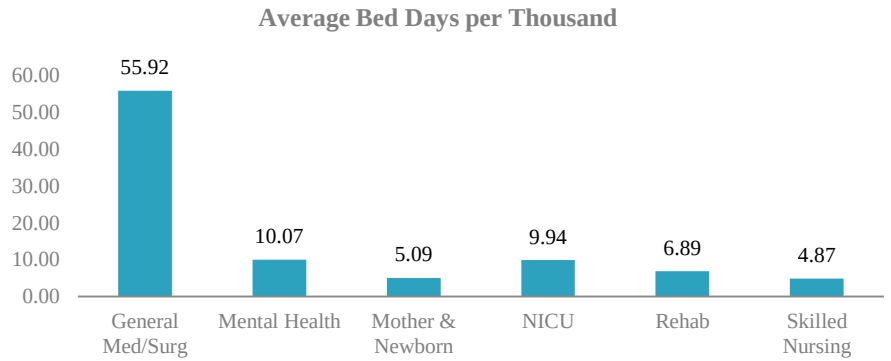
2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	118	482	4.08	55.92	13.70
Mother & Newborn	20	44	2.20	5.09	2.32
Mental Health	13	87	6.69	10.07	1.51
Skilled Nursing	5	42	8.40	4.87	0.58
NICU	3	56	18.67	9.94	0.52
Rehab	3	40	13.33	6.89	0.52
Total	**162**	**751**	**8.90**	**92.78**	**19.15**

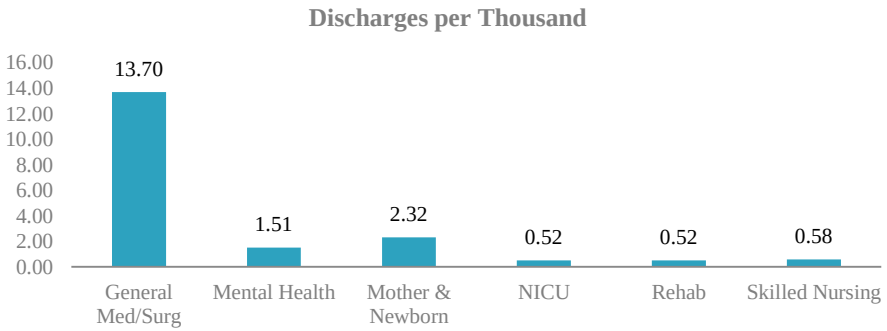
*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 17 through 18 of this report.


Total Authorizations by Specialty
140
120
100
80
60
40
20
0
118
13
20
3
3
5
General Med/Surg
Mental Health
Mother & Newborn
NICU
Rehab
Skilled Nursing

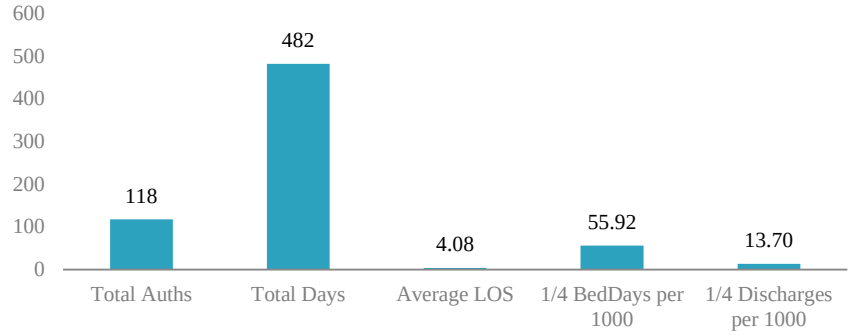

Total Days by Specialty
600
500
400
300
200
100
0
482
87
44
56
40
42
General Med/Surg
Mental Health
Mother & Newborn
NICU
Rehab
Skilled Nursing


Average LOS by Specialty
20.00
18.00
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
4.08
6.69
2.20
18.67
13.33
8.40
General Med/Surg
Mental Health
Mother & Newborn
NICU
Rehab
Skilled Nursing

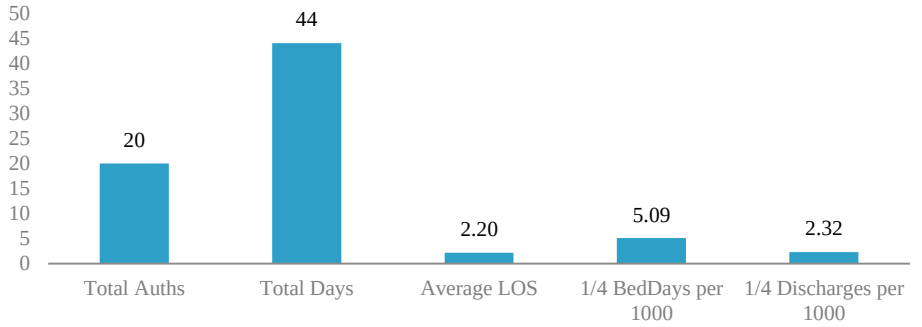

Average Bed Days per Thousand
60.00
50.00
40.00
30.00
20.00
10.00
0.00
55.92
10.07
5.09
9.94
6.89
4.87
General Med/Surg
Mental Health
Mother & Newborn
NICU
Rehab
Skilled Nursing


Discharges per Thousand
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
13.70
1.51
2.32
0.52
0.52
0.58
General Med/Surg
Mental Health
Mother & Newborn
NICU
Rehab
Skilled Nursing

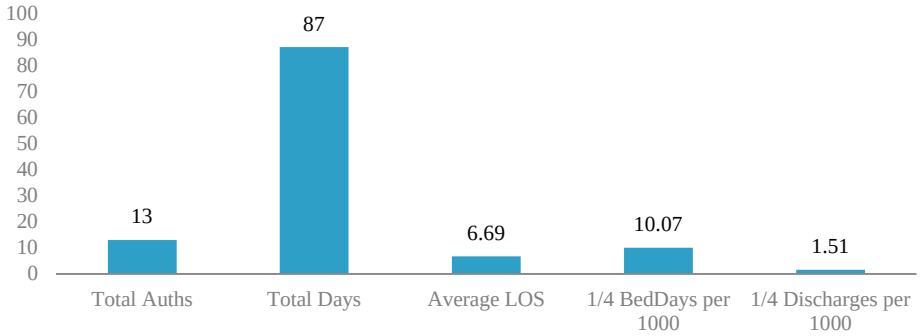
General Med/Surg



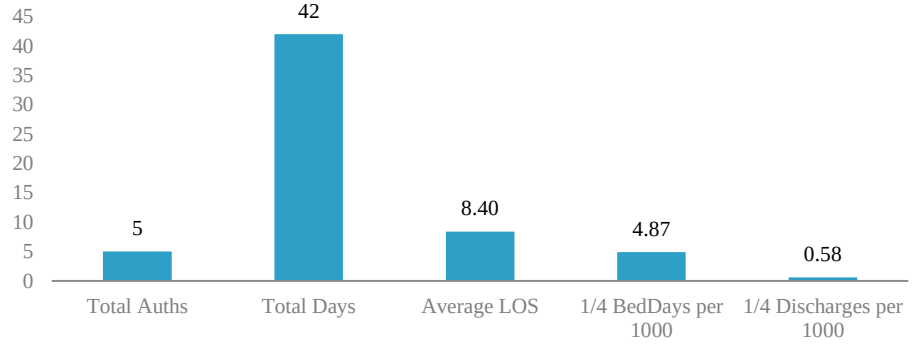
Mother & Newborn



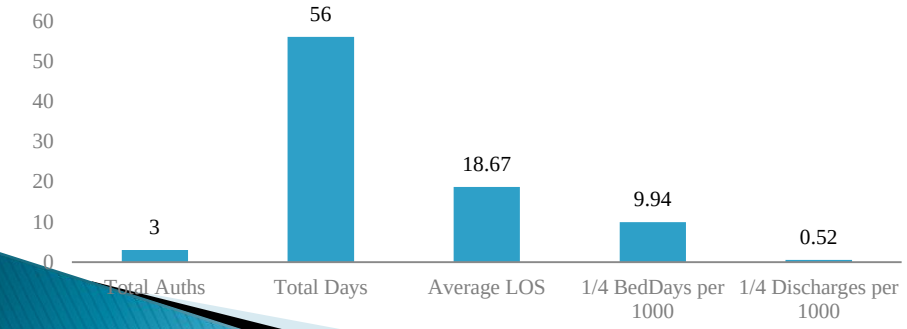
Mental Health



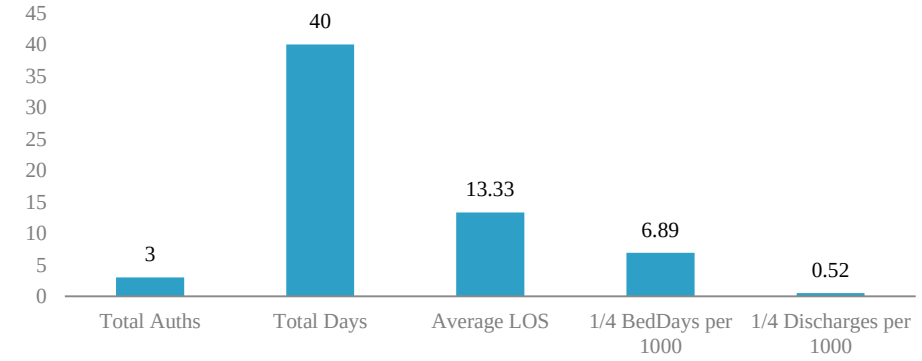
Skilled Nursing



NICU

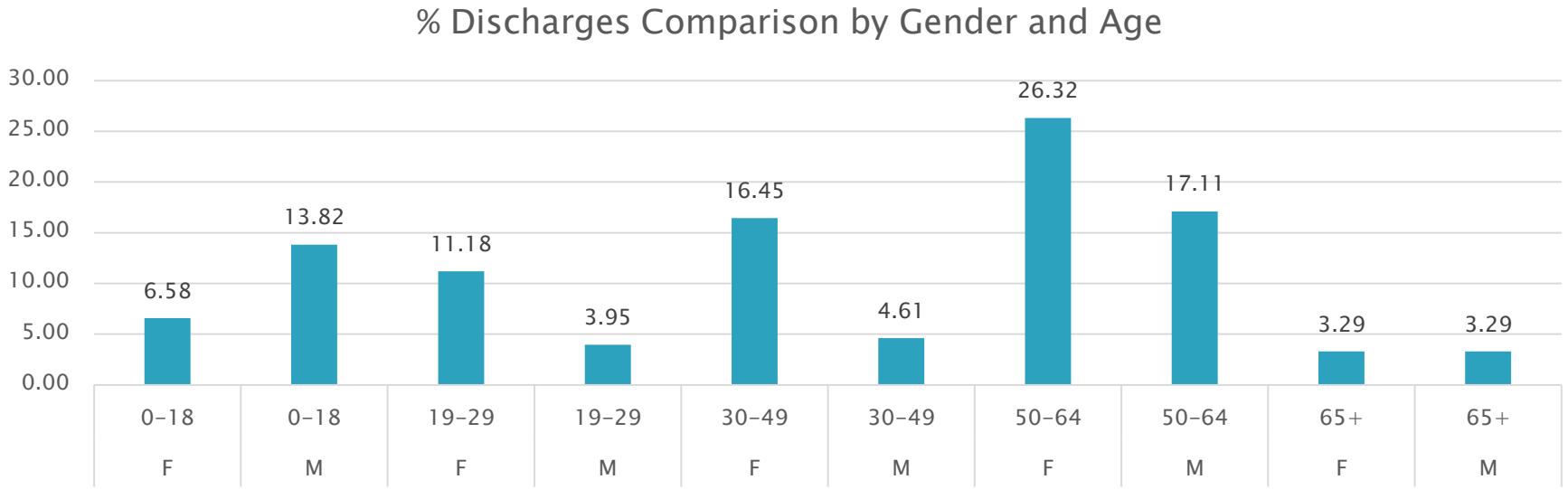


Rehab



Age & Gender Distribution

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018 Age Categories	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female	10	17	25	40	5	97
Male	21	6	7	26	5	65
Total	**31**	**23**	**32**	**66**	**10**	**162**
Total (%)	**19**	**14**	**20**	**41**	**6**	**100**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

2nd Quarter Plan Year 2019 10/01/2018 - 12/31/2018 Authorizations	
MEDICAL OFFICE SERVICES	348
OUTPATIENT SURGICAL SERVICES	309
DURABLE MEDICAL EQUIPMENT	264
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	27
HOME HEALTH SERVICES	24
OUTPATIENT REHABILITATIVE THERAPY	24
AMBULATORY SERVICES	16
OUTPATIENT MENTAL HEALTH SERVICES	9
MEDICAL TRANSPORTATION SERVICES	3
MENTAL HEALTH & SUBSTANCE ABUSE PARTIAL H	3
CARDIAC REHABILITATION SERVICES	2
HOSPICE SERVICES	2
PRENATAL CARE SERVICES	2
WOUND CARE SERVICES	1
OUTPATIENT TRANSPLANT SERVICES	1
DIALYSIS SERVICES	1
Totals	**1036**

Denials	Ambulatory	Outpatient	Medical Office	Infusion	Home Health	DME	Total
Denied, Not Medically Necessary	0	0	0	0	0	2	2
Denied, Not Covered by Plan	1	0	6	0	0	2	9
Denied Service Out Of Plan	1	4	5	0	0	1	11
Total Number of Denied Requests	**2**	**4**	**11**	**0**	**0**	**5**	**22**

Appendix A

Medical Discharges by Facility and Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
CARSON TAHOE BEHAVIORAL HLTH SVCS	6	34	Mental Health	5.666666667
CARSON TAHOE REGIONAL MEDICAL CTR	28	81	Acute	2.892857143
CARSON TAHOE REGIONAL MEDICAL CTR	1	7	Mental Health	7
CARSON TAHOE SIERRASURGERY	4	9	Acute	2.25
CARSON VALLEY MEDICAL CENTER	1	1	Acute	1
CONTINUECARE HOSP OFCARSON TAHOE	1	14	Acute	14
HUMBOLDT GENERAL HOSPITAL	1	2	Acute	2
LAKESIDE HEALTH & WELLNESS	1	2	SNF	2
LIFE CARE CENTER OFRENO	1	11	SNF	11
NORTHEASTERN NEV R/H	1	1	Acute	1
ORMSBY POST ACUTE REHAB	1	10	SNF	10
RENO BEHAVIORAL HEALTHCARE HOSP	1	5	Mental Health	5
RENOWN REGIONAL MEDICAL CENTER	86	354	Acute	4.11627907
RENOWN REHAB HOSPITAL	3	64	Rehab	21.33333333
RENOWN SOUTH MEADOWS	9	11	Acute	1.222222222
RHODE ISLAND HOSPITAL	1	1	Acute	1
SALT LAKE BEHAVIORALHEALTH	1	7	Mental Health	7
SPRING MOUNTAIN TREATMENT CENTER	1	4	Mental Health	4
STANFORD CARDIOTHORACIC SURGERY	1	3	Acute	3
STANFORD MEDICAL CENTER	3	20	Acute	6.666666667
SUNRISE HOSPITAL & MEDICAL CTR	1	18	Acute	18
UC DAVIS MEDICAL CENTER	1	1	Acute	1
UCSF MEDICAL CENTER	1	2	Acute	2
VALLEY HOSPITAL MEDICAL CENTER	1	2	Acute	2
WEST HILLS HOSPITAL-NV	3	30	Mental Health	10
WILLIAM BEE RIRIE HOSPITAL	1	4	Acute	4
WILLIAM BEE RIRIE HOSPITAL	1	8	SNF	8
WINGFIELD HILLS HEALTH & WELLNESS	1	2	SNF	2

Performance Standards & Guarantees – Self Reported

2nd Quarter Plan Year 2019 10/01/2018 – 12/31/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's Fourth party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's second party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

4.4.2.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

      4.4.2 HealthSCOPE Obesity Care Management Program enrollment & utilization

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

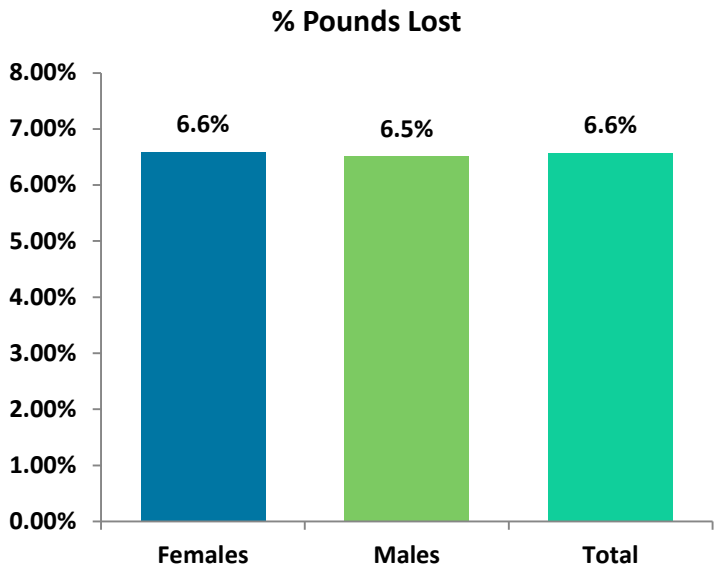
July 2018 – December 2018

HealthSCOPE BENEFITS

Obesity Care Management Overview

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

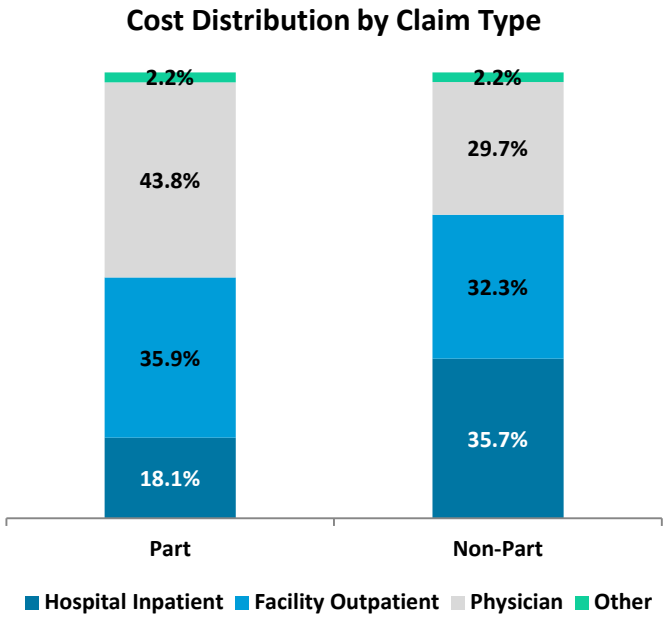
PEBP 2Q19			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	841	219	1,060
Average # Lbs. Lost	13.5	16.4	14.1
Total # Lbs. Lost	11,356.3	3,589.0	14,945.3
% Lbs. Lost	6.6%	6.5%	6.6%
Average Cost/ Member	$4,193	$4,225	$4,199



Obesity Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	932	488	90.9%
Avg # Members	1,020	663	53.8%
Member/Employee Ratio	1.1	1.4	-19.9%
Financial Summary			
Gross Cost	$3,067,828	$2,640,399	
Client Paid	$2,275,367	$2,060,789	
Employee Paid	$792,461	$579,609	
Client Paid-PEPY	$4,881	$8,440	-42.2%
Client Paid-PMPY	$4,464	$6,217	-28.2%
Client Paid-PEPM	$407	$703	-42.1%
Client Paid-PMPM	$372	$518	-28.2%
High Cost Claimants (HCC's) > $100k			
# of HCC's	1	2	
HCC's / 1,000	1.0	3.0	0.0%
Avg HCC Paid	$142,180	$323,671	0.0%
HCC's % of Plan Paid	6.3%	31.4%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$806	$2,222	-63.7%
Facility Outpatient	$1,604	$2,010	-20.2%
Physician	$1,953	$1,849	5.6%
Other	$100	$135	-25.9%
Total	$4,464	$6,217	-28.2%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	38	21	
# of Bed Days	128	191	
Paid Per Admit	$10,160	$34,686	-70.7%
Paid Per Day	$3,016	$3,814	-20.9%
Admits Per 1,000	75	63	19.0%
Days Per 1,000	251	576	-56.4%
Avg LOS	3.4	9.1	-62.6%
Physician Office			
OV Utilization per Member	9.9	7.5	32.0%
Avg Paid per OV	$77	$49	57.1%
Avg OV Paid per Member	$763	$366	108.5%
DX&L Utilization per Member	14.6	17.2	-15.1%
Avg Paid per DX&L	$60	$52	15.4%
Avg DX&L Paid per Member	$873	$893	-2.2%
Emergency Room			
# of Visits	350	231	
# of Admits	20	14	
Visits Per Member	0.69	0.70	-1.4%
Visits Per 1,000	687	697	-1.4%
Avg Paid per Visit	$845	$1,108	-23.7%
Admits Per Visit	0.06	0.06	0.0%
Urgent Care			
# of Visits	222	132	
Visits Per Member	0.44	0.4	10.0%
Visits Per 1,000	436	398	9.5%
Avg Paid per Visit	$40	$68	-41.2%
	Annualized	Annualized	

4.4.3.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

   4.4.3 The Standard Basic Life and Long Term Disability data & performance report

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
December 31, 2018

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

This is the second quarter report for the 2018-19 plan year, providing information for the period beginning July 1, 2014 and ending December 31, 2018.

Basic Life

At the half way point of the current plan year Basic Life incidence (page 4) is down year of year for active members and flat for retirees. At this time last year the overall incidence rate was 2.0 claims/1,000 lives; this year it's 1.9. The same trends apply to year loss ratios (page 5); the loss ratio for active members is down, from 24% last year to 18% this year. For retirees, the loss ratio is up, from 234% to 272%. Historically, the highest claim activity for PEBP is in the 3rd quarter of the plan year. We'll see how that impacts results.

PEBP's life claims are very consistent year over year from a diagnosis standpoint (page 4) when compared to the rest of The Standard's public sector block. Incidence and liability are higher than our block for Circulatory and Respiratory claims and lower for Cancer. We have included details regarding diagnosis codes in the report (page 10) so you can see the conditions that are in those categories.

Long Term Disability

LTD claim incidence is reported on an incurred basis, claims are charged to the plan year in which disability started. As a result, we don't have good incidence information during the first half of the plan year. At this time last year there were only three LTD claims for the plan year, a small fraction of the 26 claims that were incurred during that plan year. For the this plan year, we've only had 2 claims incurred.

LTD loss ratios are reported on a cash basis, without regard for the incurred date. At the halfway point, the loss ratio for the 2018-19 plan year is identical to the loss ratio for the 2017-18 plan year at 31%. The 31% loss ratio is lower than the five year average loss ratio of 49%.

LTD claims by diagnosis provides an interesting comparison to your Basic Life results. PEBP's LTD liability for Circulatory claims is higher than our block. However, your Cancer liability is also higher than our public block, in contrast to your life claims results. That means you have worse morbidity but better mortality for Cancer claims. The other noteworthy liability information is PEBP's significantly better results for Musculoskeletal claims when compared to our block, by almost 50%.

Basic Life Insurance Claims by Plan Year and Participant Type

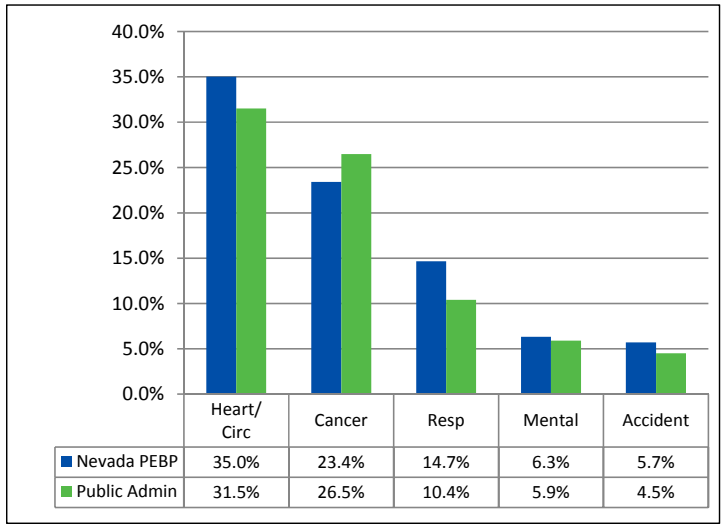
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	38	1.6	41	1.7	51	2.0	41	1.6	8	0.3
Retirees	268	19.2	270	18.3	311	20.9	282	18.6	71	4.5
Totals	**306**	**8.2**	**311**	**7.9**	**362**	**9.0**	**323**	**7.9**	**79**	**1.9**

Basic Life Insurance Claims by Diagnostic Category

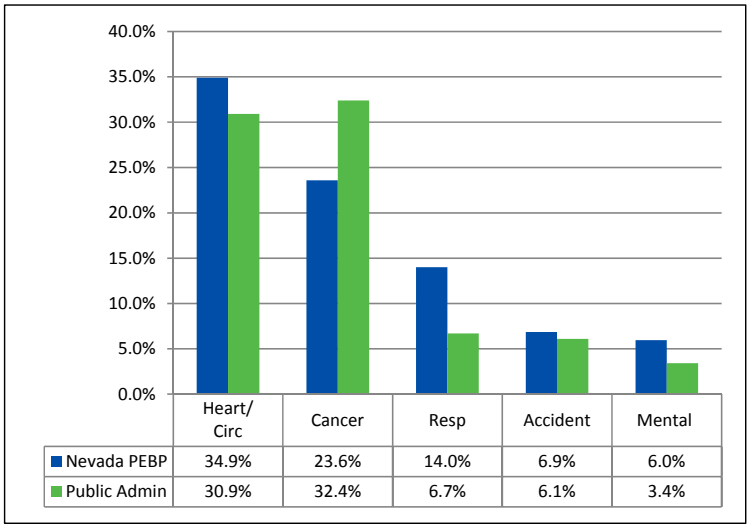
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.0%	23.4%	14.7%	6.3%	5.7%
Public Admin	31.5%	26.5%	10.4%	5.9%	4.5%

Top Five Diagnostic Categories by Liability

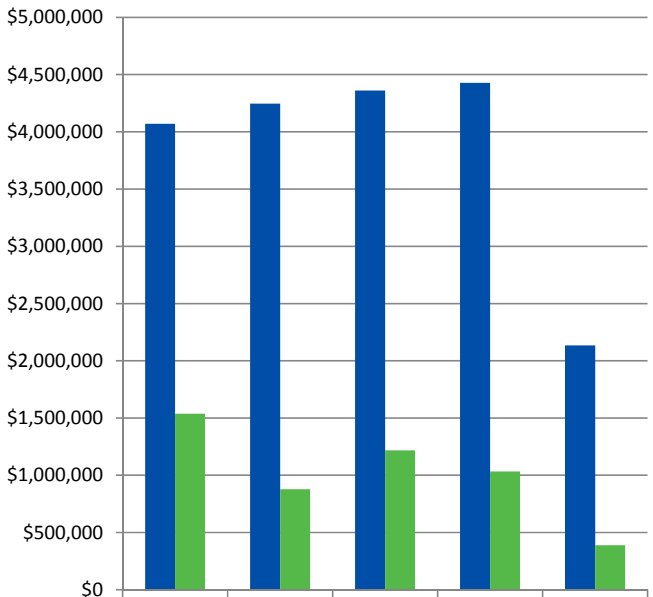


	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	34.9%	23.6%	14.0%	6.9%	6.0%
Public Admin	30.9%	32.4%	6.7%	6.1%	3.4%

Basic Life Insurance Earned Premiums & Liability by Participant Type

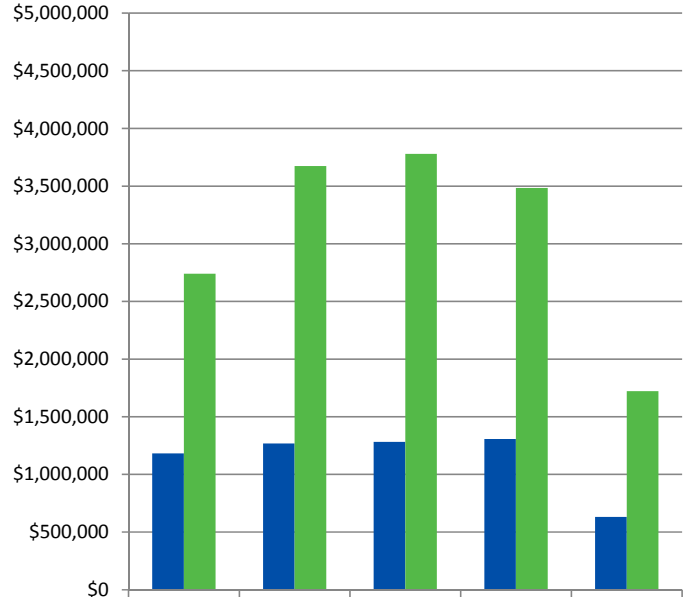
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

Active Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,069,088	$4,245,693	$4,360,152	$4,427,366	$2,134,076
Claim Liability	$1,537,010	$877,477	$1,217,375	$1,031,986	$389,367
Loss Ratio	0.38	0.21	0.28	0.23	0.18

Retired Participants

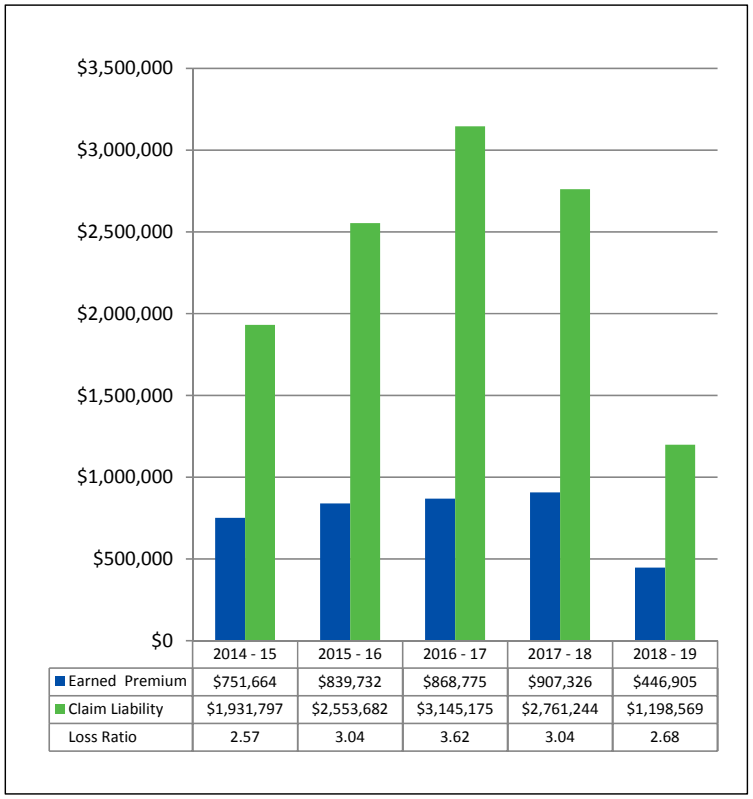


	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$1,182,171	$1,268,470	$1,282,457	$1,306,604	$631,998
Claim Liability	$2,740,269	$3,674,745	$3,779,175	$3,485,155	$1,721,741
Loss Ratio	2.32	2.90	2.95	2.67	2.72

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

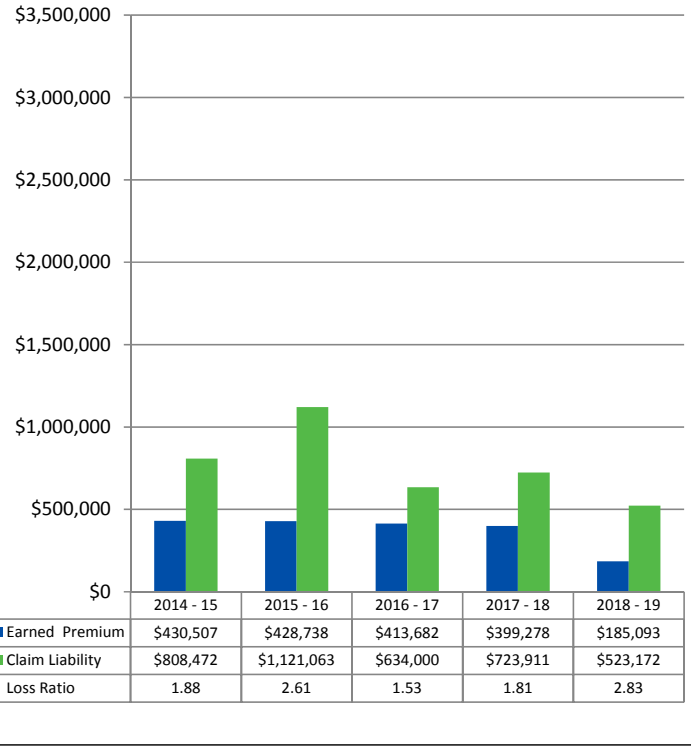
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$751,664	$839,732	$868,775	$907,326	$446,905
Claim Liability	$1,931,797	$2,553,682	$3,145,175	$2,761,244	$1,198,569
Loss Ratio	2.57	3.04	3.62	3.04	2.68

Non-State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$430,507	$428,738	$413,682	$399,278	$185,093
Claim Liability	$808,472	$1,121,063	$634,000	$723,911	$523,172
Loss Ratio	1.88	2.61	1.53	1.81	2.83

Long Term Disability Claims by Plan Year

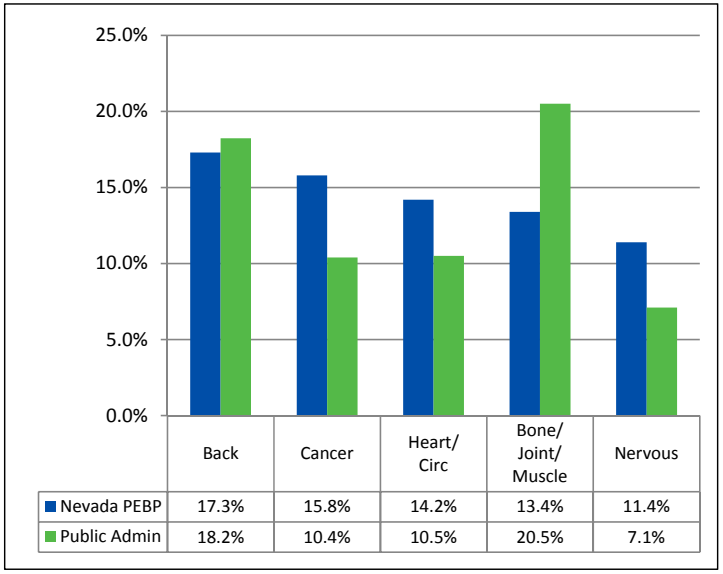
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	47	2.0	28	1.1	35	1.4	26	1.0	2	0.1

Long Term Disability Claims by Diagnostic Category

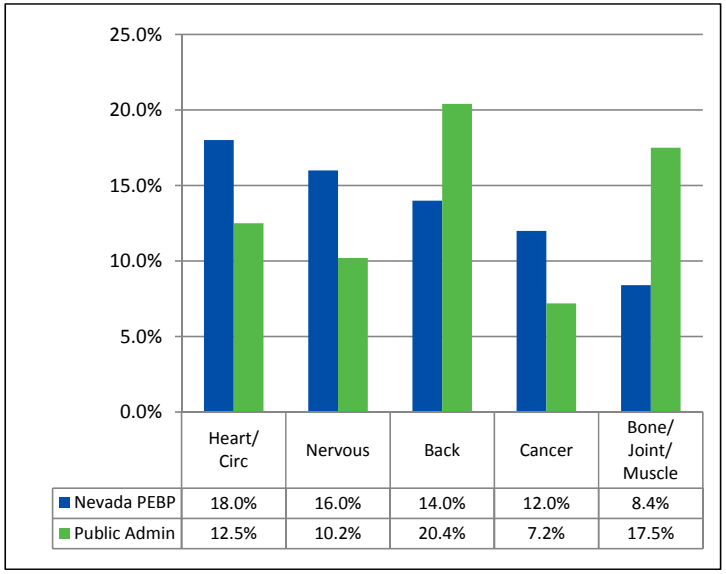
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Back	Cancer	Heart/ Circ	Bone/ Joint/ Muscle	Nervous
Nevada PEBP	17.3%	15.8%	14.2%	13.4%	11.4%
Public Admin	18.2%	10.4%	10.5%	20.5%	7.1%

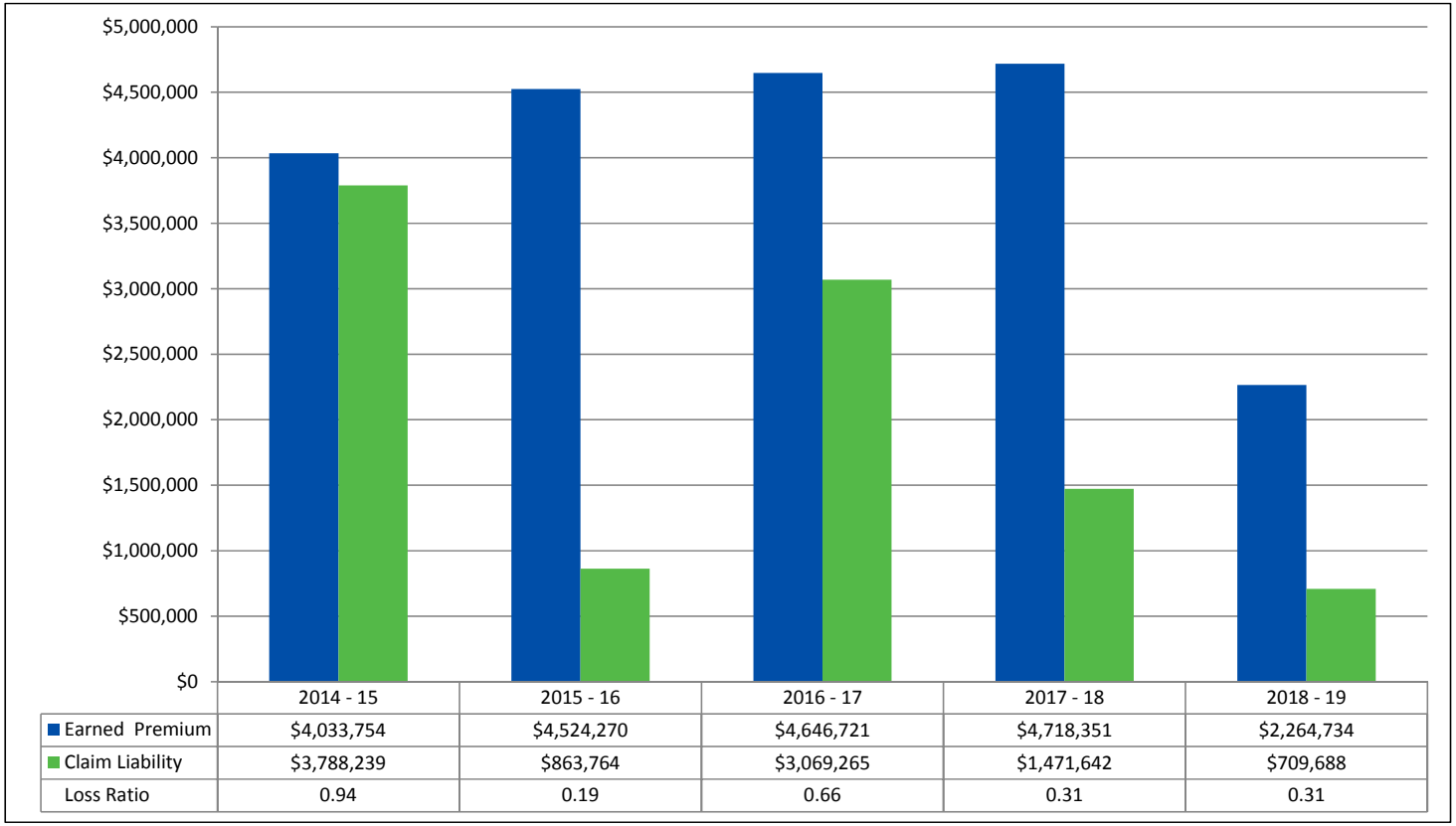
Top Five Diagnostic Categories by Liability



	Heart/ Circ	Nervous	Back	Cancer	Bone/ Joint/ Muscle
Nevada PEBP	18.0%	16.0%	14.0%	12.0%	8.4%
Public Admin	12.5%	10.2%	20.4%	7.2%	17.5%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2014 to December 31, 2018



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,033,754	$4,524,270	$4,646,721	$4,718,351	$2,264,734
Claim Liability	$3,788,239	$863,764	$3,069,265	$1,471,642	$709,688
Loss Ratio	0.94	0.19	0.66	0.31	0.31

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2018 to December 31, 2018

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	1	0	1
Long-Term Disability Claims	0	1	1	2
Short-Term Disability Claims	0	0	0	0
Total Appeals	**0**	**2**	**1**	**3**

Diagnosis Codes

Accidents and Violence
- Accident
- Amputation
- Burn
- Contusion
- Dislocation
- Fracture
- Violence
- Poisoning

Blood Diseases
- Anemia
- Graves Disease
- Other Blood Diseases

Cancer
- *All types (regardless of location)*

Circulatory
- Atherosclerosis
- Aneurysm
- Angina Pectoris
- Arteriosclerosis
- CVA (Stroke)
- Coronary Disease
- Embolism
- Endocarditis
- Heart Disease
- Hemorrhoids
- Hypertension
- Migraine Headaches
- Myocarditis
- Phlebitis
- Thrombosis
- Transient Ischemic Attack (TIA)
- Varicose Veins

Congenital Anomalies
- Anencephalus
- Spina Bifida
- Other Congenital Anomalies

Digestive
- Appendicitis
- Choloecystitis
- Chrohn's Disease
- Enteritis
- Esophageal Varices
- Gastritis
- Hiatal Hernia
- Hepatitis
- Hernia
- Peritonitis
- Ulcer, Peptic
- Ulcerative Colitis

Endocrine / Metabolic / Immunity
- Diabetes Mellitus
- Gastric Bypass Surgery
- Goiter
- Gout
- Malnutrition
- Pituitary Gland
- Thyroid

Genitourinary
- Cystitis
- Hysterectomy
- Kidney Failure
- Nephritis
- Nephrolithiasis

Genitourinary (cont.)
- Ocphoectomy
- Ovarian Cyst
- Prostate Disorders
- Pyelitis

Ill-Defined Conditions
- Chronic Fatigue Syndrome/EBV
- Coma
- Senility

Infectious / Parasitic
- AIDS
- Amebiasis
- Bacterial Food Poisoning
- Bacterial Infection
- Influenza
- Scarlet Fever
- Viral Infection

Maternity

Mental
- Anxiety
- Anorexia Nervosa
- Bi-Polar Disorder
- Depression
- Drug/Alcohol Abuse
- Post Traumatic Stress
- Psychoneurosis
- Schizophrenic Disorders
- Somatization Disorder
- Stress

Musculoskeletal / Connective
- Arthritis
- Bone Diseases
- Bursitis
- Chondromalacia
- Chronic Pain Syndrome
- Degenerative Disc Disease
- Gout
- Herniated Nucleus Pulposus
- Myalgia
- Myasthenia Gravis
- Myofascitis
- Myositis
- Osteomyelitis
- Sprain
- Strain
- Vertebral Fracture

Nervous
- Amyolateral Sclerosis
- Cataracts
- Corneal Ulcer
- Epilepsy
- Labyrinthitis
- Mastoiditis
- Meniere's Disease
- Meningitis
- Multiple Sclerosis
- Optic Neuritis
- Narcolepsy
- Neuritis
- Palsy
- Paralysis

Nervous (cont.)
- Paresis
- Parkinson's disease
- Retina, detached

Respiratory
- Asbestosis
- Asthma
- Bronchitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Laryngitis
- Pharyngitis
- Pleurisy
- Pneumonia
- Rhinitis
- Sinusitis
- Tuberculosis

Skin / Subcutaneous
- Lupus Erythematosis
- Skin Disease

Others
- *All suppressed diagnosis*

4.4.4.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

   4.4.4 The Standard Voluntary Life and Short Term Disability data & performance report

The Standard

Quarterly Report: Voluntary Life Insurance and Short Term Disability:
Quarter Ending
December 31, 2018

Report Table of Contents

Voluntary Life Insurance & Short-Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

This is the second quarter report for the 2018-19 plan year, providing information for the period beginning July 1, 2014 and ending December 31, 2018.

Voluntary Life

At the halfway point of the current plan year Voluntary Life claim incidence (page 4) is down compared to last year, from 4.2 claims per thousand to 2.5 claims per thousand. Both active employees and retirees contributed to the improved result; active employee incidence is 0.4 claims compared to 1.6 claims per thousand last year. Retiree incidence is 6.0 claims per thousand, compared to 8.3 last year.

Year to date loss ratios are also down for both active employees and retirees; from 17% this time last year to 11% this year for active employees and 44% for retires last year to 20% this year. It's worth noting that last year's results for Voluntary Life were the worst they've been over the last five plan years. It looks like the current plan year will perform much better. Time will tell…

Short Term Disability

STD experience results have become much more consistent over the past two and a half plan years. Prior to that time, we'd seen a steady increase in claim incidence and loss ratio. Claim incidence (page 6) is down slightly year over year, from 1.8 claims per hundred last year to 1.5 this year. The year to date loss ratio (page 7) is down slightly, from 73% in 2017/18 to 71% in 2018/19. You'll see that the loss ratio has been very consistent, 74% for the 2016/17 plan year, and 71% for 2017/18 and year to date for 2018/19. Our target loss ratio for STD is around 68% so the plan has been performing at a slight loss over the past 2 and a half years.

Experience by plan option is anything but consistent for the plan year. Option A (7 day waiting period) has a loss ratio of 101%, Option B (14 day waiting period) is significantly lower at 47% and Option C is the closest to target at 74%.

Voluntary Life Insurance Claims by Plan Year and Participant Type

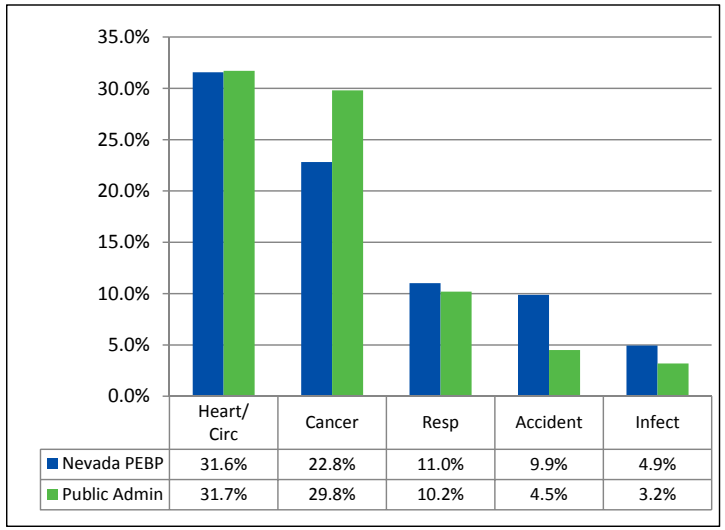
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	16	6.6	4	1.6	12	5.2	13	5.8	1	0.4
Retirees	39	21.3	53	30.3	35	21.5	55	34.6	9	6.0
Totals	**55**	**12.9**	**57**	**13.5**	**47**	**11.9**	**68**	**17.8**	**10**	**2.5**

Voluntary Life Insurance Claims by Diagnostic Category

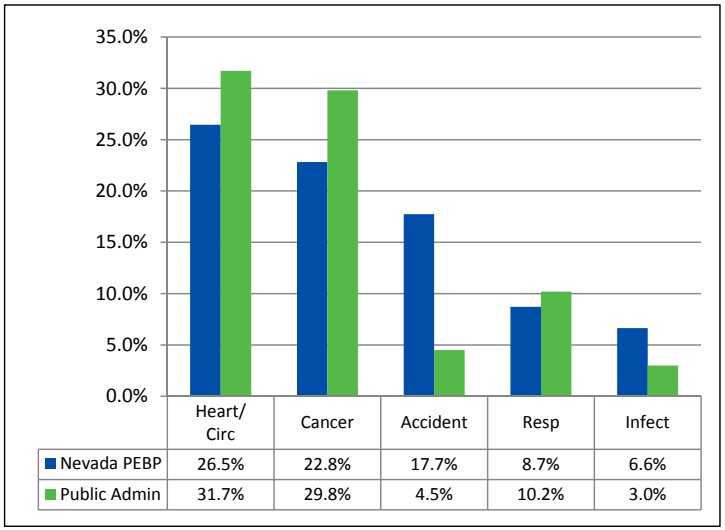
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Accident	Infect
Nevada PEBP	31.6%	22.8%	11.0%	9.9%	4.9%
Public Admin	31.7%	29.8%	10.2%	4.5%	3.2%

Top Five Diagnostic Categories by Liability

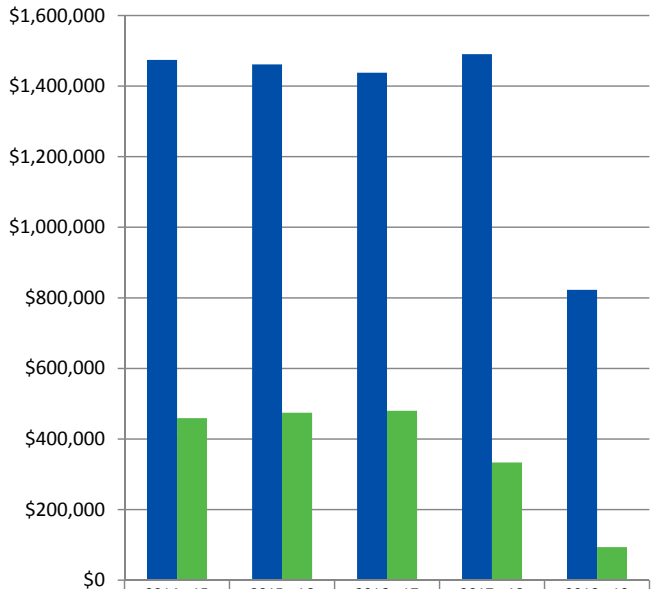


	Heart/ Circ	Cancer	Accident	Resp	Infect
Nevada PEBP	26.5%	22.8%	17.7%	8.7%	6.6%
Public Admin	31.7%	29.8%	4.5%	10.2%	3.0%

Voluntary Life Insurance Earned Premiums & Liability by Participant Type

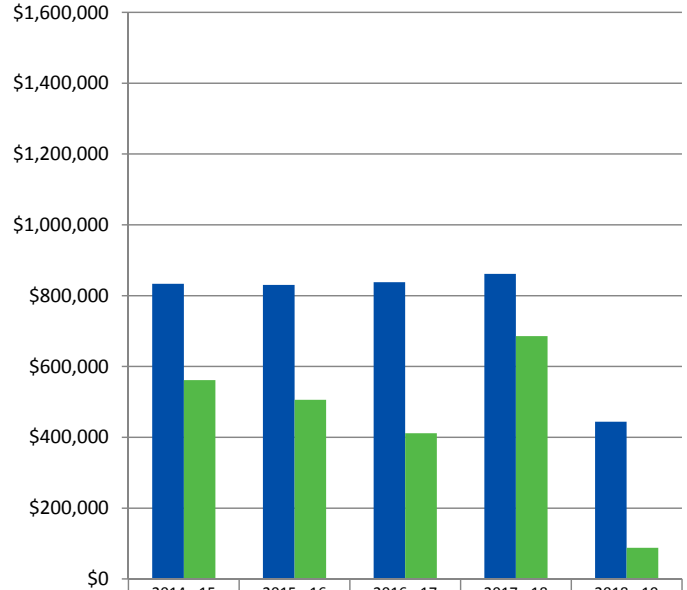
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

Active Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$1,474,370	$1,461,598	$1,437,863	$1,490,326	$822,634
Claim Liability	$458,899	$474,493	$479,950	$333,582	$93,936
Loss Ratio	0.31	0.32	0.33	0.22	0.11

Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$833,255	$830,266	$838,158	$861,463	$444,241
Claim Liability	$561,396	$505,980	$411,382	$685,667	$88,205
Loss Ratio	0.67	0.61	0.49	0.80	0.20

Short Term Disability Claims by Plan Year

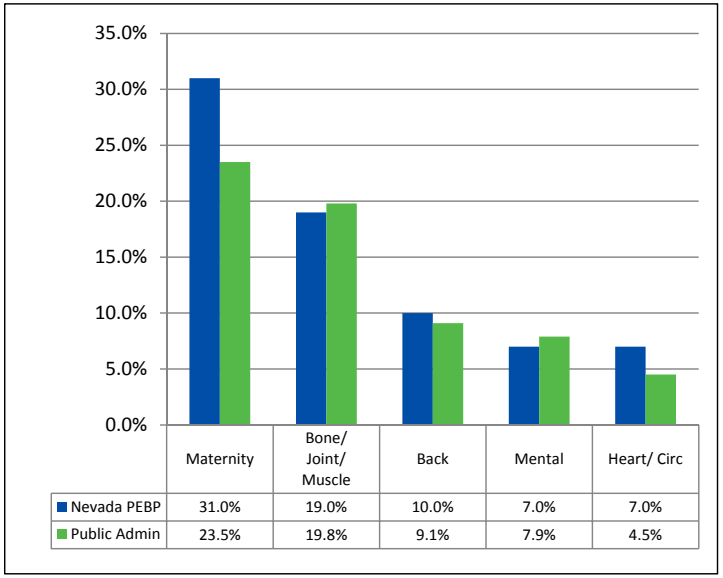
Most Recent Five Plan Years: July 01, 2014 to December 31, 2018

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100
STD Claims	58	4.4	55	3.8	77	4.9	99	6.5	28	1.5

Short Term Disability Claims by Diagnostic Category

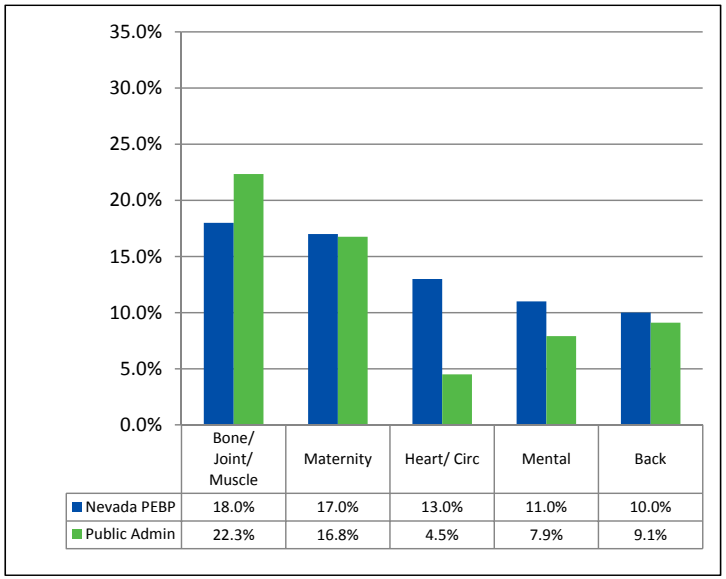
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Maternity	Bone/ Joint/ Muscle	Back	Mental	Heart/ Circ
Nevada PEBP	31.0%	19.0%	10.0%	7.0%	7.0%
Public Admin	23.5%	19.8%	9.1%	7.9%	4.5%

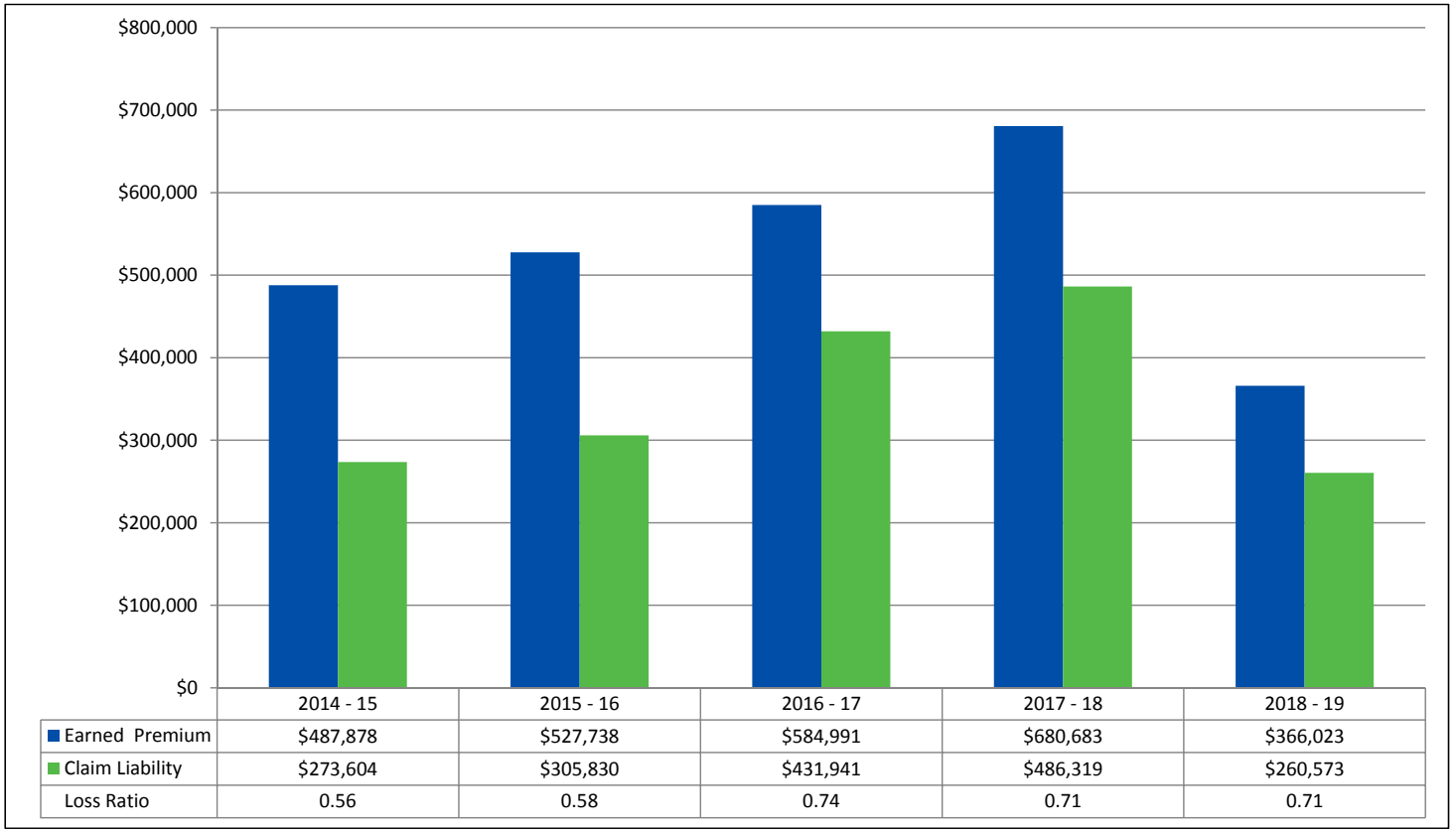
Top Five Diagnostic Categories by Liability



	Bone/ Joint/ Muscle	Maternity	Heart/ Circ	Mental	Back
Nevada PEBP	18.0%	17.0%	13.0%	11.0%	10.0%
Public Admin	22.3%	16.8%	4.5%	7.9%	9.1%

Short Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2014 to December 31, 2018



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$487,878	$527,738	$584,991	$680,683	$366,023
Claim Liability	$273,604	$305,830	$431,941	$486,319	$260,573
Loss Ratio	0.56	0.58	0.74	0.71	0.71

4.4.5.

4. Consent Agenda (Deonne Contine, 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.

   4.4 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

      4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

Nevada Public Employees Benefit Program

Quarterly Update – 2nd Quarter Plan Year 2019

Willis Towers Watson's Individual Marketplace

January 25, 2019

Willis Towers Watson

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Executive Summary

Plan Enrollment:

- At the end of Q2 2019, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 12,812. Since inception, 99 carriers have been selected by PEBP's retirees with current enrollment in 1,196 different plans.
- Medicare Supplement (MS) plan selection increased to 80% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,391 and 2,036 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected decreased 20%. Top MA carriers include Hometown Health Plan with 1,421 individual plan selection and Humana with 465 individual plan selections. The average monthly premium cost to PEBP participants increased $29.

Customer Satisfaction:

- Q2 2019, PEBP participant satisfaction with Enrollment Calls remained increased slightly with an average satisfaction score result of 4.7 out of 5.0 based on 250 surveys returned.
- The customer satisfaction score results for Service Calls increased for Q2 when compared to the prior quarter. For Q1 2019, the average satisfaction score results were 4.3 out of 5.0. For Q2 2019, the score was 4.5 with 412 survey responses.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.6 out of 5.0 for Q2 2019.
- For Funding Calls, PEBP customer satisfaction was 4.1 out of 5.0. This was an increase when compared to Q1 2019. There were 180 survey responses in Q1 compared to 104 survey responses for Q2.

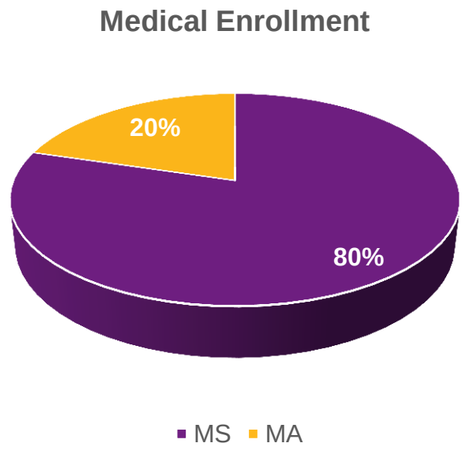
Health Reimbursement Arrangement:

- At the end of Q2 2019 there were 12,109 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 87,390 claims submitted against the HRA for reimbursement in Q2, with 79.6% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 69,544 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $9,803,270.42.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2018		Previous Qtr
Total enrolled through individual marketplace	12,812	13,796
Number of carriers**	99	98
Number of plans**	1,196	1,115

Plan Type Selection Through 12/31/2018		Previous Qtr
Medicare Advantage (MA, MAPD)	2,618	3,691 (23%)
Medicare Supplement (MS)	10,222	10,134 (73%)



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

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10,222	$147
Medicare Advantage (MA,MAPD)	2,612	$2 $29
Part D drug coverage	8,549	$27
Dental coverage	1,165	$36
Vision coverage	1,863	$14

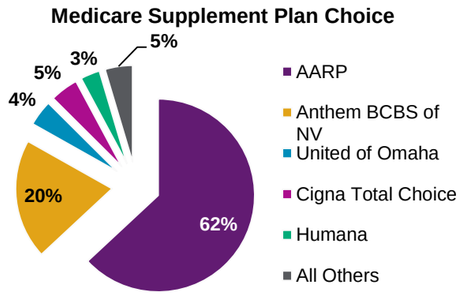
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

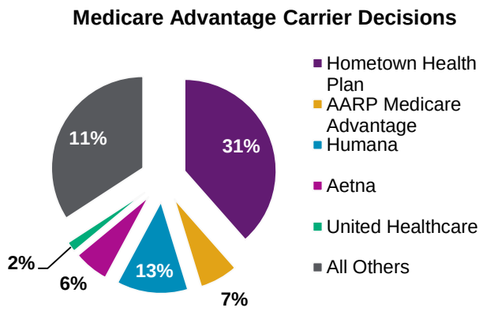
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,391
Anthem BCBS of NV	2,036
United of Omaha	436
Cigna Total Choice	476
Humana	328



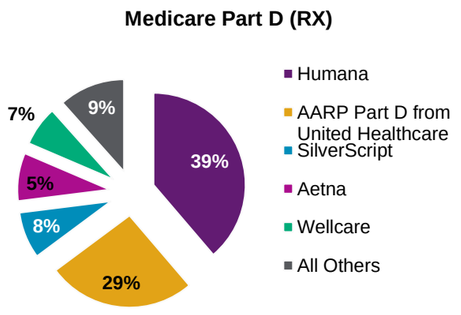
Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$143
Maximum	$395

Top Medicare Advantage Plans	Total
Hometown Health Plan	1,421
Humana	465
AARP Medicare Advantage	249
Aetna	227
United Healthcare	67



Cost Data For MA Plans	Cost
Minimum	$0
Average	$29
Median	$0
Maximum	$223

Top Medicare Part D (RX)	Total
Humana	3,345
AARP Part D from United Healthcare	2,253
SilverScript	706
Aetna	727
WellCare	601



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$27
Median	$23
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

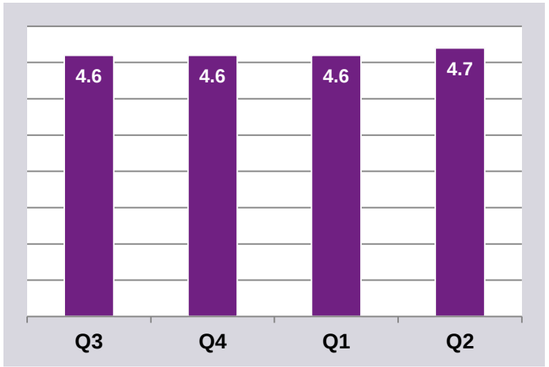
Quarterly Update – 2nd Quarter Plan Year 2019

Customer Service – Voice of the Customer (VoC)

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

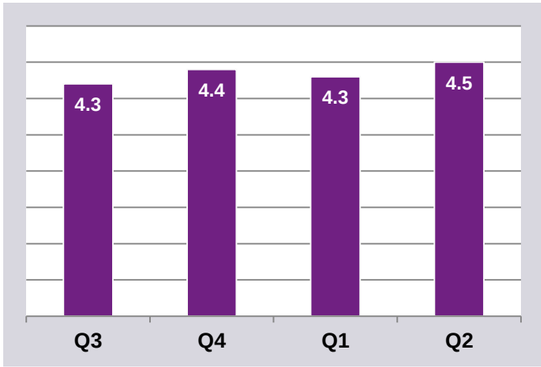
Q2 Enrollment Satisfaction

CSAT score	Count	%
5	198	79%
4	34	14%
3	13	5%
2	2	1%
1	3	1%
	250	**100%**



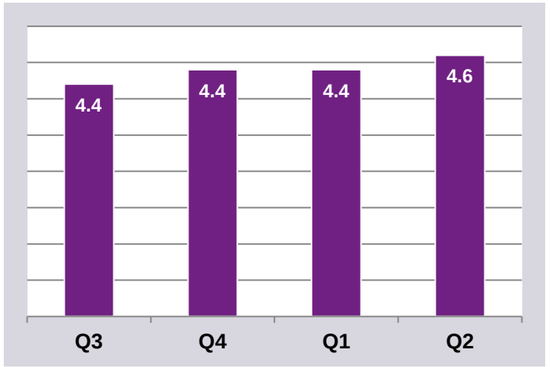
Q2 Service Satisfaction

CSAT score	Count	%
5	290	70%
4	73	18%
3	24	6%
2	12	3%
1	13	3%
	412	**100%**



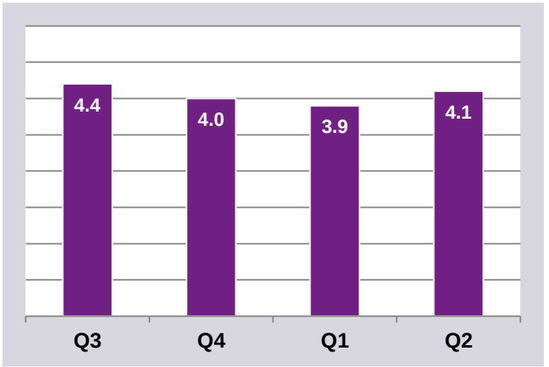
Q2 Enrollment & Service Combined

CSAT score	Count	%
5	488	74%
4	107	16%
3	37	6%
2	14	2%
1	16	2%
	662	**100%**



Q2 HRA Satisfaction

CSAT score	Count	%
5	64	62%
4	14	13%
3	10	10%
2	5	5%
1	11	11%
	104	**100%**

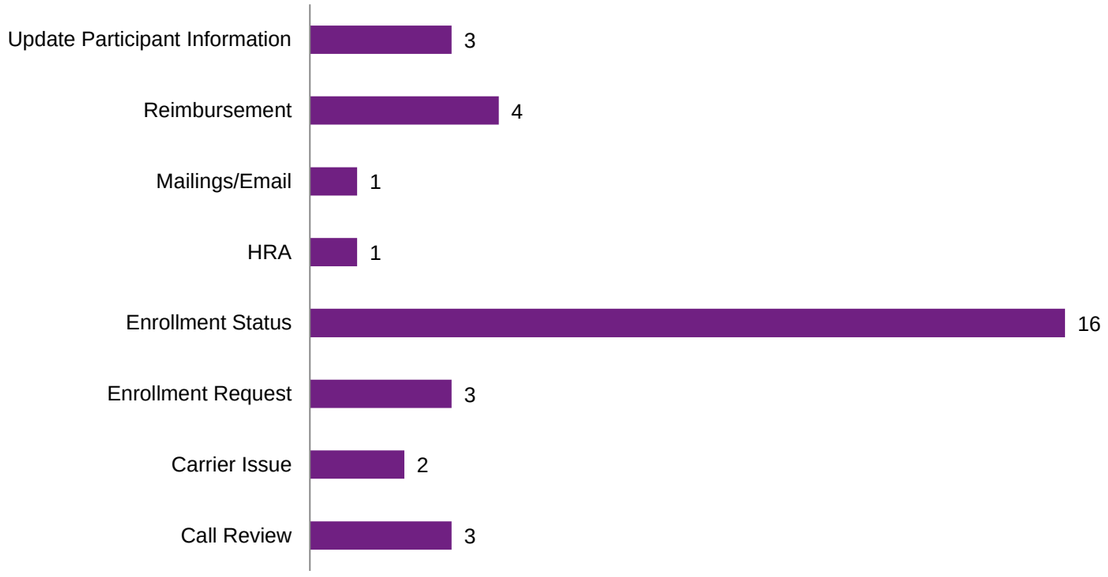


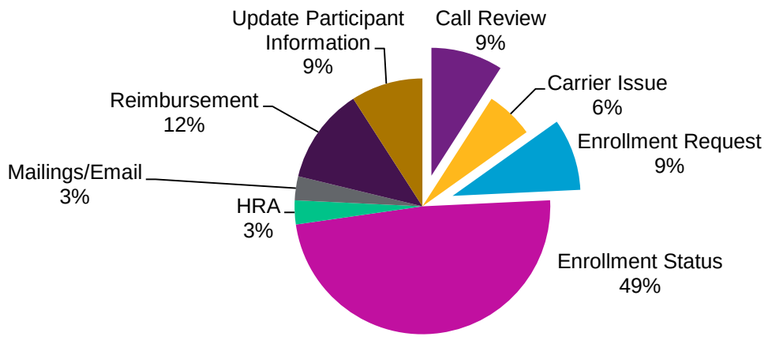
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and Willis Towers Watson that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned Willis Towers Watson staff until resolution is reached. The total number of inquiries reviewed during Q2-PY19 is 33 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,109
Number of claims paid	87,390
Accounts with no balance	5,911
Claims paid amount	$9,803,270.42

Claims By Source	Total
A/R file	69,554
Mail	14,254
Web	3,582

Call Category	Total
General / Instructional	782
Other	158
Denial Reason Explanation	159
Autopay / Auto Reimbursement	29
Date EFT / Mail Issued	51

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims turnaround time	≤ 2 days	0.57 Days	Yes
Claim financial accuracy	≥ 98%	99.49%	Yes
Claim processing financial accuracy	≥ 98%	99.25%	Yes
HRA call center abandon rate	≤ 5%	1.76%	Yes
HRA customer service - avg. speed to answer	≤ 30 seconds	12.9 Seconds	Yes
Reports	≤ 10 business days	As scheduled	Yes
HRA web services	≥ 99%	Uptime >99%	Yes
Benefits admin customer service avg. speed to answer Q2	≤ 5 minutes	31 Seconds	Yes

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

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Operations Report

Spring Retiree Meetings:

The Spring Retiree Meetings are scheduled for March 12, March 14, and March 15. The retiree meetings will be held in Las Vegas, Carson City, and Reno. At each location there will be two meetings per day with the morning meeting focusing on participants aging-in to Medicare and the afternoon meeting focusing on the HRA for those that are already Medicare eligible. The below chart include the information about the meeting dates and locations.

Date	Location
March 12	College of Southern Nevada North Las Vegas Campus C Building - Conference Room 2638 3200 E. Cheyenne Ave North Las Vegas, NV 89030
March 14	Nevada Army National Guard Auditorium 2460 Fairview Dr. Carson City, NV 89701
March 15	Truckee Meadows Community College Sierra Building, Room 105 7000 Dandini Boulevard Reno, NV 89512

Communications:

Below is information on communications that are currently in process or will be coming up.

- Spring Balance Reminder
  - This communication is sent to participants via mail and started to be sent if mid-February. The intent of this communication is to reminder participants of the balance in their HRA. It is only sent to those participants who have not had a claim reimbursement in the prior 90 days.
- Spring Newsletter
  - This communication is sent to participants via email and is typically sent in the March/April time period. The intent of this communication is educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.


Via Benefits Balance Reminder

<Date>

<First Name><Last Name>
<Address>
<City>, <State> <ZIP Code>

CONTACTING US
Return: Via Benefits
<Address>
<City>, <State> <ZIP Code>
Phone: <Client Phone Number>
Fax: <Client Fax Number>
Web: <My.ViaBenefits.com/Client>

Dear <First Name> <Last Name>,

Greetings from Via Benefits! This Balance Reminder communication is being provided as a courtesy to assist you in managing your reimbursement account.

As of <Date> the available balance in your reimbursement account was <Amount>.

Your balance is subject to change based on account activity. For up-to-date balance and account information, visit Via Benefits online anytime at the website listed at the top of this letter. Note that based on your employer's plan and your eligibility, you may be entitled to receive additional periodic contributions to your account. If so, such contributions will be automatically applied to your account. Please see your plan documents for specific information about your account.

We're Here to Help
Via Benefits is available to answer any questions you may have regarding your account. To speak with a customer service representative by phone, call us toll-free at the phone number listed at the top of this letter. We look forward to continuing to service your account.

Sincerely,

The Via Benefits Team

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2018.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	03m 32s	2,671	223	21m 39s	266
February	25s	1,890	8	18m 01s	318
March	22s	2,001	13	19m 03s	354
April	13s	1,750	7	21m 01s	170
May	14s	1,653	3	22m 45s	192
June	13s	1,615	8	23m 47s	329
July	16s	1,589	2	25m 18s	282
August	15s	1,379	0	26m 19s	224
September	15s	1,686	1	22m 56s	336
October	37s	2,484	36	29m 16s	357
November	33s	2,441	23	32m 10s	271
December	34s	2,241	24	25m 27s	322

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2019.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	1m 10s	2,623	89	22m 17s	356
February	24s	1,732	11	22m 23s	160
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

4.5.

4. Consent Agenda (Deonne Contine, 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.

   4.5 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2018.

   4.5.1 Budget Report

   4.5.2 Utilization Report

4.5.1.

4. Consent Agenda (Deonne Contine, 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.

   4.5 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2018.

   4.5.1 Budget Report

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: IV.V.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of December 31, 2018 to include:

1. Budget Status
2. Budget Totals
3. Claims Summary

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of December 31, 2018 with comparisons to the same period in Fiscal Year 2018. 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 $182.6 million as of December 31, 2018 compared to $145.2 million as of December 31, 2017 or an increase of 25.7%. Total expenses for the period have decreased by $8.7 million or 4.8% for the same period.

The budget status report shows Realized Funding Available (cash) at $152.8 million. This compares to $97.6 million for last year. After subtracting $51.8 million for reserves for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve and $31.7 million for the HRA Reserve, the remaining balance is $29.4 million in Excess reserves. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338						
	FISCAL YEAR 2019			FISCAL YEAR 2018		
	Actual as of 12/31/2018	Work Program	Percent	Actual as of 12/31/2017	Fiscal Year 2018 Close	Percent
Beginning Cash	143,129,728	143,129,728	100%	134,046,196	134,046,196	100%
Premium Income	177,248,452	384,570,407	46%	139,903,678	365,798,560	38%
All Other Income	5,352,384	1,884,806	284%	5,306,801	55,678,580	10%
Total Income	182,600,836	386,455,213	47%	145,210,479	421,477,139	34%
Personnel Services	1,269,566	2,695,176	47%	1,107,662	2,457,675	45%
Operating - Other than Personnel	1,040,040	2,392,466	43%	1,483,751	2,467,105	60%
Insurance Program Expenses	170,146,158	377,035,392	45%	178,623,704	360,212,838	50%
All Other Expenses	521,305	1,125,737	46%	485,187	1,007,397	48%
Total Expenses	172,977,069	383,248,771	45%	181,700,304	366,145,015	50%
Change in Cash	9,623,767	3,206,442		(36,489,825)	55,332,124	
REALIZED FUNDING AVAILABLE	152,753,495	146,336,170	104%	97,556,371	189,378,320	52%
Incurred But Not Reported Liability	(51,800,000)	(51,800,000)		(35,300,000)	(35,300,000)	
Catastrophic Reserve	(39,900,000)	(39,900,000)		(19,400,000)	(19,400,000)	
HRA Reserve	(31,676,056)	(31,676,056)		(30,167,672)	(30,167,672)	
NET REALIZED FUNDING AVAILABLE	29,377,439	22,960,114		12,688,699	104,510,648	

Current Budget Projections

The following table represents projections for FY 2019 based on data available as of December 31, 2018. The projection reflects total income to be less than budgeted by 2.3% ($517.4 million vs $529.6 million), total expenditures are projected to be less than budgeted by 10.3% ($343.6 million vs $383.2 million); total reserves are projected to be more than budgeted by 18.7% ($173.8 million vs $146.3 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/18**	**Projected**	**Difference**	
Carryforward	143,129,728	143,129,728	143,129,728	0	0.0%
State Subsidies	278,587,976	133,701,217	276,508,132	(2,079,844)	-0.7%
Non-State Subsidies	26,970,841	14,543,765	28,966,435	1,995,594	7.4%
Premium	79,011,590	29,003,469	58,097,203	(20,914,387)	-26.5%
All Other	1,884,806	5,352,384	10,714,996	8,830,190	468.5%
Total	529,584,941	325,730,564	517,416,494	(12,168,447)	-2.3%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/18**	**Projected**	**Difference**	
Operating	6,213,379	2,830,912	6,277,764	(64,385)	-1.0%
State Employee Ins Cost	267,524,373	126,766,968	237,277,119	30,247,254	11.3%
State Retirees Ins Cost	53,764,043	17,926,151	44,861,280	8,902,763	16.6%
Non-State Employees Ins Cost	192,165	36,966	108,659	83,506	43.5%
Non-State Retirees Ins Cost	20,859,393	6,447,413	16,389,618	4,469,775	21.4%
State Medicare Ret Ins Cost	18,975,657	11,668,633	22,205,307	(3,229,650)	-17.0%
Non-State Medicare Ret Ins Cost	15,719,761	7,300,026	16,527,284	(807,523)	-5.1%
Total Insurance Costs	377,035,392	170,146,158	337,369,268	39,666,124	10.5%
Total Expenses	383,248,771	172,977,069	343,647,032	39,601,739	10.3%
Restricted Reserves	123,376,056	123,376,056	129,203,722	(5,827,666)	-4.7%
Excess Reserves for Benefit Enhancements	22,960,114	29,377,439	44,565,740	(21,605,626)	-94.1%
Total Reserves	146,336,170	152,753,495	173,769,462	(27,433,292)	-18.7%
Total of Expenses and Reserves	529,584,941	325,730,564	517,416,494	12,168,447	2.3%

State Subsidies are projected to be less than the budgeted amount by $2.1 million (0.7%), Non-State Subsidies are projected to be more than budgeted by $2 million (7.4%), and Premium Income is projected to be less than budgeted by $20.9 million (26.5%). This overall decrease in projected revenue is due in part to a decrease in actual rates as compared to the budgeted rates as well as a decrease in average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 1.79% fewer state actives,
- 5.13% fewer state non-Medicare retirees,
- 11.1% fewer non-state actives,
- 3.9% fewer non-state, non-Medicare retirees
- 0.32% more state Medicare retirees, and
- 5.87% fewer non-state Medicare retirees.

Expenses for Fiscal Year 2019 are projected to be $39.6 million (10.3%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.06 million (1%). Employee and Retiree insurances costs are projected to be less than budgeted by $39.7 million (10.5%) when taken in total (see table above for specific information).

Total reserves for the year ending December 31, 2018 are projected to be $173.8 million. Reserves include $51.8 million for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve to insure plan solvency, $37.5 million in HRA reserves, and a balance in excess of the required reserves of $44.5 million. At the November 2018 Board meeting, the PEBP Board allocated approximately $2.1 million for plan design enhancements in Plan Year 2020. Reserve levels will continue to be monitored during Fiscal Year 2019.

Recommendations

None.

4.5.2.

4. Consent Agenda (Deonne Contine, 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.

   4.5 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2018.

   4.5.2 Utilization Report

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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www.pebp.state.nv.us

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: IV.V.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending December 31, 2018

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending December 31, 2018. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix B for Plan Year 2019 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2019 compared to Plan Year 2018 is summarized below.

- Population:
  - 1.7% increase for primary participants
  - 1.8% increase for primary participants plus dependents (members)
- Medical Cost:
  - 2.3% decrease for primary participants
  - 2.5% decrease for primary participants plus dependents (members)
- High Cost Claims:
  - There were 75 High Cost Claimants accounting for 23.8% of the total plan paid for Q2 in Plan Year 2019
  - 17.3% increase in High Cost Claimants per 1,000 members
  - 15% decrease in average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($3.9 million) – 24.4% of paid claims
  - Injury and Poisoning ($1.7 million) – 10.9% of paid claims
  - Diseases of the Circulatory System ($1.7 million) – 10.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 8.5%
  - Average paid per ER visit increased 3.6% from Q2 in Plan Year 2018
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 5%
  - Average paid per Urgent Care visit decreased 9.4% from Q2 in Plan Year 2018
- Network Utilization:
  - 95.4% of claims are from In-Network providers
  - In-Network utilization decreased 1% from Q2 in Plan Year 2018
  - In-Network discounts increased 0.8% from Q2 in Plan Year 2018
- Preventative Services:
  - Overall Preventive Services Compliance Rates increased or remained flat from Plan Year 2018 in all categories with the exception of:
    - Cervical Cancer Screenings (Women 21-29) decreased by 0.7%
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 1.8%
    - Total Gross Claims Costs increased 7.4% ($1.5 million)
    - Average Total Cost per Claim increased 9.3%
      - From $83.82 to $91.64
  - Member:
    - Total Member Cost decreased 5.2%
    - Average Participant Share per Claim decreased 3.4%
    - Net Member PMPM decreased 6.7%
      - From $24.79 to $23.13

- Plan
  - Total Plan Cost increased 12.7%
  - Average Plan Share per Claim increased 14.8%
  - Net Plan PMPM increased 10.9%
    - From $57.87 to $64.19

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2019 is summarized below.

- Population:
  - Average of 4,651 primary participants
  - Average of 8,478 primary participants plus dependents (members)
- Medical Cost:
  - Primary participants cost $511 PEPM
  - Primary participants plus dependents (members) cost $281 PMPM
- High Cost Claims:
  - There were 11 High Cost Claimants accounting for 16.8% of the total plan paid for Q2 in Plan Year 2019
  - Total of 1.3 High Cost Claimants per 1,000 members
  - Total of $218,014 average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Diseases of the Circulatory System ($661k) – 4.1% of paid claims
  - Neoplasms ($505k) – 3.1% of paid claims
  - Injury and Poisoning ($343k) – 2.1% of paid claims
- Emergency Room:
  - Total of 124 ER visits per 1,000 members
  - Average of $2,514 paid per ER visit
- Urgent Care:
  - Total of 214 Urgent Care visits per 1,000 members
  - Average of $123 paid per Urgent Care visit
- Network Utilization:
  - 98% of claims are from In-Network providers
- Preventative Services: Compliance %
  - Preventive Office Visit: 44.5%
  - Cholesterol Screening: 46.7%
  - Cervical Cancer Screening (Females 21-29) 76.7%
  - Cervical Cancer Screening (Females 30-65) 61.9%
  - Breast Cancer Screening (Females 40+) 52.2%
  - PSA (Prostate-specific antigen) Screening (Males 50+) 43.8%
  - Colorectal Screening (All 50+) 47.8%
- Prescription Drug Utilization (Compared to Q1 2019):
  - Overall:
    - Total Net Claims increased 5.7%
    - Total Gross Claims Costs increased 16.4% ($579k)
    - Average Total Cost per Claim increased 10.1%
      - From $89.62 to $98.67

- Member:
  - Total Member Cost decreased 4.6%
  - Average Participant Share per Claim decreased 9.7%
  - Net Member PMPM decreased 4.5%
    - From $14.35 to $13.71
- Plan
  - Total Plan Cost increased 21.9%
  - Average Plan Share per Claim increased 15.3%
  - Net Plan PMPM increased 22%
    - From $55.07 to $67.17

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2019 is summarized below.

- Dental Cost:
  - Total of $12,555,063 paid for Dental claims
    - Preventative claims account for 41.9% ($5.3 million)
    - Basic claims account for 28.8% ($3.6 million)
    - Major claims account for 22.4% ($2.8 million)
    - Periodontal claims account for 6.9% ($863k)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2018.

HRA Account Balances as of December 31, 2018			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,030	$ -	$ -
$.01 - $500.00	2,602	$ 568,881.95	$ 218.63
$500.01 - $1,000	2,537	$ 1,820,728.18	$ 717.67
$1,000.01 - $1,500	980	$ 1,214,266.58	$ 1,239.05
$1,500.01 - $2,000	526	$ 914,993.38	$ 1,739.53
$2,000.01 - $2,500	387	$ 878,052.93	$ 2,268.87
$2,500.01 - $3,000	293	$ 801,026.51	$ 2,733.88
$3,000.01 - $3,500	227	$ 729,956.93	$ 3,215.67
$3,500.01 - $4,000	196	$ 732,946.38	$ 3,739.52
$4,000.01 - $4,500	134	$ 568,251.12	$ 4,240.68
$4,500.01 - $5,000	161	$ 764,469.03	$ 4,748.25
$5,000.01 +	**889**	**$ 6,504,032.58**	**$ 7,316.12**
Total	**9,962**	**$ 15,497,605.57**	**$ 1,555.67**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the second quarter of Plan Year 2019. The CDHP is seeing total plan paid costs remain relatively flat over Plan Year 2018. The EPO Plan, although still in its first year, is running better than expected. For HMO utilization and cost data please see the report provided in Appendix C.

PEBP staff and its partners continue to monitor data, research options and implement measures to provide cost savings to the plan while also providing the care our participants require.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2018 – December 31, 2018

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2018 – December 31, 2018

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
CDHP Plan

July 2018 – December 2018

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q19 was $57,576,958 of which 74.2% was spent in the State Active population. When compared to 2Q18, spending was about equal with a slight decrease of .7%.
  - When compared to 2Q17, 2Q19 reflected a slight increase of 1.0% in plan spend, with State Actives having an increase of 8.0%. This is relative to the increase in headcount.
- On a PEPY basis, 2Q19 reflected a decrease of 2.3% when compared to 2Q18. The largest group, State Actives, remained flat.
  - When compared to 2Q17, 2Q19 reflected a decrease in PEPY of 3.2%, with State Actives increasing slightly by 1.9%.
- 93.5% of the Average Membership had paid Medical claims less than $2,500, with 30.8% of those having no claims paid at all during the reporting period.
- There were 75 High Cost Claimants (HCC's) over $100K, that account for 23.8% of the total spend. HCC's accounted for 23.0% of total spend during 2Q18, with 62 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury and Poisoning Diagnosis Grouper, with plan spend of $1,176,036.
- IP Paid per Admit was $18,364 which is a slight decrease of 1.4% over 2Q18 Paid per Admit of $18,626.
- ER Paid per Visit is $1,825, which is an increase of 3.6% from 2Q18 ER Paid per Visit of $1,762.
- 95.4% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.1%, which is slightly higher than PY18 discount of 64.3%.

Paid Claims by Age Group (p. 1 of 2)

Paid Claims by Age Group										
	2Q18									
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 2,208,499	$ 1,165	$ 5,056	$ 3	$ 2,207	$ 1	$ 2,215,762	$ 1,169
1	$ 415,217	$ 174	$ 3,843	$ 2	$ 23,100	$ 7	$ 442,160	$ 183
2 - 4	$ 477,691	$ 61	$ 26,986	$ 3	$ 180,348	$ 17	$ 685,025	$ 81
5 - 9	$ 778,274	$ 51	$ 91,406	$ 6	$ 594,855	$ 29	$ 1,464,535	$ 85
10 - 14	$ 1,256,437	$ 75	$ 130,480	$ 8	$ 605,329	$ 26	$ 1,992,246	$ 109
15 - 19	$ 1,477,965	$ 83	$ 288,644	$ 16	$ 736,865	$ 30	$ 2,503,474	$ 129
20 - 24	$ 1,779,014	$ 88	$ 382,670	$ 19	$ 508,732	$ 19	$ 2,670,416	$ 126
25 - 29	$ 1,571,893	$ 98	$ 292,426	$ 18	$ 524,494	$ 26	$ 2,388,813	$ 143
30 - 34	$ 2,574,775	$ 154	$ 383,555	$ 23	$ 639,160	$ 30	$ 3,597,490	$ 207
35 - 39	$ 2,962,295	$ 161	$ 699,364	$ 38	$ 713,887	$ 30	$ 4,375,546	$ 228
40 - 44	$ 3,259,972	$ 188	$ 704,579	$ 41	$ 699,344	$ 30	$ 4,663,895	$ 259
45 - 49	$ 4,534,078	$ 235	$ 1,095,189	$ 57	$ 825,567	$ 30	$ 6,454,834	$ 322
50 - 54	$ 5,671,773	$ 283	$ 2,077,515	$ 104	$ 949,817	$ 33	$ 8,699,105	$ 421
55 - 59	$ 7,340,622	$ 324	$ 2,108,353	$ 93	$ 1,154,953	$ 36	$ 10,603,928	$ 453
60 - 64	$ 15,785,515	$ 605	$ 3,563,749	$ 136	$ 1,419,119	$ 37	$ 20,768,383	$ 778
65+	$ 5,872,182	$ 462	$ 3,006,908	$ 237	$ 2,967,093	$ 41	$ 11,846,183	$ 739
Total	**$ 57,966,202**	**$ 230**	**$ 14,860,723**	**$ 59**	**$ 12,544,870**	**$ 32**	**$ 85,371,795**	**$ 321**

Paid Claims by Age Group (p. 2 of 2)

Paid Claims by Age Group										
	2Q19								% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 2,759,369	$ 1,381	$ 7,179	$ 4	$ 2,495	$ 1	$ 2,769,043	$ 1,386	-20.0%	-15.6%
1	$ 320,198	$ 137	$ 15,180	$ 7	$ 21,565	$ 7	$ 356,943	$ 151	23.9%	21.5%
2 - 4	$ 567,224	$ 71	$ 30,551	$ 4	$ 195,738	$ 18	$ 793,513	$ 93	-13.7%	-12.8%
5 - 9	$ 670,517	$ 43	$ 155,395	$ 10	$ 598,655	$ 29	$ 1,424,567	$ 82	2.8%	3.6%
10 - 14	$ 1,457,624	$ 87	$ 147,715	$ 9	$ 601,347	$ 26	$ 2,206,685	$ 121	-9.7%	-10.0%
15 - 19	$ 1,555,779	$ 86	$ 369,756	$ 20	$ 739,514	$ 30	$ 2,665,048	$ 136	-6.1%	-5.0%
20 - 24	$ 3,477,681	$ 170	$ 369,754	$ 18	$ 492,227	$ 18	$ 4,339,662	$ 206	-38.5%	-38.9%
25 - 29	$ 2,143,593	$ 129	$ 422,863	$ 25	$ 490,068	$ 24	$ 3,056,523	$ 178	-21.8%	-19.8%
30 - 34	$ 2,817,629	$ 161	$ 546,553	$ 31	$ 591,013	$ 26	$ 3,955,195	$ 219	-9.0%	-5.4%
35 - 39	$ 2,782,539	$ 141	$ 738,196	$ 37	$ 691,540	$ 27	$ 4,212,276	$ 206	3.9%	10.7%
40 - 44	$ 2,625,352	$ 148	$ 1,089,738	$ 62	$ 708,162	$ 30	$ 4,423,252	$ 240	5.4%	7.9%
45 - 49	$ 3,898,525	$ 199	$ 1,533,761	$ 78	$ 807,758	$ 30	$ 6,240,044	$ 306	3.4%	5.1%
50 - 54	$ 6,653,340	$ 327	$ 1,845,329	$ 91	$ 937,333	$ 33	$ 9,436,002	$ 451	-7.8%	-6.6%
55 - 59	$ 7,290,939	$ 324	$ 3,153,162	$ 140	$ 1,143,936	$ 36	$ 11,588,036	$ 500	-8.5%	-9.4%
60 - 64	$ 12,306,369	$ 479	$ 4,311,394	$ 168	$ 1,426,908	$ 39	$ 18,044,671	$ 685	15.1%	13.6%
65+	$ 6,250,280	$ 471	$ 2,902,235	$ 218	$ 3,106,803	$ 40	$ 12,259,318	$ 729	-3.4%	1.3%
Total	**$ 57,576,958**	**$ 225**	**$ 17,638,758**	**$ 69**	**$ 12,555,063**	**$ 31**	**$ 87,770,779**	**$ 325**	**-2.7%**	**-1.1%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**
Enrollment												
Avg # Employees	22,513	23,087	23,482	1.7%	18,387	19,009	19,494	2.6%	5	4	4	0.0%
Avg # Members	40,582	41,936	42,703	1.8%	34,939	36,259	37,031	2.1%	6	7	7	0.0%
Ratio	1.8	1.8	1.8	1.1%	1.9	1.9	1.9	0.0%	1.4	1.7	1.8	2.9%
Financial Summary												
Gross Cost	$78,086,238	$79,977,800	$79,638,308	-0.4%	$56,164,411	$59,194,922	$60,229,544	1.7%	$7,783	$26,159	$10,236	-60.9%
Client Paid	$57,037,729	$57,966,202	$57,576,958	-0.7%	$39,553,008	$41,800,895	$42,715,160	2.2%	$4,245	$19,382	$7,062	-63.6%
Employee Paid	$21,048,508	$22,011,598	$22,061,195	0.2%	$16,611,403	$17,394,027	$17,514,229	0.7%	$3,539	$6,778	$3,174	-53.2%
Client Paid-PEPY	$5,067	$5,022	$4,904	-2.3%	$4,302	$4,398	$4,382	-0.4%	$1,886	$9,303	$3,531	-62.0%
Client Paid-PMPY	$2,811	$2,765	$2,697	-2.5%	$2,264	$2,306	$2,307	0.0%	$1,377	$5,409	$2,018	-62.7%
Client Paid-PEPM	$422	$418	$409	-2.2%	$359	$367	$365	-0.5%	$157	$775	$294	-62.1%
Client Paid-PMPM	$234	$230	$225	-2.2%	$189	$192	$192	0.0%	$115	$451	$168	-62.7%
High Cost Claimants (HCC's) > $100k												
# of HCC's	75	62	75	21.0%	38	39	52	33.3%	0	0	0	0.0%
HCC's / 1,000	1.9	1.5	1.8	17.3%	1.1	1.1	1.4	27.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$180,898	$214,667	$182,390	-15.0%	$184,325	$231,450	$183,935	-20.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	23.8%	23.0%	23.8%	3.5%	17.7%	21.6%	22.4%	3.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$929	$867	$878	1.3%	$648	$678	$740	9.1%	$0	$0	$0	0.0%
Facility Outpatient	$912	$899	$827	-8.0%	$755	$743	$683	-8.1%	$740	$1,908	$333	-82.5%
Physician	$888	$909	$928	2.1%	$795	$817	$836	2.3%	$637	$3,346	$1,563	-53.3%
Other	$81	$89	$64	-28.1%	$66	$68	$48	-29.4%	$0	$155	$121	0.0%
Total	$2,811	$2,765	$2,697	-2.5%	$2,264	$2,306	$2,307	0.0%	$1,377	$5,409	$2,018	-62.7%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,084	3,169	3,222	1.7%	1,038	904	762	-15.7%	
Avg # Members	4,497	4,676	4,800	2.7%	1,140	994	865	-13.0%	
Ratio	1.5	1.5	1.5	-0.7%	1.1	1.1	1.1	2.7%	1.8
Financial Summary									
Gross Cost	$15,512,072	$15,688,206	$14,750,103	-6.0%	$6,401,972	$5,068,513	$4,648,425	-8.3%	
Client Paid	$12,148,604	$12,002,656	$10,981,049	-8.5%	$5,331,872	$4,143,270	$3,873,687	-6.5%	
Employee Paid	$3,363,468	$3,685,551	$3,769,054	2.3%	$1,070,099	$925,243	$774,738	-16.3%	
Client Paid-PEPY	$7,878	$7,574	$6,816	-10.0%	$10,278	$9,165	$10,167	10.9%	$6,209
Client Paid-PMPY	$5,403	$5,134	$4,575	-10.9%	$9,356	$8,338	$8,960	7.5%	$3,437
Client Paid-PEPM	$656	$631	$568	-10.0%	$857	$764	$847	10.9%	$517
Client Paid-PMPM	$450	$428	$381	-11.0%	$780	$695	$747	7.5%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	23	16	18	12.5%	14	8	8	0.0%	
HCC's / 1,000	5.1	3.4	3.8	10.3%	12.3	8.1	9.3	14.2%	
Avg HCC Paid	$191,622	$199,999	$129,001	-35.5%	$153,977	$135,355	$224,076	65.5%	
HCC's % of Plan Paid	36.3%	26.7%	21.1%	-21.0%	40.4%	26.1%	46.3%	77.4%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,358	$1,723	$1,262	-26.8%	$3,925	$3,724	$4,647	24.8%	$1,057
Facility Outpatient	$1,614	$1,770	$1,641	-7.3%	$2,946	$2,480	$2,467	-0.5%	$1,145
Physician	$1,261	$1,389	$1,514	9.0%	$2,286	$2,011	$1,621	-19.4%	$1,122
Other	$170	$252	$159	-36.9%	$198	$123	$225	82.9%	$113
Total	$5,403	$5,134	$4,575	-10.9%	$9,356	$8,338	$8,960	7.5%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 14,827,925	$ 3,697,412	$ 942,117	$ 19,467,454	$ 16,049,697	$ 2,630,700	$ 930,676	$ 19,611,073	0.7%
Outpatient	$ 26,972,970	$ 6,534,196	$ 828,931	$ 34,336,097	$ 26,665,587	$ 6,342,593	$ 1,077,079	$ 34,085,260	-0.7%
Total - Medical	$ 41,800,895	$ 10,231,608	$ 1,771,048	$ 53,803,551	$ 42,715,285	$ 8,973,293	$ 2,007,755	$ 53,696,333	-0.2%
Dental	$ 8,663,951	$ 966,628	$ 250,004	$ 9,880,583	$ 8,514,222	$ 1,029,708	$ 252,743	$ 9,796,674	-0.8%
Dental Exchange	$ -	$ -	$ 1,326,515	$ 1,326,515	$ -	$ -	$ 1,488,119	$ 1,488,119	12.2%
Total	**$ 50,464,846**	**$ 11,198,236**	**$ 3,347,567**	**$ 65,010,649**	**$ 51,229,507**	**$ 10,003,002**	**$ 3,748,617**	**$ 64,981,126**	**0.0%**

Net Paid Claims - Per Participant per Month	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 367	$ 666	$ 485	$ 404	$ 365	$ 573	$ 547	$ 394	-2.5%
Dental	$ 55	$ 48	$ 57	$ 54	$ 53	$ 51	$ 57	$ 53	-1.6%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 50	$ 50	2.4%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 1,516,488	$ 453,211	$ 1,969,699	$ -	$ 1,577,363	$ 558,675	$ 2,136,038	8.4%
Outpatient	$ 19,382	$ 2,003,065	$ 170,506	$ 2,192,952	$ 7,062	$ 1,520,537	$ 216,987	$ 1,744,586	-20.4%
Total - Medical	$ 19,382	$ 3,519,552	$ 623,717	$ 4,162,651	$ 7,062	$ 3,097,900	$ 775,662	$ 3,880,624	-6.8%
Dental	$ 939	$ 280,264	$ 108,471	$ 389,674	$ 2,485	$ 223,893	$ 104,908	$ 331,285	-15.0%
Dental Exchange	$ -	$ -	$ 950,601	$ 950,601	$ -	$ -	$ 938,985	$ 938,985	-1.2%
Total	**$ 20,320**	**$ 3,799,817**	**$ 1,682,789**	**$ 5,502,926**	**$ 9,547**	**$ 3,321,792**	**$ 1,819,555**	**$ 5,150,894**	**-6.4%**

Net Paid Claims - Per Participant per Month	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 775	$ 876	$ 444	$ 764	$ 294	$ 1,020	$ 505	$ 844	10.5%
Dental	$ 19	$ 41	$ 46	$ 42	$ 52	$ 44	$ 42	$ 44	4.0%
Dental Exchange	$ -	$ -	$ 45	$ 45	$ -	$ -	$ 44	$ 44	-3.2%

Paid Claims by Claim Type – Total

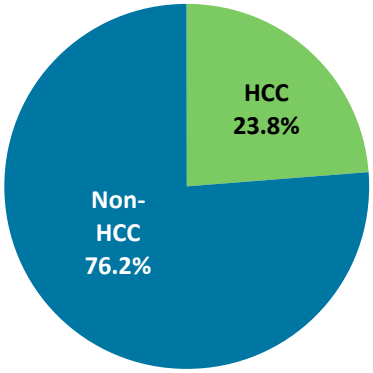
Net Paid Claims - Total Total Participants	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 14,827,925	$ 5,213,900	$ 1,395,328	$ 21,437,153	$ 16,049,697	$ 4,208,063	$ 1,489,351	$ 21,747,112	1.4%
Outpatient	$ 26,992,352	$ 8,537,260	$ 999,437	$ 36,529,049	$ 26,672,649	$ 7,863,130	$ 1,294,066	$ 35,829,846	-1.9%
Total - Medical	$ 41,820,277	$ 13,751,160	$ 2,394,765	$ 57,966,202	$ 42,722,347	$ 12,071,193	$ 2,783,417	$ 57,576,958	-0.7%
Dental	$ 8,664,889	$ 1,246,892	$ 358,475	$ 10,270,256	$ 8,516,707	$ 1,253,601	$ 357,651	$ 10,127,959	-1.4%
Dental Exchange	$ -	$ -	$ 2,277,116	$ 2,277,116	$ -	$ -	$ 2,427,104	$ 2,427,104	6.6%
Total	**$ 50,485,166**	**$ 14,998,052**	**$ 5,030,356**	**$ 70,513,574**	**$ 51,239,054**	**$ 13,324,794**	**$ 5,568,172**	**$ 70,132,020**	**-0.5%**

Net Paid Claims - Per Participant per Month	2Q18				2Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 367	$ 709	$ 473	$ 418	$ 365	$ 646	$ 535	$ 409	-2.2%
Dental	$ 55	$ 46	$ 53	$ 54	$ 53	$ 50	$ 52	$ 53	-2.3%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 47	$ 47	0.8%

Cost Distribution – Medical Claims

2Q18							2Q19					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
55	0.1%	$13,309,354	23.0%	$265,049	1.2%	$100,000.01 Plus	63	0.1%	$13,630,985	23.7%	$496,662	2.3%
108	0.3%	$8,488,415	14.6%	$544,398	2.5%	$50,000.01-$100,000.00	103	0.2%	$8,162,390	14.2%	$671,311	3.0%
206	0.5%	$7,823,451	13.5%	$1,077,473	4.9%	$25,000.01-$50,000.00	196	0.5%	$7,539,865	13.1%	$968,449	4.4%
592	1.4%	$9,485,553	16.4%	$2,689,497	12.2%	$10,000.01-$25,000.00	584	1.4%	$9,457,137	16.4%	$2,587,894	11.7%
822	2.0%	$6,126,657	10.6%	$2,564,546	11.7%	$5,000.01-$10,000.00	810	1.9%	$6,027,661	10.5%	$2,559,029	11.6%
1,125	2.7%	$4,193,760	7.2%	$2,571,032	11.7%	$2,500.01-$5,000.00	1,059	2.5%	$4,047,813	7.0%	$2,372,941	10.8%
19,058	45.4%	$8,539,013	14.7%	$9,736,457	44.2%	$0.01-$2,500.00	19,580	45.9%	$8,711,106	15.1%	$9,882,996	44.8%
7,167	17.1%	$0	0.0%	$2,563,146	11.6%	$0.00	7,173	16.8%	$0	0.0%	$2,521,913	11.6%
12,802	30.5%	$0	0.0%	$0	0.0%	No Claims	13,136	30.8%	$0	0.0%	$0	-0.2%
41,935	**100.0%**	**$57,966,202**	**100.0%**	**$22,011,598**	**100.0%**		**42,703**	**100.0%**	**$57,576,958**	**100.0%**	**$22,061,195**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 2) Neoplasms	41	$3,919,110	24.4%
(CCS 16) Injury And Poisoning	28	$1,749,482	10.9%
(CCS 7) Diseases Of The Circulatory System	50	$1,748,897	10.9%
(CCS 15) Certain Conditions Originating In The Perinatal Period	7	$1,244,559	7.7%
(CCS 1) Infectious And Parasitic Diseases	35	$958,251	6.0%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	32	$817,647	5.1%
(CCS 5) Mental Illness	21	$778,667	4.8%
(CCS 9) Diseases Of The Digestive System	36	$571,544	3.6%
(CCS 8) Diseases Of The Respiratory System	44	$457,929	2.8%
(CCS 10) Diseases Of The Genitourinary System	23	$367,550	2.3%
(CCS 6) Diseases Of The Nervous System And Sense Organs	43	$351,108	2.2%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	69	$293,191	1.8%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	36	$205,361	1.3%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	28	$91,356	0.6%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	35	$76,549	0.5%
(CCS 14) Congenital Anomalies	10	$44,065	0.3%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	12	$3,782	0.0%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	1	$203	0.0%
Overall	**----**	**$13,679,251**	**100.0%**

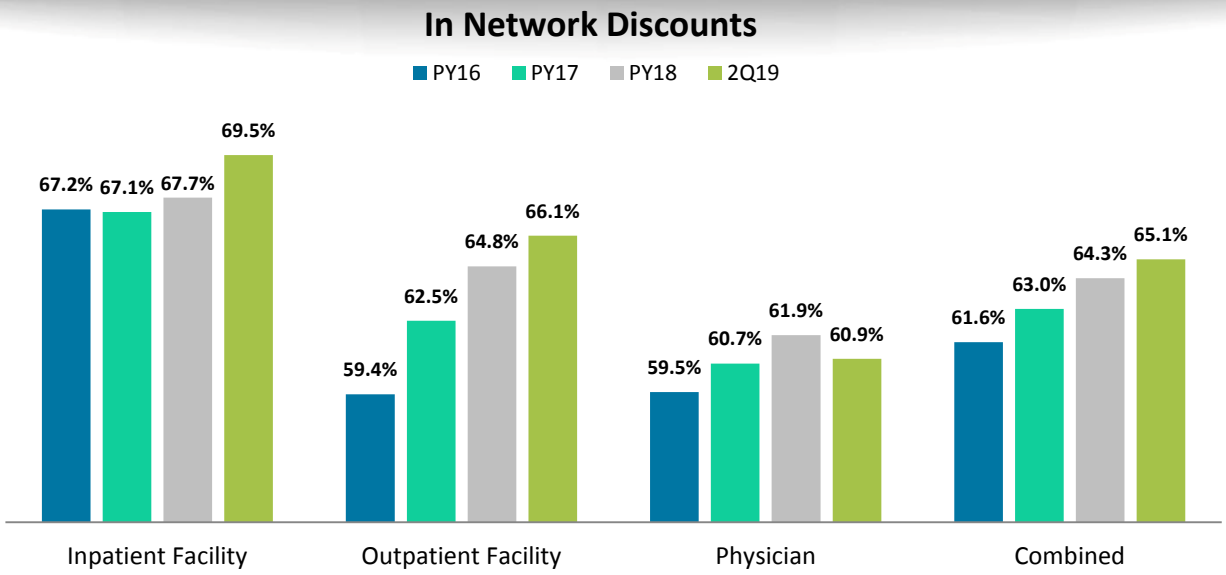
Utilization Summary (p. 1 of 2)

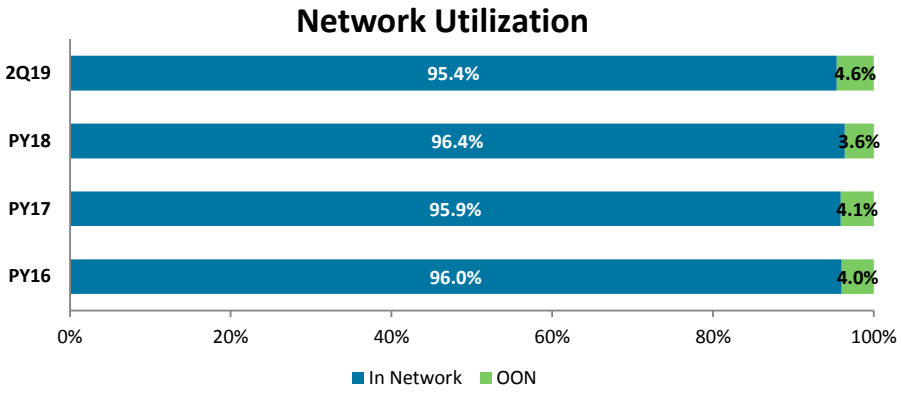
	Total				State Active				Non-State Active			
Summary	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**
Inpatient Facility												
# of Admits	1,103	1,074	1,078		804	804	841		0	0	0	
# of Bed Days	5,271	4,793	7,353		3,311	3,380	4,000		0	0	0	
Paid Per Admit	$17,950	$18,626	$18,364	-1.4%	$14,976	$17,295	$17,473	1.0%	$0	$0	$0	0.0%
Paid Per Day	$3,756	$4,174	$2,702	-35.3%	$3,636	$4,114	$3,674	-10.7%	$0	$0	$0	0.0%
Admits Per 1,000	54	51	51	0.0%	46	44	45	2.3%	0	0	0	0.0%
Days Per 1,000	260	229	344	50.2%	190	186	216	16.1%	0	0	0	0.0%
Avg LOS	4.8	4.5	6.8	51.1%	4.1	4.2	4.8	14.3%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.4	3.5	3.4	-2.9%	3.1	3.2	3.2	0.0%	4.2	10	3.7	-63.0%
Avg Paid per OV	$41	$41	$40	-2.4%	$40	$41	$40	-2.4%	$18	$74	$73	0.0%
Avg OV Paid per Member	$139	$142	$136	-4.2%	$126	$131	$127	-3.1%	$78	$748	$271	0.0%
DX&L Utilization per Member	7.3	7.4	7.3	-1.4%	6.6	6.7	6.8	1.5%	0	9.8	0	0.0%
Avg Paid per DX&L	$58	$56	$59	5.4%	$55	$53	$54	1.9%	$0	$55	$0	0.0%
Avg DX&L Paid per Member	$425	$413	$432	4.6%	$363	$356	$363	2.0%	$0	$541	$0	0.0%
Emergency Room												
# of Visits	3,145	3,470	3,232		2,562	2,833	2,610		1	2	0	
# of Admits	485	498	499		332	349	369		0	0	0	
Visits Per Member	0.15	0.17	0.15	-11.8%	0.15	0.16	0.14	-12.5%	0.32	0.56	0	0.0%
Visits Per 1,000	155	165	151	-8.5%	147	156	141	-9.6%	324	558	0	0.0%
Avg Paid per Visit	$1,730	$1,762	$1,825	3.6%	$1,695	$1,707	$1,755	2.8%	$1,922	$1,342	$0	0.0%
Admits Per Visit	0.15	0.14	0.15	7.1%	0.13	0.12	0.14	16.7%	0.00	0.00	0.00	0.0%
Urgent Care												
# of Visits	4,473	4,169	4,466		3,989	3,706	4,001		2	2	0	
Visits Per Member	0.22	0.20	0.21	5.0%	0.23	0.20	0.22	10.0%	0.65	0.56	0.00	-100.0%
Visits Per 1,000	220	199	209	5.0%	228	204	216	5.9%	649	558	0	-100.0%
Avg Paid per Visit	$31	$32	$29	-9.4%	$28	$28	$28	0.0%	$0	$140	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**2Q17**	**2Q18**	**2Q19**	**Variance to PY18**	**HSB Peer Index**
Inpatient Facility									
# of Admits	205	186	179		94	84	58		
# of Bed Days	1,221	1,018	914		739	395	2,439		
Paid Per Admit	$26,298	$22,084	$17,608	-20.3%	$25,189	$23,712	$34,692	46.3%	$16,173
Paid Per Day	$4,415	$4,035	$3,448	-14.5%	$3,204	$5,043	$825	-83.6%	$3,708
Admits Per 1,000	91	80	75	-6.3%	165	169	134	-20.7%	61
Days Per 1,000	543	435	381	-12.4%	1,297	795	5,641	609.6%	264
Avg LOS	6	5.5	5.1	-7.3%	7.9	4.7	42.1	795.7%	4.3
Physician Office									
OV Utilization per Member	4.9	4.9	4.7	-4.1%	6.5	6.2	6.3	1.6%	3.3
Avg Paid per OV	$44	$43	$42	-2.3%	$37	$35	$34	-2.9%	$50
Avg OV Paid per Member	$216	$210	$198	-5.7%	$242	$214	$216	0.9%	$167
DX&L Utilization per Member	10.3	10.7	10.6	-0.9%	14.6	14.1	13.4	-5.0%	8.3
Avg Paid per DX&L	$70	$72	$79	9.7%	$78	$59	$85	44.1%	$67
Avg DX&L Paid per Member	$725	$766	$836	9.1%	$1,140	$835	$1,133	35.7%	$554
Emergency Room									
# of Visits	418	484	476		164	151	146		
# of Admits	102	108	98		51	41	32		
Visits Per Member	0.19	0.21	0.2	-4.8%	0.29	0.3	0.34	13.3%	0.17
Visits Per 1,000	186	207	198	-4.3%	288	304	338	11.2%	174
Avg Paid per Visit	$1,893	$2,025	$2,136	5.5%	$1,856	$1,961	$2,052	4.6%	$1,684
Admits Per Visit	0.24	0.22	0.21	-4.5%	0.31	0.27	0.22	-18.5%	0.14
Urgent Care									
# of Visits	356	372	373		126	89	92		
Visits Per Member	0.16	0.16	0.16	0.0%	0.22	0.18	0.21	16.7%	0.24
Visits Per 1,000	159	159	155	-2.5%	221	179	213	19.0%	242
Avg Paid per Visit	$56	$69	$35	-49.3%	$55	$46	$33	-28.3%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





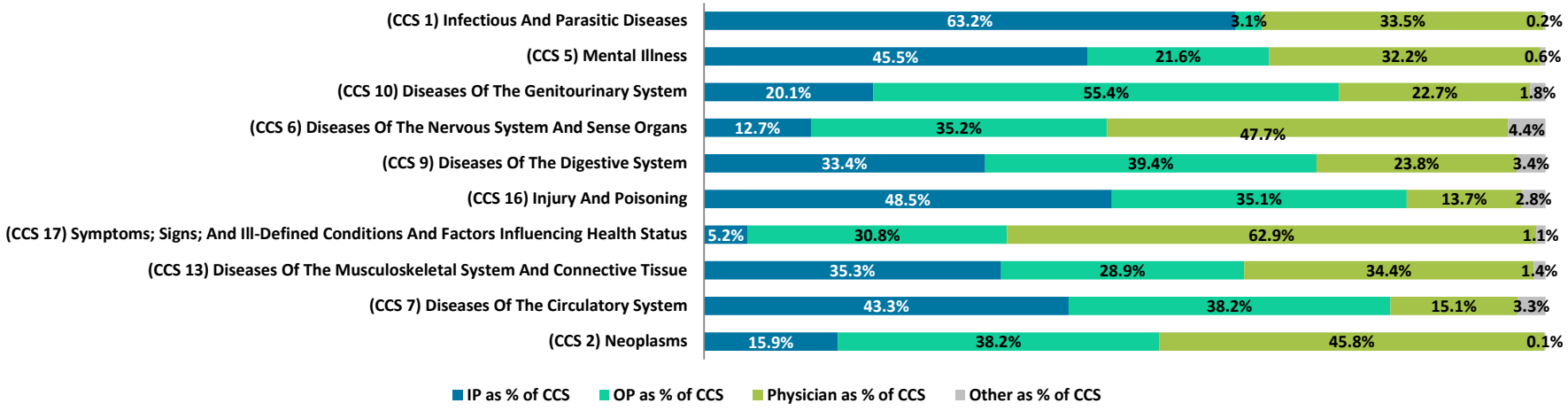
PEBP PY19 Additional Savings Total			
Savings Description	**1Q**	**2Q**	**PY19**
Non-Network Negotiations	$763,598	$810,847	$1,574,445
Subrogation	$196,825	$327,641	$524,466
Transplant Savings	$633,271	$470,386	$1,103,657
Total Savings	**$1,593,694**	**$1,608,874**	**$3,202,568**

AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 2) Neoplasms	$9,082,502	15.8%	$7,436,004	$1,552,616	$93,882	$4,278,190	$4,804,312
(CCS 7) Diseases Of The Circulatory System	$6,012,941	10.4%	$4,835,936	$1,067,533	$109,473	$3,323,370	$2,689,571
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$5,892,830	10.2%	$3,994,399	$1,156,946	$741,485	$2,402,536	$3,490,295
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$5,323,320	9.2%	$3,465,788	$760,143	$1,097,388	$1,891,226	$3,432,094
(CCS 16) Injury And Poisoning	$5,147,518	8.9%	$2,692,592	$416,043	$2,038,883	$3,303,570	$1,843,948
(CCS 9) Diseases Of The Digestive System	$3,676,942	6.4%	$2,676,321	$521,457	$479,164	$1,790,300	$1,886,643
(CCS 6) Diseases Of The Nervous System And Sense Organs	$3,635,812	6.3%	$2,379,919	$748,036	$507,858	$1,342,696	$2,293,116
(CCS 10) Diseases Of The Genitourinary System	$2,880,148	5.0%	$1,840,591	$520,187	$519,370	$1,210,090	$1,670,058
(CCS 5) Mental Illness	$2,795,448	4.9%	$982,120	$402,850	$1,410,478	$1,184,500	$1,610,948
(CCS 1) Infectious And Parasitic Diseases	$2,618,427	4.5%	$1,489,964	$368,884	$759,579	$1,475,903	$1,142,524
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$2,262,536	3.9%	$1,459,864	$673,179	$129,493	$6,519	$2,256,016
(CCS 15) Certain Conditions Originating In The Perinatal Period	$2,135,744	3.7%	$8,903	$1,278	$2,125,563	$782,190	$1,353,554
(CCS 8) Diseases Of The Respiratory System	$2,090,526	3.6%	$1,210,561	$319,286	$560,679	$1,110,539	$979,987
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$1,885,044	3.3%	$1,359,330	$277,960	$247,754	$786,739	$1,098,304
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$660,703	1.1%	$500,348	$96,006	$64,349	$341,700	$319,003
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$558,722	1.0%	$400,437	$111,780	$46,505	$357,266	$201,456
(CCS 14) Congenital Anomalies	$498,147	0.9%	$58,273	$7,794	$432,080	$278,442	$219,705
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$419,647	0.7%	$322,622	$54,607	$42,418	$133,118	$286,529
Total	**$57,576,958**	**100.0%**	**$37,113,973**	**$9,056,584**	**$11,406,401**	**$25,998,895**	**$31,578,063**

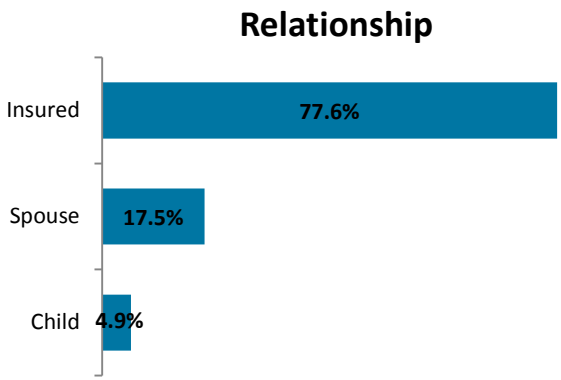
Top 10 Categories by Claim Type

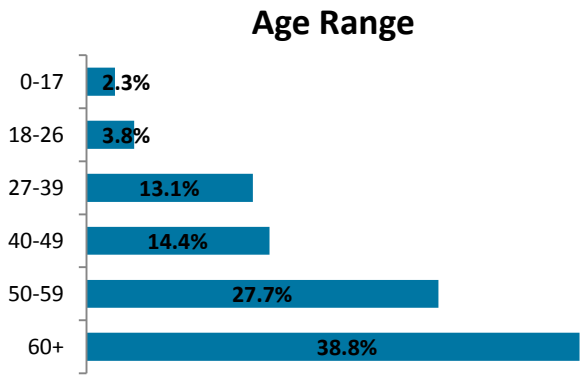


AHRQ Category - Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Maintenance Chemotherapy; Radiotherapy [45.]	78	379	$1,477,006	16.3%
Cancer Of Skin	373	1,135	$1,356,391	14.9%
Cancer Of Breast [24.]	259	2,214	$1,310,081	14.4%
Cancer; Other Primary	144	1,137	$928,321	10.2%
Cancer Of Lymphatic And Hematopoietic Tissue	95	1,068	$859,371	9.5%
Benign Neoplasms	1,655	2,815	$839,972	9.2%
Secondary Malignancies [42.]	88	465	$452,347	5.0%
Other Gastrointestinal Cancer	29	406	$432,512	4.8%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	1,195	1,851	$274,658	3.0%
Cancer Of Uterus And Cervix	165	402	$234,415	2.6%
Cancer Of Bronchus; Lung [19.]	28	260	$230,639	2.5%
Colorectal Cancer	59	391	$201,682	2.2%
Cancer Of Ovary And Other Female Genital Organs	40	205	$184,926	2.0%
Cancer Of Male Genital Organs	125	483	$127,765	1.4%
Cancer Of Urinary Organs	49	213	$95,622	1.1%
Malignant Neoplasm Without Specification Of Site [43.]	19	102	$76,794	0.8%
Overall	**----**	**----**	**$9,082,502**	**100.0%**

*Patient and claim counts are unique only within the category

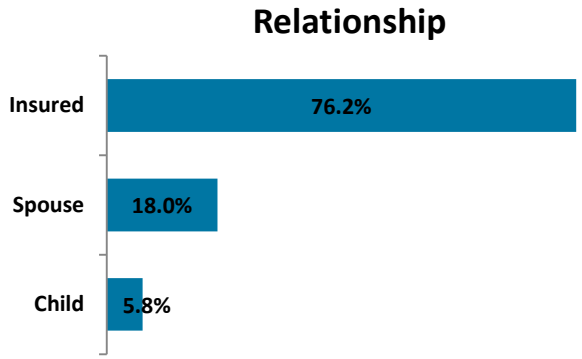


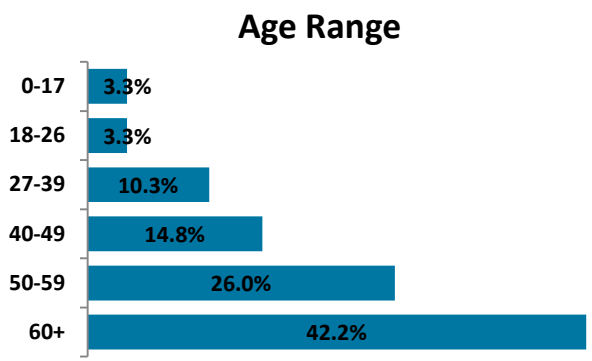


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	2,292	8,114	$4,291,390	71.4%
Diseases Of Veins And Lymphatics	421	1,134	$629,639	10.5%
Cerebrovascular Disease	268	922	$520,413	8.7%
Hypertension	2,350	4,346	$396,575	6.6%
Diseases Of Arteries; Arterioles; And Capillaries	458	769	$174,925	2.9%
Overall	**----**	**----**	**$6,012,941**	**100.0%**

*Patient and claim counts are unique only within the category

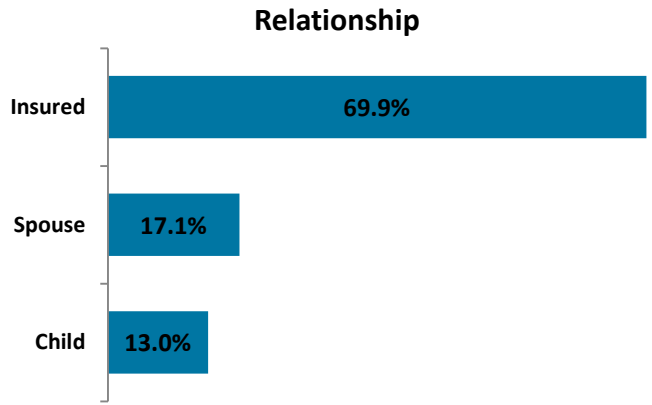


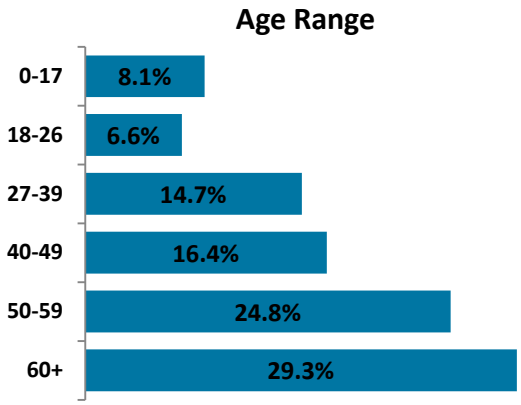


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	2,916	13,851	$2,150,019	36.5%
Non-Traumatic Joint Disorders	2,880	12,611	$1,568,079	26.6%
Other Connective Tissue Disease [211.]	2,585	7,963	$827,173	14.0%
Acquired Deformities	422	1,354	$574,637	9.8%
Other Bone Disease And Musculoskeletal Deformities [212.]	1,468	5,509	$479,186	8.1%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	40	260	$226,709	3.8%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	97	260	$29,717	0.5%
Osteoporosis [206.]	144	252	$28,119	0.5%
Pathological Fracture [207.]	8	17	$9,192	0.2%
	----	----	$5,892,830	100.0%

*Patient and claim counts are unique only within the category

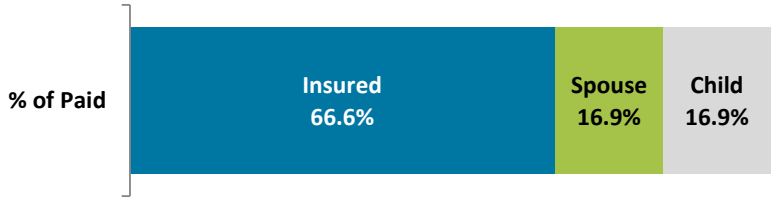




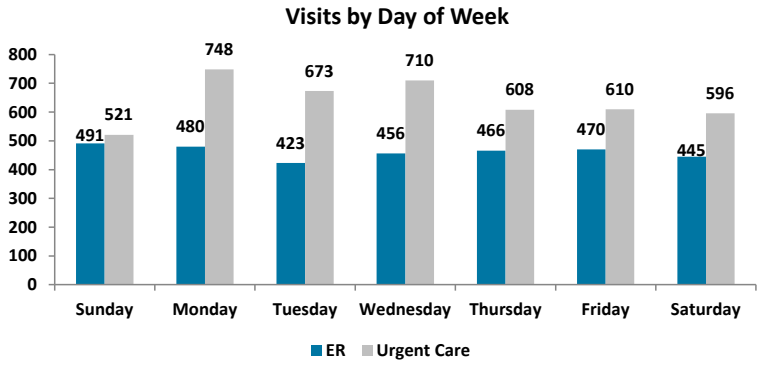
Emergency Room / Urgent Care Summary

	2Q18		2Q19		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	3,470	4,169	3,231	4,466		
Number of Admits	498	----	499	----		
Visits Per Member	0.17	0.20	0.15	0.21	0.17	0.24
Visits/1000 Members	165	199	151	209	174	242
Avg Paid Per Visit	$1,761	$32	$1,824	$29	$1,684	$74
Admits per Visit	0.14	----	0.15	----	0.14	
% of Visits with HSB ER Dx	51.1%	0	77.6%	----		
% of Visits with a Physician OV*	76.8%	72.7%	77.8%	72.9%		
Total Plan Paid	**$6,111,533**	**$135,052**	**$5,893,731**	**$128,707**		

*looks back 12 months from ER visit



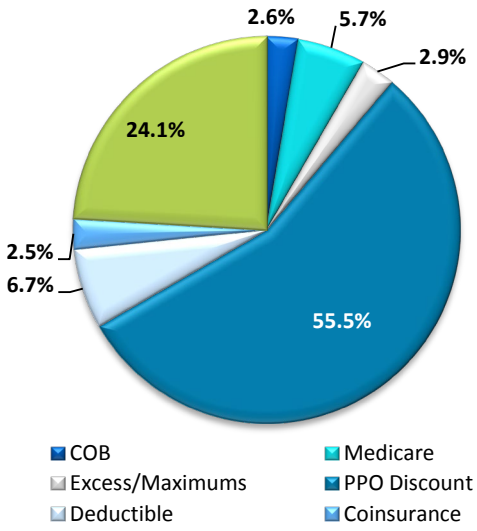
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,895	81	2,623	112	4,518	192
Spouse	494	90	524	95	1,018	185
Child	842	61	1,319	96	2,161	158
Total	**3,231**	**76**	**4,466**	**105**	**7,697**	**180**

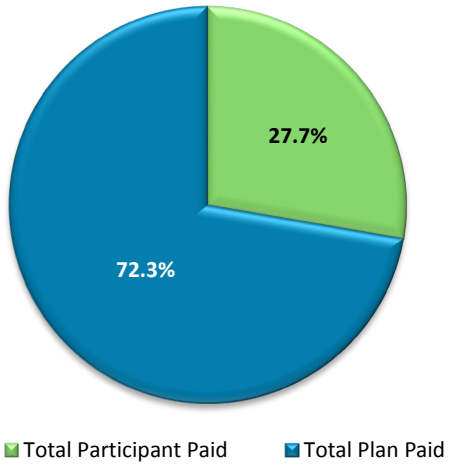


Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$239,197,293	$1,698	100.0%
COB	$6,198,499	$44	2.6%
Medicare	$13,576,783	$96	5.7%
Excess/Maximums	$6,979,073	$50	2.9%
PPO Discount	$132,804,785	$943	55.5%
Deductible	$16,066,135	$114	6.7%
Coinsurance	$5,995,061	$43	2.5%
Total Participant Paid	**$22,061,195**	**$157**	**9.2%**
Total Plan Paid	**$57,576,958**	**$409**	**24.1%**

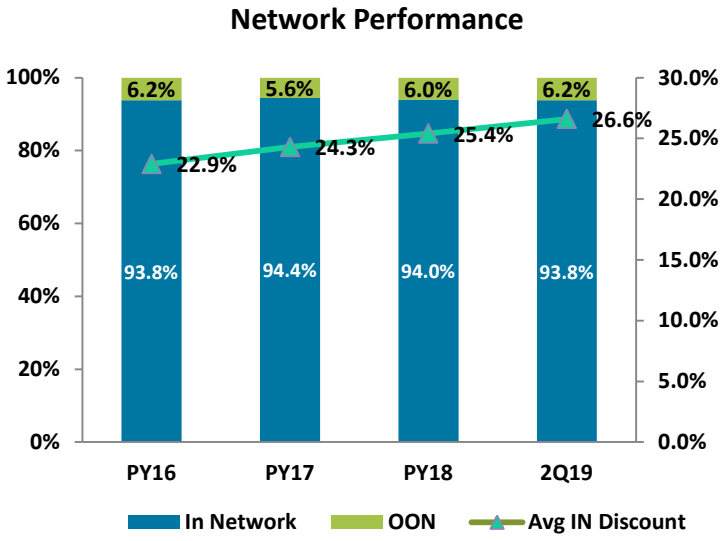
Total Participant Paid - PY18	**$141**
Total Plan Paid - PY18	**$450**



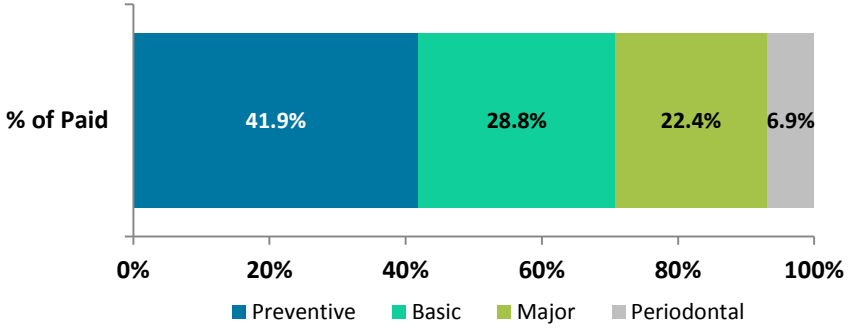


Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	3,015	4.5%	11,046	15.7%	$4,370,083	34.8%	$2,981,213	46.7%
$750.01-$1,000.00	1,278	1.9%	3,866	5.5%	$1,140,776	9.1%	$693,503	10.9%
$500.01-$750.00	2,443	3.6%	6,470	9.2%	$1,525,765	12.2%	$945,866	14.8%
$250.01-$500.00	5,188	7.7%	11,852	16.9%	$1,824,083	14.5%	$776,783	12.2%
$0.01-$250.00	26,775	39.6%	36,168	51.5%	$3,694,357	29.5%	$939,058	14.7%
$0.00	769	1.1%	822	1.2%	$0	0.0%	$43,150	0.7%
No Claims	28,116	41.6%	0	0.0%	$0	0.0%	$0	0.0%
Total	**67,584**	**100.0%**	**70,224**	**100.0%**	**$12,555,063**	**100.0%**	**$6,379,572**	**100.0%**



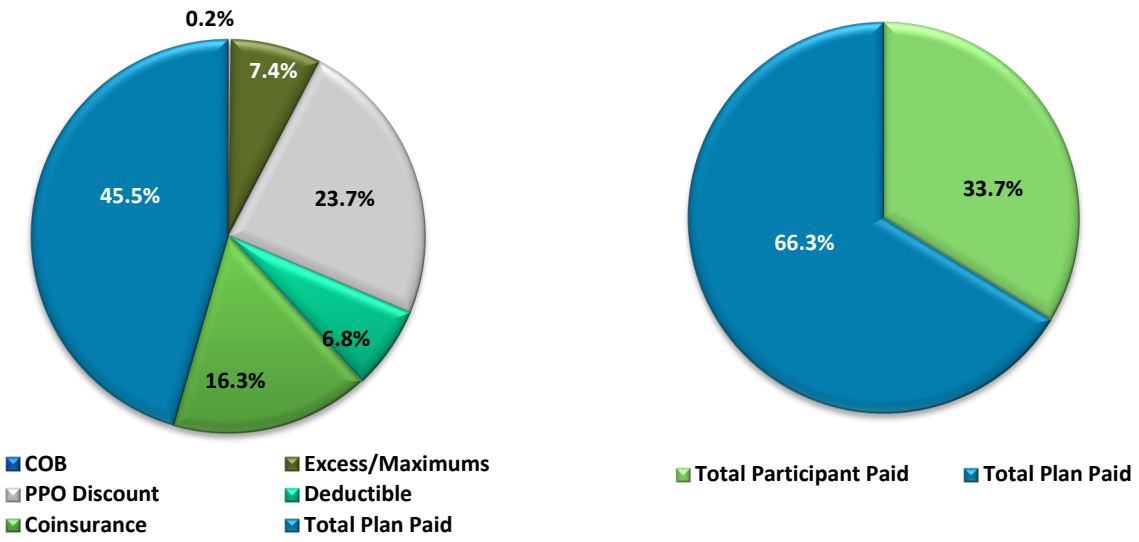
Claim Category	Total Paid	% of Paid
Preventive	$5,266,251	41.9%
Basic	$3,610,977	28.8%
Major	$2,814,913	22.4%
Periodontal	$862,922	6.9%
Total	**$12,555,063**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$27,582,627	$68	100.0%
COB	$66,008	$0	0.2%
Excess/Maximums	$2,051,600	$5	7.4%
PPO Discount	$6,530,385	$16	23.7%
Deductible	$1,876,911	$5	6.8%
Coinsurance	$4,502,660	$11	16.3%
Total Participant Paid	**$6,379,571**	**$16**	**23.1%**
Total Plan Paid	**$12,555,063**	**$31**	**45.5%**

Total Participant Paid - PY18	**$14**
Total Plan Paid - PY18	**$31**



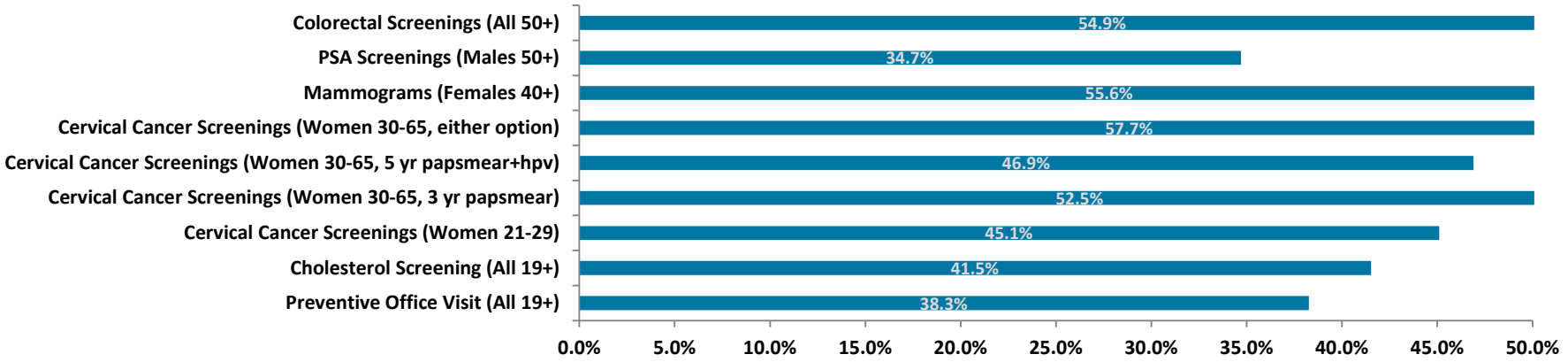
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	16,833	8,400	49.9%	14,865	3,731	25.1%	31,698	12,131	38.3%
Cholesterol Screening (All 19+)	16,833	7,558	44.9%	14,865	5,604	37.7%	31,698	13,162	41.5%
Cervical Cancer Screenings (Women 21-29)	2,612	1,178	45.1%	----	----	----	2,612	1,178	45.1%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	12,741	6,689	52.5%	----	----	----	12,741	6,689	52.5%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	12,741	5,976	46.9%	----	----	----	12,741	5,976	46.9%
Cervical Cancer Screenings (Women 30-65, either option)	12,741	7,352	57.7%	----	----	----	12,741	7,352	57.7%
Mammograms (Females 40+)	10,555	5,869	55.6%	----	----	----	10,555	5,869	55.6%
PSA Screenings (Males 50+)	----	----	----	6,284	2,181	34.7%	6,284	2,181	34.7%
Colorectal Screenings (All 50+)	7,363	4,204	57.1%	6,284	3,287	52.3%	13,647	7,491	54.9%

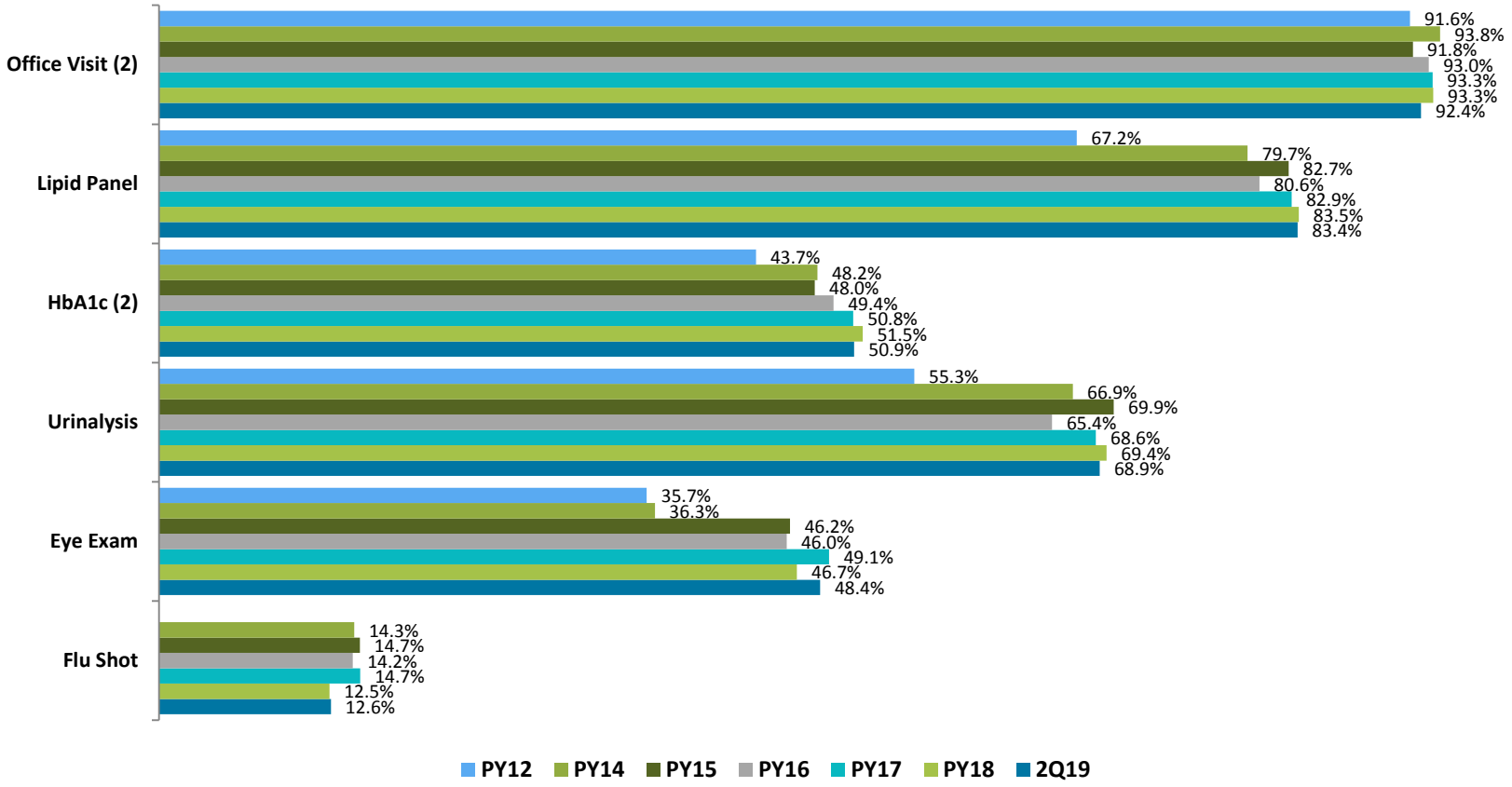
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population								
Year	PY12	PY13	PY14	PY15	PY16	PY17	PY18	2Q19
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,725

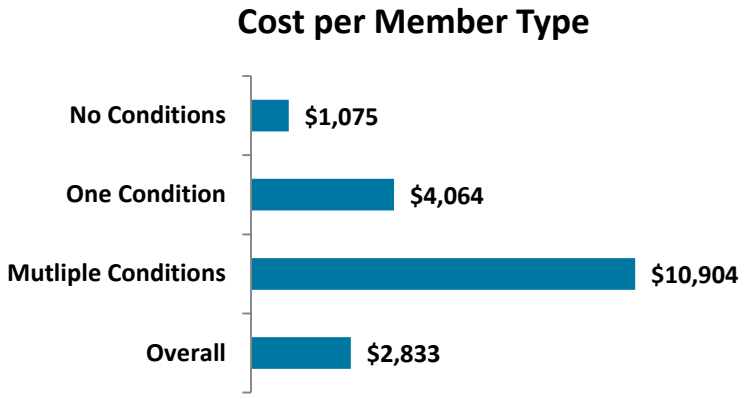


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	1,060	1,035	27	39	$7,183,319	$6,777	99.2%	1 Office Visit
Cancer	1,223	1,194	31	58	$25,822,843	$21,114	----	----
Chronic Kidney Disease	305	300	8	61	$5,815,369	$19,067	----	----
Chronic Obstructive Pulmonary Disease (COPD)	259	252	7	61	$3,857,407	$14,893	98.8%	1 Office Visit
Congestive Heart Failure (CHF)	117	113	3	62	$6,523,468	$55,756	21.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	562	554	14	62	$7,618,807	$13,557	28.5%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,237	1,201	31	42	$11,327,751	$9,157	96.8%	1 Office Visit
Diabetes	1,725	1,685	44	56	$14,700,720	$8,522	20.4%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,008	2,954	77	55	$13,691,028	$4,552	43.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,354	3,283	85	57	$27,778,315	$8,282	31.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	740	724	19	44	$4,593,924	$6,208	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	26,484	31	45.9%	11.0%	43.1%
One Condition	8,313	47	71.7%	15.7%	12.6%
Multiple Conditions	4,502	56	79.5%	17.9%	2.6%
Overall	**39,299**	**37**	**55.1%**	**12.7%**	**32.2%**



Public Employees' Benefits Program – CDHP RX Costs
PY 2019 – Quarter Ending December 31, 2018

Membership Summary	2Q FY2019	2Q FY2018	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,681	41,997	684	1.6%
Utilizing Member Count (Patients)	25,262	24,646	616	2.5%
Percent Utilizing (Utilization)	59.2%	58.7%	0.01	0.9%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	244,003	248,493	(4,490)	-1.8%
Claims per Elig Member per Month (Claims PMPM)	1.91	0.99	0.92	92.9%
Total Claims for Brand (Brand Rx)	35,360	34,789	571.00	1.6%
Total Claims for Generic (Generic Rx)	208,643	213,704	(5,061.00)	-2.4%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	3,880	3,893	(13.00)	-0.3%
Total Non-Specialty Claims	241,946	246,692	(4,746.00)	-1.9%
Total Specialty Claims	2,057	1,801	256.00	14.2%
Generic % of Total Claims (GFR)	**85.5%**	**86.0%**	(0.00)	-0.6%
Generic Effective Rate (GCR)	**98.2%**	**98.2%**	(0.00)	0.0%
Mail Order Claims	32,087	30,715	1,372.00	4.5%
Mail Penetration Rate*	15.1%	14.2%	0.01	0.9%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$22,359,490.00	$20,828,586.00	$1,530,904.00	7.4%
Total Brand Gross Cost	$17,969,797.00	$16,039,751.00	$1,930,046.00	12.0%
Total Generic Gross Cost	$4,389,694.00	$232,343.00	$4,157,351.00	1789.3%
Total MSB Gross Cost	$554,344.00	$4,788,836.00	($4,234,492.00)	-88.4%
Total Ingredient Cost	$22,144,547.00	$20,663,392.00	$1,481,155.00	7.2%
Total Dispensing Fee	$207,350.00	$155,970.00	$51,380.00	32.9%
Total Other (e.g. tax)	$7,593.00	$9,404.00	($1,811.00)	-19.3%
Avg Total Cost per Claim (Gross Cost/Rx)	$91.64	$83.82	$7.82	9.3%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$508.20	$461.06	$47.14	10.2%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$21.04	$1.09	$19.95	1830.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$142.87	$1,230.11	($1,087.24)	-88.4%

Public Employees' Benefits Program – CDHP RX Costs
PY 2019 – Quarter Ending December 31, 2018 (cont.)

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$5,922,565.00**	**$6,246,876.00**	($324,311.00)	-5.2%
Total Copay	$2,362,959.00	$2,339,964.00	$22,995.00	1.0%
Total Deductible	$3,559,605.00	$3,906,913.00	($347,308.00)	-8.9%
Avg Copay per Claim (Copay/Rx)	$9.68	$9.42	$0.27	2.8%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$24.27**	**$25.14**	**($0.87)**	**-3.4%**
Avg Copay for Brand (Copay/Brand Rx)	$103.19	$104.35	($1.16)	-1.1%
Avg Copay for Generic (Copay/Generic Rx)	$10.90	$12.24	($1.34)	-10.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$74.79	$80.35	($5.56)	-6.9%
Net PMPM (Participant Cost PMPM)	**$23.13**	**$24.79**	($1.66)	-6.7%
Copay % of Total Prescription Cost (Member Cost Share %)	26.5%	30.0%	-3.5%	-11.7%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$16,436,925.00**	**$14,581,710.00**	**$1,855,215.00**	**12.7%**
Total Specialty Drug Cost (Specialty Plan Cost)	$9,271,891.00	$7,771,372.00	$1,500,519.00	19.3%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$7,165,035.00	$6,810,338.00	$354,697.00	5.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$67.36**	**$58.68**	$8.68	14.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$405.00	$356.71	$48.29	13.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$10.15	$10.16	($0.01)	-0.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$68.08	$30.39	$37.69	124.0%
Net PMPM (Plan Cost PMPM)	**$64.19**	**$57.87**	**$6.32**	**10.9%**
PMPM for Specialty Only (Specialty PMPM)	$72.41	$30.84	$41.57	134.8%
PMPM without Specialty (Non-Specialty PMPM)	$55.96	$27.03	$28.93	107.0%

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2018 – December 2018

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q19 was $14,273,373 with an annualized plan cost per employee per year of $6,138. This is 1.1% below the HSB Book of Business Index.
  - IP Cost per Admit is $15,828 which is 2.1% lower than the HSB Index.
  - ER Cost per Visit is $2,514 which is 49.3% higher than the HSB Index.
- Employees shared in 12.4% of the medical cost.
- Inpatient facility costs were 23.4% of the plan spend.
- For the reporting period, 27.5% of members did not incur cost to the plan. Of that, 27.0% of total members did not have any claims paid by the plan at all during the reporting period.
- 11 members exceeded the $50k high cost threshold during the reporting period, which accounted for 16.8% of the plan spend. The highest diagnosis category was Diseases of the Circulatory System, accounting for 27.6% of the high cost claimant dollars.
- Total spending with in-network providers was 98.0%. The overall in-network discount was 58.5%.

Paid Claims by Age Group

Paid Claims by Age Group										
	2Q19									
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Net Pay		PMPM	
<1	$	232,192	$	461	$	1,668	$	7	$	233,860	$	467
1	$	106,988	$	196	$	2,634	$	10	$	109,622	$	206
2 - 4	$	122,774	$	79	$	7,297	$	9	$	130,071	$	88
5 - 9	$	180,861	$	58	$	42,536	$	27	$	223,397	$	85
10 - 14	$	496,008	$	129	$	116,776	$	61	$	612,784	$	190
15 - 19	$	610,972	$	150	$	124,235	$	61	$	735,207	$	211
20 - 24	$	274,380	$	80	$	178,702	$	104	$	453,082	$	184
25 - 29	$	538,969	$	260	$	130,614	$	126	$	669,583	$	387
30 - 34	$	1,465,167	$	539	$	154,398	$	114	$	1,619,565	$	653
35 - 39	$	798,698	$	251	$	309,629	$	194	$	1,108,327	$	445
40 - 44	$	746,921	$	234	$	350,758	$	220	$	1,097,679	$	455
45 - 49	$	1,006,752	$	239	$	650,392	$	309	$	1,657,144	$	549
50 - 54	$	1,835,273	$	399	$	891,406	$	387	$	2,726,679	$	786
55 - 59	$	1,904,231	$	350	$	1,081,398	$	398	$	2,985,629	$	748
60 - 64	$	3,156,919	$	526	$	1,320,450	$	440	$	4,477,369	$	965
65+	$	796,268	$	331	$	504,227	$	419	$	1,300,495	$	750
Total	**$**	**14,273,373**	**$**	**280**	**$**	**5,867,120**	**$**	**231**	**$**	**20,140,493**	**$**	**511**

Financial Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**2Q19**	**2Q19**	**2Q19**	**2Q19**	**2Q19**	**HSB Peer Index**
Enrollment						
Avg # Employees	4,651	3,862	4	594	191	
Avg # Members	8,478	7,412	5	822	240	
Ratio	1.8	1.9	1.3	1.4	1.3	1.8
Financial Summary						
Gross Cost	$16,286,093	$12,962,583	$5,084	$2,389,617	$928,808	
Client Paid	$14,273,373	$11,291,987	$4,356	$2,114,893	$862,136	
Employee Paid	$2,012,720	$1,670,596	$728	$274,724	$66,672	
Client Paid-PEPY	$6,138	$5,848	$2,178	$7,125	$9,012	$6,209
Client Paid-PMPY	$3,367	$3,047	$1,743	$5,149	$7,199	$3,437
Client Paid-PEPM	$511	$487	$182	$594	$751	$517
Client Paid-PMPM	$281	$254	$145	$429	$600	$286
High Cost Claimants (HCC's) > $100k						
# of HCC's	11	6	0	3	2	
HCC's / 1,000	1.3	0.8	0.0	3.7	8.4	
Avg HCC Paid	$218,014	$230,673	$0	$154,751	$274,929	
HCC's % of Plan Paid	16.8%	12.3%	0.0%	22.0%	63.8%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$704	$583	$0	$944	$3,626	$1,057
Facility Outpatient	$1,107	$1,001	$711	$1,781	$2,054	$1,145
Physician	$1,435	$1,355	$1,032	$2,148	$1,488	$1,122
Other	$122	$108	$0	$275	$32	$113
Total	$3,367	$3,047	$1,743	$5,149	$7,199	$3,437
	Annualized	Annualized	Annualized	Annualized	Annualized	

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 2,768,528	$ 437,997	$ 52,827	$ 3,259,352
Outpatient	$ 8,523,459	$ 1,453,749	$ 170,320	$ 10,147,529
Total - Medical	**$ 11,291,987**	**$ 1,891,746**	**$ 223,147**	**$ 13,406,881**

Net Paid Claims - Per Participant per Month	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 487	$ 625	$ 416	$ 501

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ -	$ 467,150	$ 4,516	$ 471,666
Outpatient	$ 4,356	$ 311,138	$ 79,331	$ 394,826
Total - Medical	**$ 4,356**	**$ 778,288**	**$ 83,847**	**$ 866,492**

Net Paid Claims - Per Participant per Month	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 182	$ 941	$ 261	$ 739

Paid Claims by Claim Type – Total

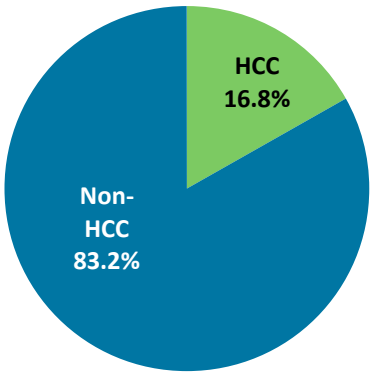
Net Paid Claims - Total Total Participants	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 2,768,528	$ 905,147	$ 57,343	$ 3,731,018
Outpatient	$ 8,527,815	$ 1,764,888	$ 249,652	$ 10,542,355
Total - Medical	**$ 11,296,343**	**$ 2,670,034**	**$ 306,995**	**$ 14,273,373**

Net Paid Claims - Per Participant per Month	2Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 487	$ 693	$ 358	$ 511

Cost Distribution – Medical Claims

Paid Claims Category	2Q19 Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	10	0.1%	$2,344,452	16.4%	$54,837	2.7%
$50,000.01-$100,000.00	19	0.2%	$1,239,292	8.7%	$98,636	4.9%
$25,000.01-$50,000.00	49	0.6%	$1,723,894	12.1%	$144,146	7.2%
$10,000.01-$25,000.00	185	2.2%	$2,775,328	19.4%	$269,139	13.4%
$5,000.01-$10,000.00	244	2.9%	$1,784,281	12.5%	$240,643	12.0%
$2,500.01-$5,000.00	354	4.2%	$1,259,312	8.8%	$256,770	12.8%
$0.01-$2,500.00	5,281	62.3%	$3,146,714	22.0%	$940,035	46.7%
$0.00	46	0.5%	$0	0.0%	$8,514	0.4%
No Claims	2,292	27.0%	$98	0.0%	$0	0.0%
	8,478	**100.0%**	**$14,273,373**	**100.0%**	**$2,012,720**	**100.0%**

Distribution of HCC Medical Claims Paid



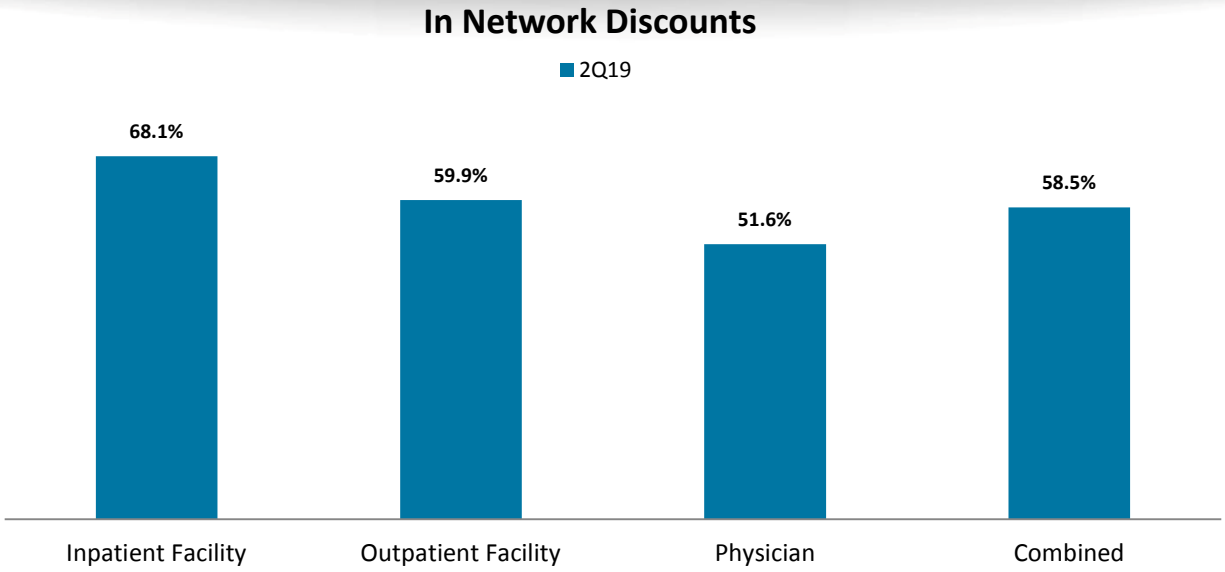
HCC – High Cost Claimant over $100K

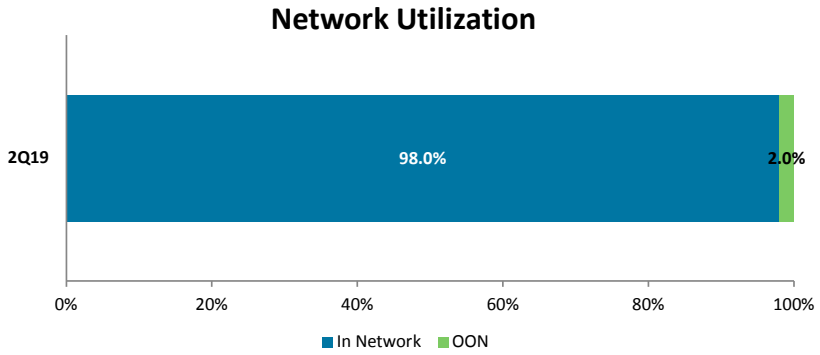
HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 7) Diseases Of The Circulatory System	5	$661,181	4.1%
(CCS 2) Neoplasms	7	$505,261	3.1%
(CCS 16) Injury And Poisoning	5	$342,945	2.1%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	5	$300,945	1.9%
(CCS 8) Diseases Of The Respiratory System	8	$177,857	1.1%
(CCS 5) Mental Illness	6	$164,486	1.0%
(CCS 1) Infectious And Parasitic Diseases	2	$141,241	0.9%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	5	$26,098	0.2%
(CCS 10) Diseases Of The Genitourinary System	4	$22,924	0.1%
(CCS 14) Congenital Anomalies	1	$16,045	0.1%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	6	$15,176	0.1%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	9	$11,089	0.1%
(CCS 6) Diseases Of The Nervous System And Sense Organs	8	$5,430	0.0%
(CCS 9) Diseases Of The Digestive System	4	$5,331	0.0%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	3	$1,681	0.0%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	3	$461	0.0%
Overall	**----**	**$2,398,151**	**100.0%**

Utilization Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**2Q19**	**2Q19**	**2Q19**	**2Q19**	**2Q19**	**HSB Peer Index**
Inpatient Facility						
# of Admits	186	158	0	22	6	
# of Bed Days	736	592	0	104	40	
Paid Per Admit	$15,828	$13,507	$0	$17,626	$72,373	$16,173
Paid Per Day	$4,016	$3,605	$0	$3,729	$10,856	$3,708
Admits Per 1,000	44	43	0	54	50	61
Days Per 1,000	174	160	0	253	334	264
Avg LOS	3.9	3.7	0	4.7	6.7	4.3
Physician Office						
OV Utilization per Member	3.7	3.5	5.2	4.7	4.2	3.3
Avg Paid per OV	$91	$92	$116	$83	$87	$50
Avg OV Paid per Member	$331	$323	$602	$393	$364	$167
DX&L Utilization per Member	6.9	6.5	0	9.4	10.9	8.3
Avg Paid per DX&L	$81	$79	$0	$84	$109	$67
Avg DX&L Paid per Member	$558	$513	$0	$787	$1,183	$554
Emergency Room						
# of Visits	527	452	0	61	14	
# of Admits	73	55	0	13	5	
Visits Per Member	0.12	0.12	0	0.15	0.12	0.17
Visits Per 1,000	124	122	0	149	117	174
Avg Paid per Visit	$2,514	$2,401	$0	$3,488	$1,936	$1,684
Admits Per Visit	0.14	0.12	0.00	0.21	0.36	0.14
Urgent Care						
# of Visits	908	830	0	57	21	
Visits Per Member	0.21	0.22	0.00	0.14	0.18	0.24
Visits Per 1,000	214	224	0	139	175	242
Avg Paid per Visit	$123	$125	$0	$111	$52	$74
	Annualized	Annualized	Annualized	Annualized	Annualized	

Provider Network Summary

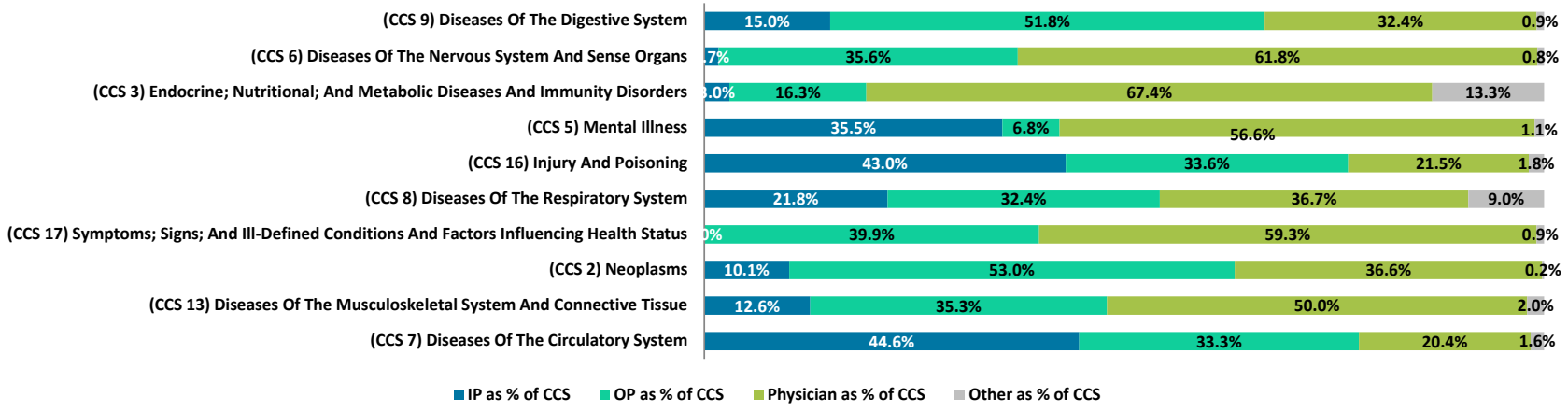




AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

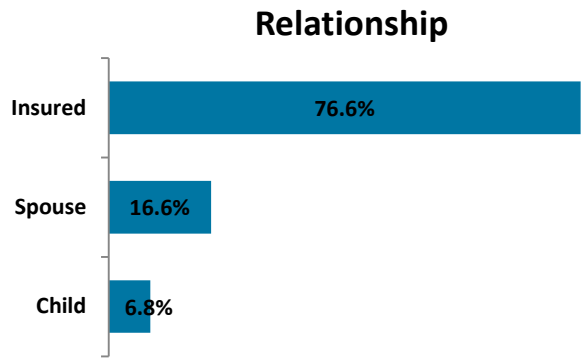
AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 7) Diseases Of The Circulatory System	$1,757,481	12.3%	$1,379,428	$336,259	$41,795	$1,271,959	$485,523
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$1,613,969	11.3%	$1,166,576	$377,054	$70,339	$552,349	$1,061,620
(CCS 2) Neoplasms	$1,345,546	9.4%	$1,102,206	$223,820	$19,521	$557,341	$788,205
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$1,293,666	9.1%	$808,807	$164,264	$320,594	$430,362	$863,303
(CCS 8) Diseases Of The Respiratory System	$1,140,811	8.0%	$779,826	$76,329	$284,655	$563,983	$576,827
(CCS 16) Injury And Poisoning	$1,004,604	7.0%	$772,557	$124,777	$107,270	$655,023	$349,581
(CCS 5) Mental Illness	$948,848	6.6%	$418,903	$73,305	$456,641	$341,338	$607,510
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$888,160	6.2%	$696,013	$58,955	$133,192	$329,333	$558,826
(CCS 6) Diseases Of The Nervous System And Sense Organs	$825,951	5.8%	$563,771	$120,437	$141,743	$298,354	$527,597
(CCS 9) Diseases Of The Digestive System	$798,615	5.6%	$624,328	$93,047	$81,241	$241,099	$557,517
(CCS 10) Diseases Of The Genitourinary System	$762,026	5.3%	$562,987	$104,534	$94,505	$236,942	$525,084
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$698,887	4.9%	$519,833	$152,497	$26,558	$1,310	$697,577
(CCS 1) Infectious And Parasitic Diseases	$421,726	3.0%	$275,436	$25,567	$120,723	$292,828	$128,898
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$323,009	2.3%	$254,903	$50,935	$17,171	$174,653	$148,355
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$184,329	1.3%	$137,137	$25,843	$21,349	$78,269	$106,060
(CCS 14) Congenital Anomalies	$128,119	0.9%	$25,385	$4,012	$98,722	$101,662	$26,457
(CCS 15) Certain Conditions Originating In The Perinatal Period	$86,608	0.6%	$0	$266	$86,341	$35,634	$50,974
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$51,019	0.4%	$38,069	$12,233	$718	$14,316	$36,703
Total	$14,273,373	100.0%	$10,126,163	$2,024,134	$2,123,076	$6,176,754	$8,096,619

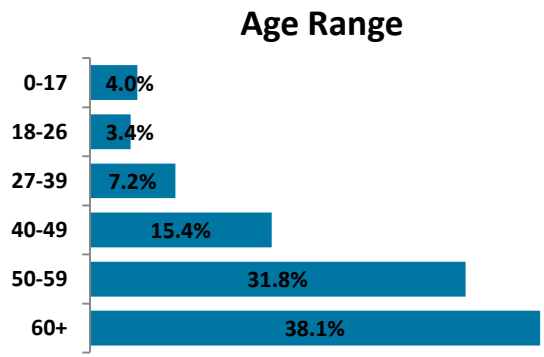


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	422	1,438	$1,311,760	74.6%
Cerebrovascular Disease	42	227	$220,541	12.5%
Hypertension	390	660	$117,335	6.7%
Diseases Of Arteries; Arterioles; And Capillaries	80	150	$66,663	3.8%
Diseases Of Veins And Lymphatics	94	200	$41,182	2.3%
Overall	**----**	**----**	**$1,757,481**	**100.0%**

*Patient and claim counts are unique only within the category

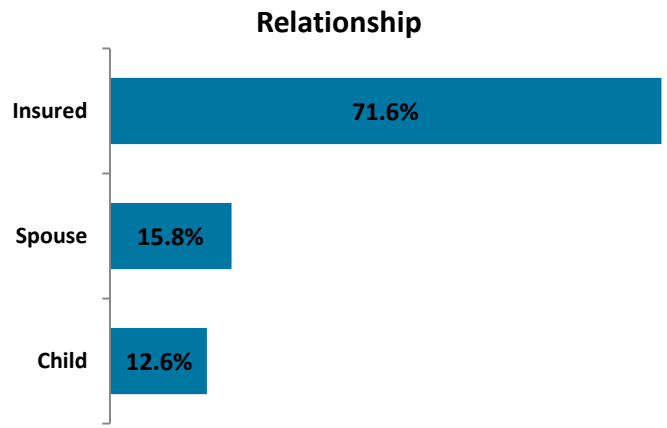


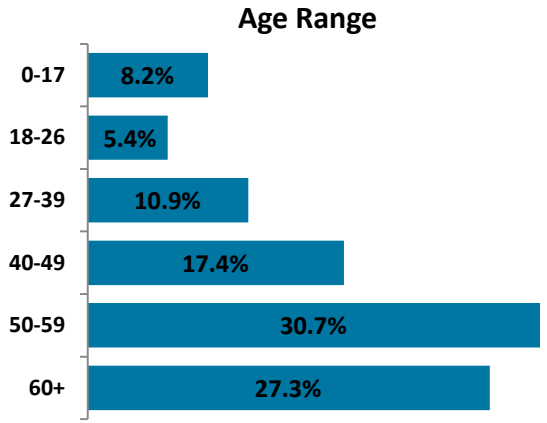


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	690	3,395	$714,871	44.3%
Non-Traumatic Joint Disorders	716	2,511	$465,620	28.8%
Other Connective Tissue Disease [211.]	587	1,608	$219,363	13.6%
Pathological Fracture [207.]	4	16	$57,872	3.6%
Acquired Deformities	89	247	$52,645	3.3%
Other Bone Disease And Musculoskeletal Deformities [212.]	237	820	$48,424	3.0%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	16	64	$34,799	2.2%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	5	83	$10,973	0.7%
Osteoporosis [206.]	33	46	$9,401	0.6%
	----	----	$1,613,969	100.0%

*Patient and claim counts are unique only within the category

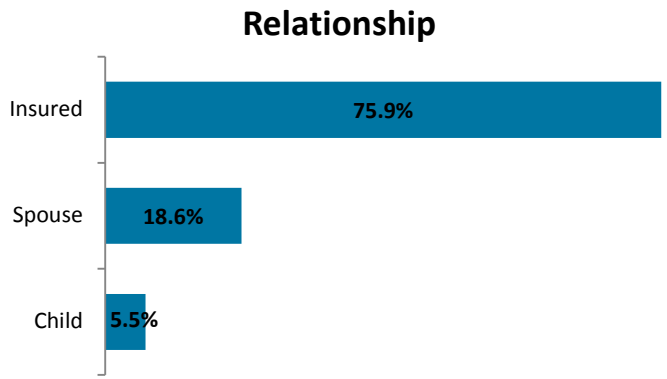


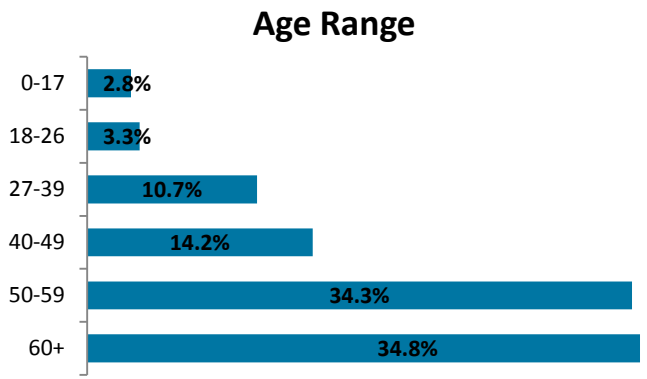


AHRQ Category - Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cancer Of Breast [24.]	35	229	$332,176	24.7%
Cancer Of Lymphatic And Hematopoietic Tissue	18	272	$288,611	21.4%
Benign Neoplasms	282	457	$146,083	10.9%
Maintenance Chemotherapy; Radiotherapy [45.]	13	40	$138,811	10.3%
Secondary Malignancies [42.]	9	55	$85,580	6.4%
Cancer Of Urinary Organs	7	37	$81,802	6.1%
Cancer Of Bronchus; Lung [19.]	5	84	$61,350	4.6%
Cancer Of Male Genital Organs	18	52	$48,975	3.6%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	244	366	$43,666	3.2%
Cancer Of Skin	63	135	$38,685	2.9%
Colorectal Cancer	5	23	$29,125	2.2%
Cancer; Other Primary	18	63	$28,132	2.1%
Other Gastrointestinal Cancer	3	38	$13,354	1.0%
Cancer Of Uterus And Cervix	14	23	$3,514	0.3%
Malignant Neoplasm Without Specification Of Site [43.]	4	8	$3,427	0.3%
Cancer Of Ovary And Other Female Genital Organs	5	12	$2,255	0.2%
Overall	**----**	**----**	**$1,345,546**	**100.0%**

*Patient and claim counts are unique only within the category

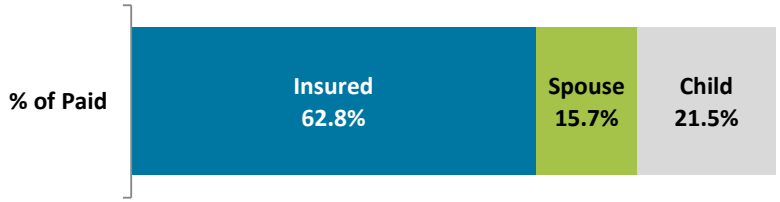




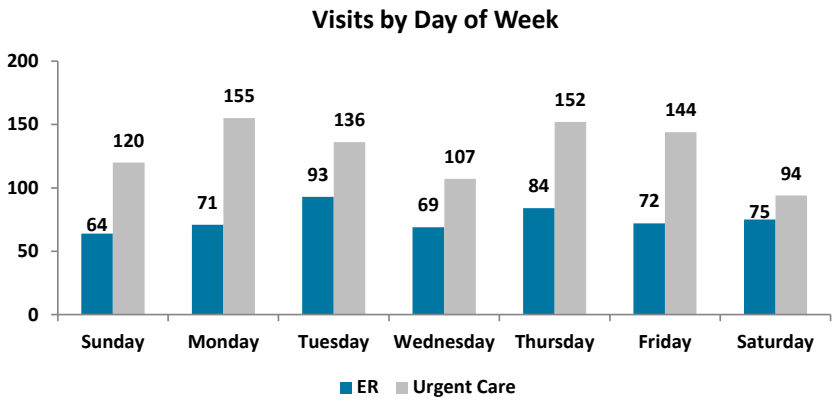
Emergency Room / Urgent Care Summary

	2Q19		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	528	908		
Number of Admits	73	----		
Visits Per Member	0.12	0.21	0.17	0.24
Visits/1000 Members	125	214	174	242
Avg Paid Per Visit	$2,507	$123	$1,684	$74
Admits per Visit	0.14	----	0.14	
% of Visits with HSB ER Dx	78.0%	----		
% of Visits with a Physician OV*	55.7%	53.0%		
Total Plan Paid	**$1,323,541**	**$111,541**		

*looks back 12 months from ER visit

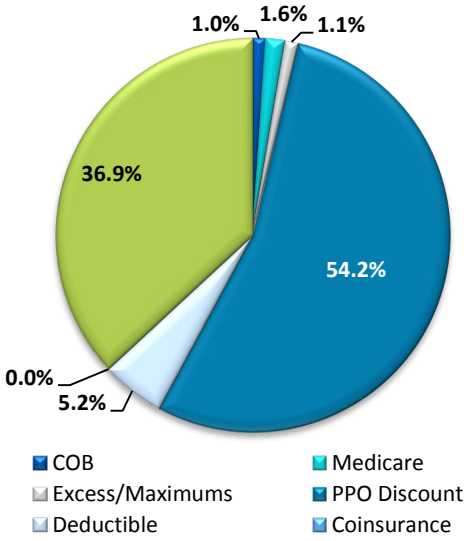


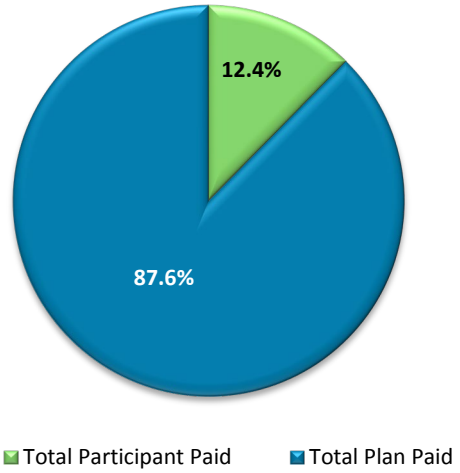
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	315	68	517	111	832	179
Spouse	71	75	98	104	169	180
Child	142	49	293	102	435	151
Total	**528**	**62**	**908**	**107**	**1,436**	**169**



Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$38,673,245	$1,386	100.0%
COB	$385,610	$14	1.0%
Medicare	$616,080	$22	1.6%
Excess/Maximums	$422,851	$15	1.1%
PPO Discount	$20,962,611	$751	54.2%
Deductible	$2,012,649	$72	5.2%
Coinsurance	$71	$0	0.0%
Total Participant Paid	**$2,012,720**	**$72**	**5.2%**
Total Plan Paid	**$14,273,373**	**$511**	**36.9%**





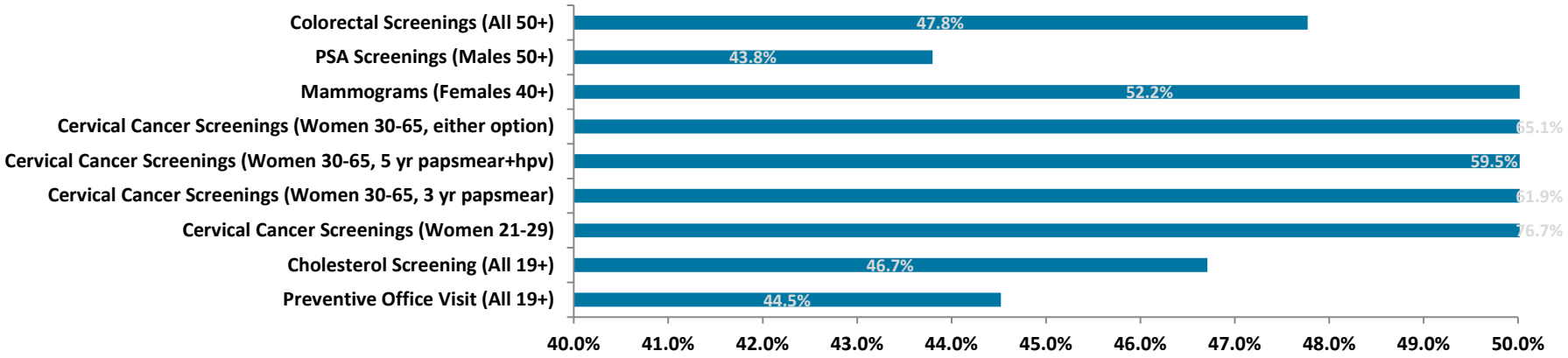
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	162	93	57.4%	112	29	25.9%	274	122	44.5%
Cholesterol Screening (All 19+)	162	75	46.3%	112	53	47.3%	274	128	46.7%
Cervical Cancer Screenings (Women 21-29)	30	23	76.7%	----	----	----	30	23	76.7%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	126	78	61.9%	----	----	----	126	78	61.9%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	126	75	59.5%	----	----	----	126	75	59.5%
Cervical Cancer Screenings (Women 30-65, either option)	126	82	65.1%	----	----	----	126	82	65.1%
Mammograms (Females 40+)	69	36	52.2%	----	----	----	69	36	52.2%
PSA Screenings (Males 50+)	----	----	----	32	14	43.8%	32	14	43.8%
Colorectal Screenings (All 50+)	35	18	51.4%	32	14	43.8%	67	32	47.8%

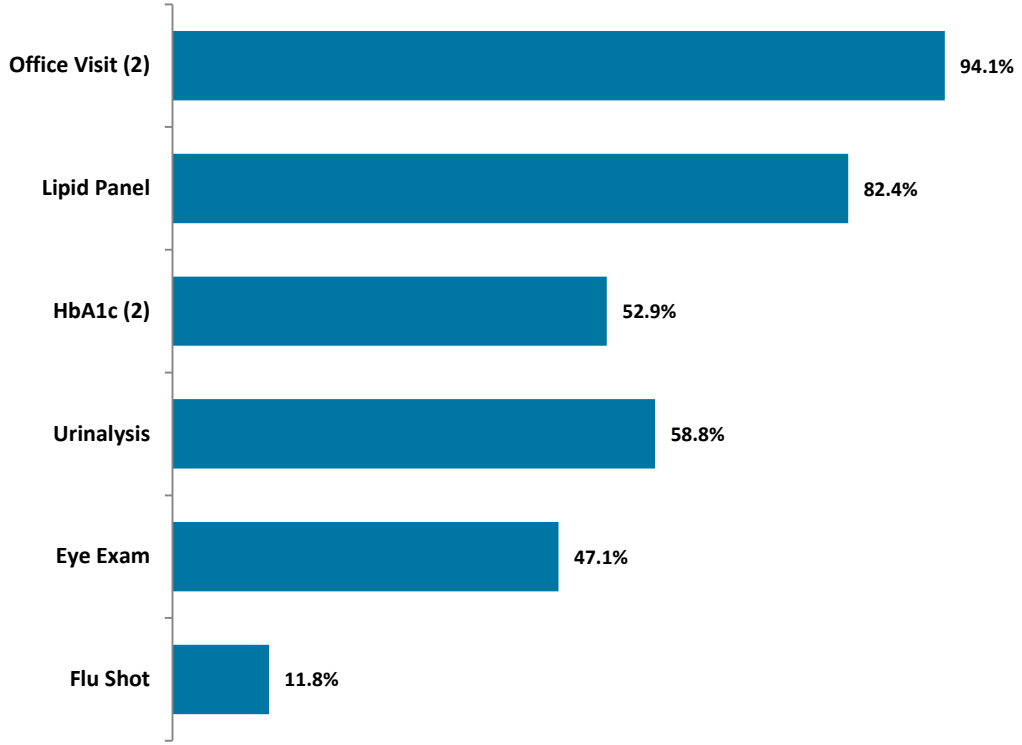
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population	
Year	2Q19
Members	17

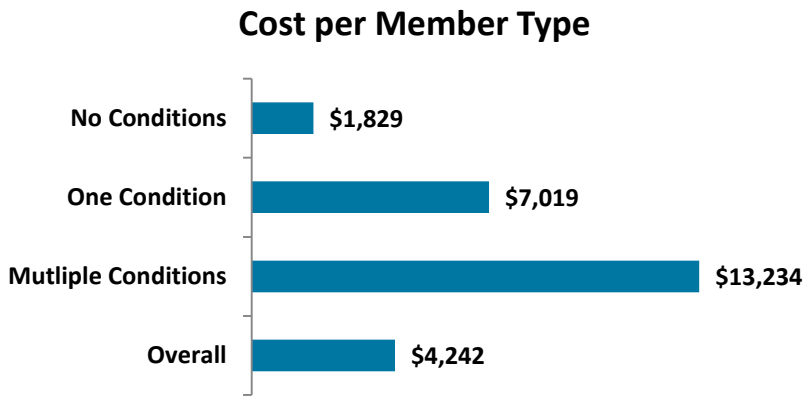


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	10	10	26	30	$51,926	$5,193	100.0%	1 Office Visit
Cancer	7	7	18	53	$269,734	$38,533	----	----
Chronic Kidney Disease	0	0	0	0	$0	$0	----	----
Chronic Obstructive Pulmonary Disease (COPD)	0	0	0	0	$0	$0	0.0%	1 Office Visit
Congestive Heart Failure (CHF)	0	0	0	0	$0	$0	0.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	1	1	3	50	$1,742	$1,742	100.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	28	27	74	38	$349,419	$12,479	96.4%	1 Office Visit
Diabetes	17	16	45	49	$42,530	$2,502	11.8%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	19	18	50	50	$69,543	$3,660	42.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	28	28	74	52	$274,690	$9,810	32.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	13	13	34	42	$61,859	$4,758	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	250	25	43.8%	6.5%	49.6%
One Condition	91	40	70.2%	10.6%	19.1%
Multiple Conditions	39	48	90.0%	7.5%	2.5%
Overall	**380**	**31**	**54.8%**	**7.6%**	**37.6%**



Public Employees' Benefits Program – EPO RX Costs
PY 2019 – Quarter Ending December 31, 2018

Membership Summary	2Q FY2019 EPO	1Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,472	8,479	(7)	-0.1%
Utilizing Member Count (Patients)	5,294	4,883	411	8.4%
Percent Utilizing (Utilization)	62.5%	57.6%	0	8.5%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	41,662	39,404	2,258	5.7%
Claims per Elig Member per Month (Claims PMPM)	1.64	1.55	0.09	5.8%
Total Claims for Brand (Brand Rx)	5,952	5,255	697.00	13.3%
Total Claims for Generic (Generic Rx)	35,710	34,149	1,561.00	4.6%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	658	633	25.00	3.9%
Total Non-Specialty Claims	39,024	37,603	1,421.00	3.8%
Total Specialty Claims	2,638	1,801	837.00	46.5%
Generic % of Total Claims (GFR)	**85.7%**	**86.7%**	(0.01)	-1.1%
Generic Effective Rate (GCR)	**98.2%**	**98.2%**	0.00	0.0%
Mail Order Claims	38,777	30,714	8,063.00	26.3%
Mail Penetration Rate*	13.6%	14.2%	(0.01)	-0.6%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$4,110,834.00	$3,531,529.00	$579,305.00	16.4%
Total Brand Gross Cost	$3,131,632.00	$2,707,361.00	$424,271.00	15.7%
Total Generic Gross Cost	$109,153.00	$16,724.00	$92,429.00	552.7%
Total MSB Gross Cost	$979,201.00	$824,168.00	$155,033.00	18.8%
Total Ingredient Cost	$4,084,138.00	$3,512,566.00	$571,572.00	16.3%
Total Dispensing Fee	$26,193.00	$18,534.00	$7,659.00	41.3%
Total Other (e.g. tax)	$502.00	$430.00	$72.00	16.7%
Avg Total Cost per Claim (Gross Cost/Rx)	**$98.67**	**$89.62**	$9.05	10.1%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$526.15	$515.20	$10.95	2.1%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$3.06	$0.49	$2.57	524.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$1,488.15	$1,302.00	$186.15	14.3%

Public Employees' Benefits Program – EPO RX Costs
PY 2019 – Quarter Ending December 31, 2018 (cont.)

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$696,690.36**	**$730,020.71**	($33,330.35)	-4.6%
Total Copay	$696,690.36	$730,020.71	($33,330.35)	-4.6%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$16.72	$18.53	($1.80)	-9.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$16.72**	**$18.53**	**($1.80)**	**-9.7%**
Avg Copay for Brand (Copay/Brand Rx)	$78.60	$97.58	($18.98)	-19.5%
Avg Copay for Generic (Copay/Generic Rx)	$6.41	$6.36	$0.05	0.8%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$25.42	$27.65	($2.23)	-8.1%
Net PMPM (Participant Cost PMPM)	**$13.71**	**$14.35**	($0.64)	-4.5%
Copay % of Total Prescription Cost (Member Cost Share %)	16.9%	20.7%	-3.7%	-18.0%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$3,414,143.00**	**$2,801,508.00**	**$612,635.00**	**21.9%**
Total Specialty Drug Cost (Specialty Plan Cost)	$1,258,909.00	$929,017.00	$329,892.00	35.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,155,234.00	$1,872,491.00	$282,743.00	15.1%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$81.95**	**$71.10**	$10.85	15.3%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$447.55	$417.61	$29.94	7.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$21.01	$17.77	$3.24	18.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$140.47	$101.00	$39.47	39.1%
Net PMPM (Plan Cost PMPM)	**$67.17**	**$55.07**	**$12.10**	**22.0%**
PMPM for Specialty Only (Specialty PMPM)	$49.53	$36.52	$13.01	35.6%
PMPM without Specialty (Non-Specialty PMPM)	$84.80	$73.61	$11.19	15.2%

Quarterly Health Plan Performance Review

Prepared For PEBP

State of Nevada

HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

35+ years experience caring for Nevadans and their families

Member Centered Solutions

Access to Southwest Medical/OptumCare

Cost Structure & Network Strength

Local Service & Wellness Resources

On-Site Hospital Case Managers

Our Care Delivery Assets in Nevada

- ✓ 40 OptumCare locations and expanding
- ✓ Over 400 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 4 MedExpress urgent care centers
- ✓ 7 convenient care walk-in locations
- ✓ 2 ambulatory surgery centers
- ✓ Brand new 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Adding new and more ways for your members to receive the care they need when they need it
- ✓ Expansion of specialty network in these areas: pulmonary, allergy, dermatology, general surgery, orthotics & prosthetic vendors
- ✓ Real Appeal weight lost program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ 16 additional locations for physical therapy services
- ✓ P3 Primary Care with 9 locations added to network
- ✓ $0 telemedicine visits for your members
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication

Key Performance Indicators

Demographics & Cost Data

Data Definitions:

- **Prior Period** - July 1, 2017 through December 31, 2017
- **Current Period** - July 1, 2018 through December 31, 2018

Demographic Overview

HEALTH PLAN OF NEVADA
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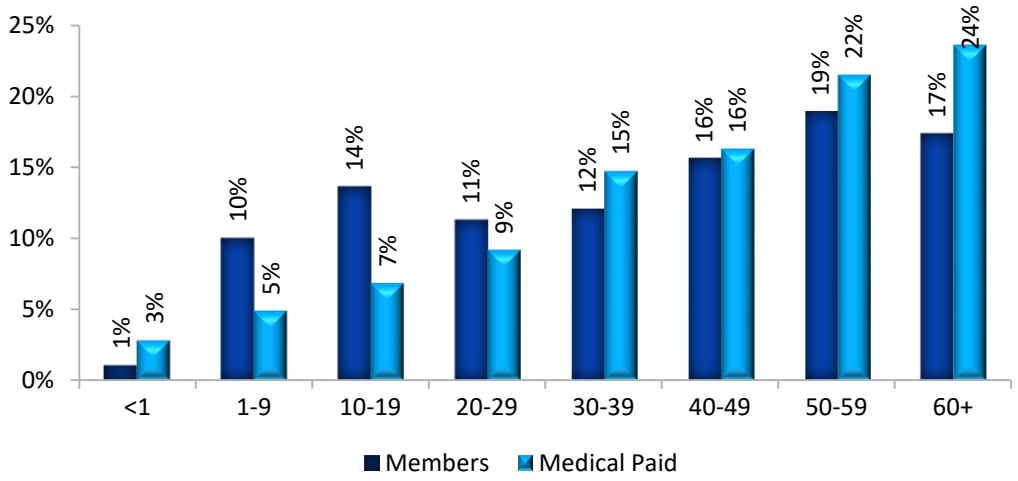
Population Measure	Prior	Current	Δ	Peer	Δ
Employees	3,984	3,886	-2.5%		
Average Age	49.6	49.4	-0.4%	44.2	11.8%
% Female	60.8%	61.6%	1.3%	49.5%	24.3%
Membership	6,819	6,707	-1.6%		
Average Age	38.3	37.9	-0.9%	34.9	8.6%
% Female	57.2%	56.9%	-0.4%	51.2%	11.3%
% Female (20 -44)	18.1%	18.3%	1.3%	21.1%	-13.1%
% Children (<18)	21.2%	21.7%	2.5%	21.8%	-0.4%
% Dependents (18-25)	11.2%	11.3%	0.3%	12.4%	-9.3%
Average Family Size	1.71	1.73	0.8%	1.82	-5.1%
Age Gender Factor	1.21	1.20	-0.6%	1.05	14.9%
HHS Population Risk Factor	1.75	1.70	-2.8%	1.23	39.1%



Population Insights

Membership decreased **-1.6%** to 6,707 covered under the medical plan for this period

Females are **56.9%** of membership driving **62.7%** of spend

Age 40+ are **51.9%** of members and drive **61.4%** of spend

HHS Risk Factor decreased **-2.8%** from prior period, but is still **39.1%** higher than Peer

Financial Highlights

HEALTH PLAN OF NEVADA
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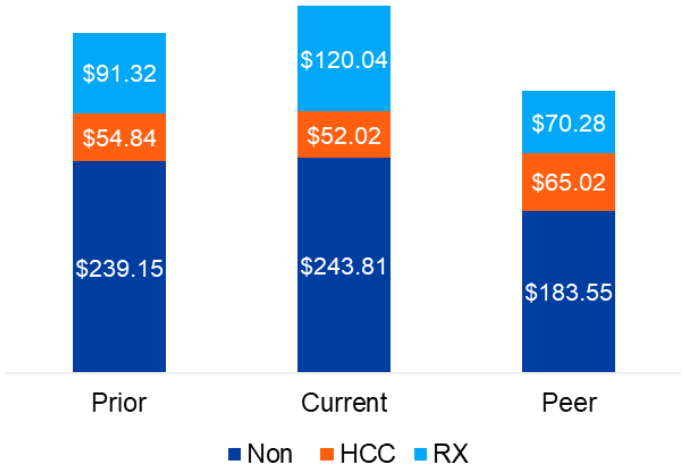
		Prior	Current		Δ	Peer	Δ
Financial	Net Paid PMPM	$293.98	$295.84		0.6%	$248.56	19.0%
	Non-Catastrophic	$239.15	$243.81		2.0%	$183.55	
	Catastrophic	$54.84	$52.02	▼	-5.1%	$65.02	
	Plan Cost Share	76.3%	71.1%		-6.8%	78.0%	-8.8%
	Pharmacy PMPM	$91.32	$120.04	▲	31.5%	$70.28	70.8%
Catastrophic	Catastrophic Cases	24	18	▼	-25.0%		
	% of Members	0.28%	0.23%		-17.9%	0.30%	-23.5%
	Average Net Paid	$97,236	$117,710	▲	21.1%	$114,345	2.9%
	% of Total Medical Net Paid	14.8%	12.7%		-14.5%	21.1%	-39.9%

Trends Period over Period

- Medical PMPM Trend: **0.6%**
- Rx PMPM Trend: **31.5%**
- Combined PMPM trend: **7.9%**



Emergent/Urgent Services

HEALTH PLAN OF NEVADA
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Metrics	Prior	Current	Change	Peer	Δ
ER Visits	409	348	-14.8%		
ER Paid	$1,079,606	$925,947	-14.2%		
ER Net Paid / Visit	$2,642	$2,660	0.7%	$2,471	7.7%
ER Visits per K	60	52	-13.4%	16	233.6%
UC Visits	2,076	2,382	14.7%		
UC Paid	$27,115	$41,478	53.0%		
UC Net Paid / Visit	$94	$96	1.9%	$89	7.1%
UC Visits per K	304	355	16.7%	81	336.9%

ER and Urgent Care Overview

- Number of free-standing emergency rooms growing in Nevada
- ER per 1000 utilization is lower in current period by 13%
- Higher use of urgent cares
- Urgent care average cost under $100 compared to ER visit of $2,600

Top 10 ER Diagnosis by Spend	ER Visits
Nonspecific Chest Pain	26
Abdominal Pain	26
Other Complications Of Pregnancy	18
Injuries And Conditions Due To External Causes	12
Conditions Associated With Dizziness Or Vertigo	8
Biliary Tract Disease	7
Superficial Injury; Contusion	14
Asthma	6
Sprains And Strains	12
Headache; Including Migraine	12

On-Demand Care Services

HEALTH PLAN OF NEVADA
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ADVICE NURSE for care guidance, treatment alternatives and options

24/7

VIRTUAL VISITS through NowClinic to see a provider from any location

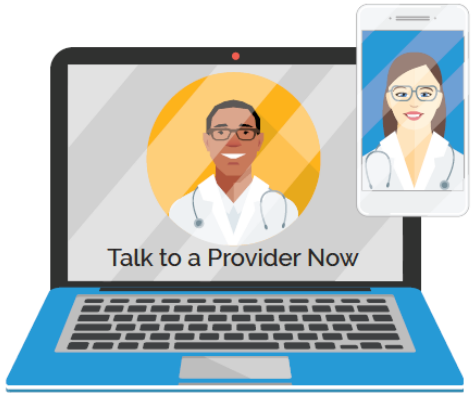
Advice Nurse Utilization

Prior	Current
228	252

NowClinic Visits

Prior	Current
126	142

Top Outcomes of Advice Nurse Call	Prior	Current
Sent to Urgent Care	85	93
Scheduled Appointment with Provider	37	46
Sent to Emergency Room	32	34
Provided Self-Care Options	29	26



High Cost Claimant (HCC) Data

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Overview of High Cost Claimants

HCC Summary	Prior	Current	Change	Peer	Var
High Cost Members (>= $50,000)	24	18	-25.0%		
HCC's per 1,000	2.77	2.28	-17.9%	2.97	-23.5%
% of Members as High Cost	0.28%	0.23%	-17.9%	0.30%	-23.5%
% of Dollars as High Cost	14.8%	12.7%	-14.5%	21.1%	-39.9%
HHS Risk Score	36.44	31.30	-14.1%	27.79	12.6%
High Cost Claimant Average Cost	**$97,236**	**$117,710**	**21.1%**	**$114,345**	**2.9%**
High Cost Claimant Average Med Cost	$93,486	$116,310	24.4%	$110,732	5.0%
High Cost Claimant Average Rx Cost	$3,750	$1,400	-62.7%	$3,613	-61.2%

- Defined as $50,000+ in spend during measurement period
- High cost claimant paid dollars accounts for 17.6% of total medical spend
- Lower number of claimants in current period
- Average cost per claimant increased in current period by 21%

High Cost Claimant (HCC) Details

HEALTH PLAN OF NEVADA
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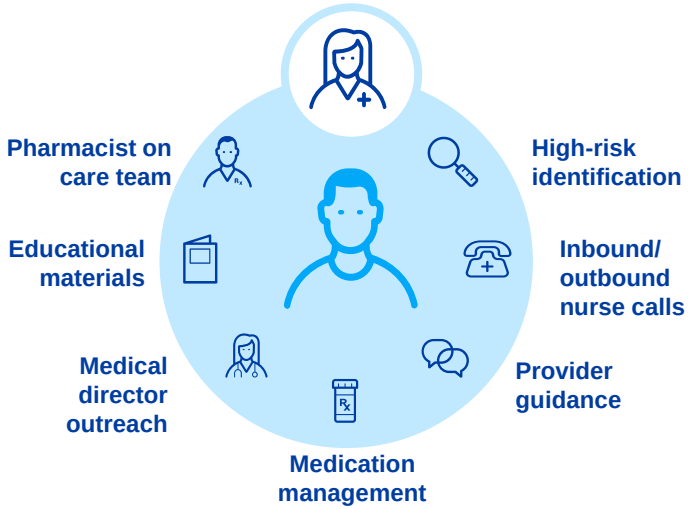
Largest 10 Cases by Paid in Current Period

Case #	AHRQ Category Description	Relation	Paid	Eligible
1	Complication of device; implant or graft	H	$264,659	YES
2	Rehabilitation care; fitting of prostheses; and adjustment of devices	M	$244,939	YES
3	Heart valve disorders	W	$208,628	YES
4	Acute myocardial infarction	M	$168,168	YES
5	Other injuries and conditions due to external causes	M	$162,248	YES
6	Cancer of pancreas	M	$152,952	YES
7	Hypertension with complications and secondary hypertension	M	$115,127	YES
8	Other nutritional; endocrine; and metabolic disorders	W	$114,970	YES
9	Complication of device; implant or graft	H	$98,634	YES
10	Hypertension with complications and secondary hypertension	M	$86,542	YES



- Care management team engagement
- All ten high cost claimants are currently eligible
- Largest claimant is under $300,000
- Medical management works to ensure services are medically necessary and received at the appropriate level

Relationship Definitions:
M = Employee
H = Husband
W = Wife

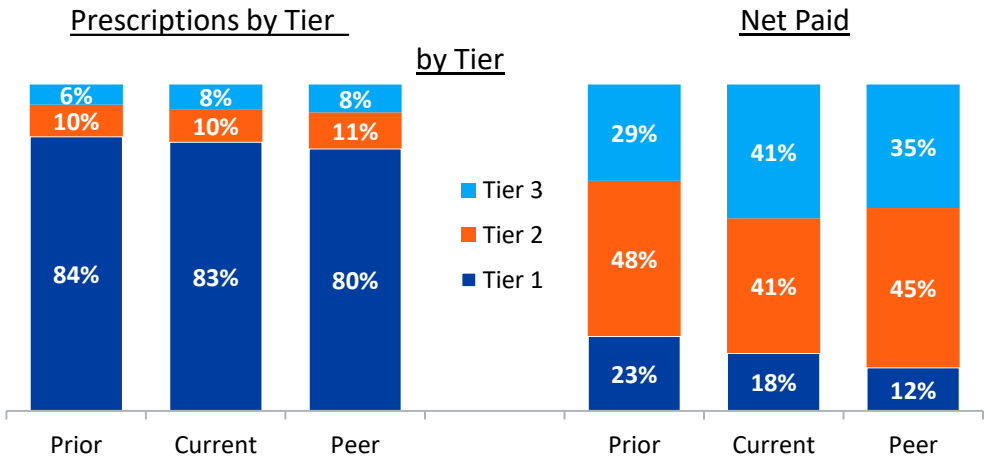
Pharmacy Data

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Measures	Prior	Current	Change	Peer	Δ
Enrolled Members	6,819	6,707	-1.6%		
Average Prescriptions PMPY	17.5	17.5	0.1%	10.5	67.0%
Formulary Rate	94.2%	92.7%	-1.6%	91.2%	1.6%
Generic Use Rate	87.8%	86.9%	-1.1%	86.5%	0.4%
Generic Substitution Rate	97.4%	97.5%	0.2%	96.5%	1.1%
Employee Cost Share PMPM	$23.12	$16.76	-27.5%	$11.54	45.2%
Avg Net Paid per Prescription	$62.73	$82.42	31.4%	$80.60	2.2%
Net Paid PMPM	$91.32	$120.04	31.5%	$70.29	70.8%

Pharmacy PMPM trend is 31.5%

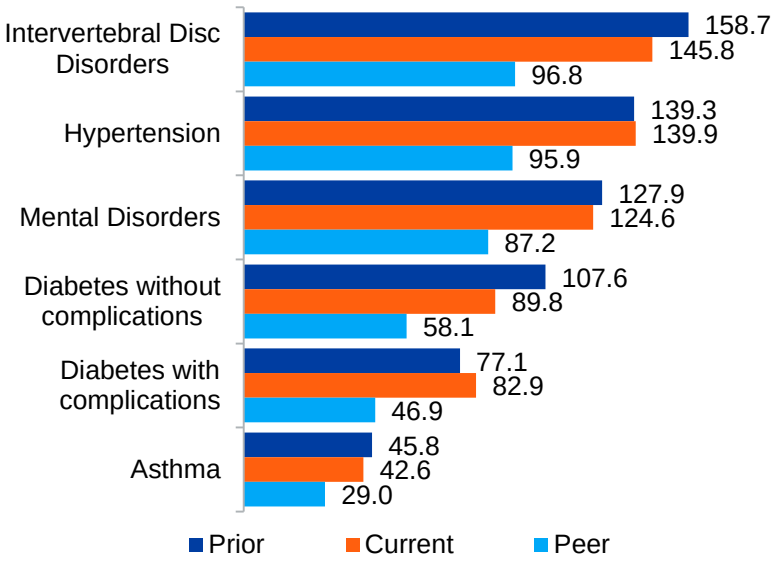
- Average net paid per script increased 31%
- 83% of prescriptions were in Tier 1 and drove only 18% of spend
- Tier 3 spend increased 38.9% from prior period
- Cancer and Anti Diabetic Drugs driving spend



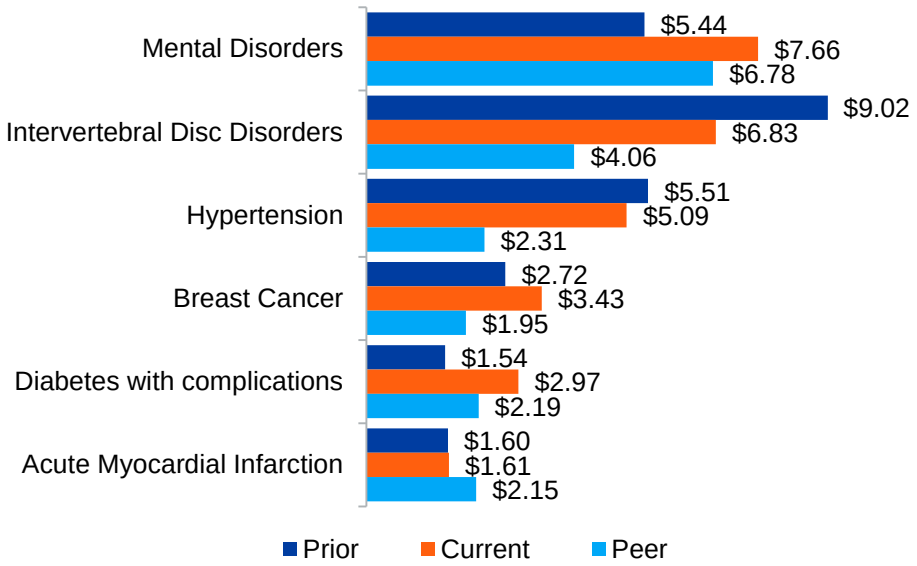
Common Diagnosis Categories

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Top Common Conditions by Prevalence



Top Conditions by Paid PMPM



- Intervertebral Disc Disorders, Hypertension and Mental Disorders are the most prevalent clinical conditions within the population.
- Intervertebral Disc Disorders decreased -5.1% on a Per K basis from prior period
- PMPM Mental Disorders increased 33.8% to $7.66 pmpm
- Chronic illnesses are driving the top common conditions

4.6.

4. Consent Agenda (Deonne Contine, 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.

   4.6 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2019 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2019 – 06/30/2020
Coverage for: Individual | **Plan Type:** CDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual $1,500	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services in the CDHP Master Plan Document at www.pebp.state.nv.us.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,900 for out-of-network providers $10,600	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, excluded services and prescription drug copay assistance.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232** for a list of participating providers.	You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Specialist visit	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Preventive care/screening/ immunization	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). Balance billing applies to out-of-network claims.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization. Balance billing applies to out-of-network claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	20% coinsurance	Not Covered.	Non-preferred generic and non-preferred brand drugs are not covered and do not apply to deductible and out-of-pocket maximum. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% coinsurance	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	20% coinsurance	Not Covered.	30-day supply through Accredo specialty pharmacy. Some Specialty drugs require preauthorization. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance billing applies to out-of-network claims. See Plan Document for air ambulance benefits and limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for Preauthorization requirements.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. Balance billing applies to out-of-network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. Balance billing applies to out-of-network provider claims.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 visits per person plan year. Balance billing applies to out-of-network provider claims.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Habilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
If your child needs dental or eye care	Children's eye exam	$25 copayment	$25 copayment	Limited to 1 routine vision exam plan year. $95 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Vision exam (limited to one screening exam)
• Obesity Care Management Program	• Hearing aids	• Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about benefits, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

Does this plan provide Minimum Essential Coverage? Yes.
If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$2,260
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$1,180
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,740**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$85
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,585**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-763-8232.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-763-8232.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-763-8232.

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279). (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بتماس بگیرید. 1

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2019 – 06/30/2020
Coverage for: Family| **Plan Type:** CDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Family $3,000 / Individual $2,700	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services in the CDHP Master Plan Document at www.pebp.state.nv.us.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: Individual $6,850 / Family $7,800; out-of-network Individual $10,600 / Family $21,200	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, excluded services and prescription drug copay assistance.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232** for a list of participating providers.	You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Specialist visit	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Preventive care/screening/ immunization	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). Balance billing applies to out-of-network claims.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization. Balance billing applies to out-of-network claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	20% coinsurance	Not Covered.	Non-preferred generic and non-preferred brand drugs are not covered and do not apply to deductible and out-of-pocket maximum. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% coinsurance	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	20% coinsurance	Not Covered.	30-day supply through Accredo specialty pharmacy. Some Specialty drugs require preauthorization. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance billing applies to out-of-network claims. See Plan Document for air ambulance benefits and limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for Preauthorization requirements.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. Balance billing applies to out-of-network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. Balance billing applies to out-of-network provider claims.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 visits per person plan year. Balance billing applies to out-of-network provider claims.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
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	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
If your child needs dental or eye care	Children's eye exam	$25 copayment	$25 copayment	Limited to 1 routine vision exam plan year. $95 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

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Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Vision exam (limited to one screening exam)
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Does this plan provide Minimum Essential Coverage? **Yes.**
If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0.00
Coinsurance	$2,020
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,780**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0.00
Coinsurance	$940
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0.00
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بتماس بگیرید. 1

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2019 – 06/30/2020

Coverage for: Individual and Family | **Plan Type:** EPO (Premier Plan)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $0 Person/$0 Family Out of Network: N/A Individual / N/A Family	This Plan does not require deductibles.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This Plan does not require a deductible, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	This Plan does not require deductibles.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 Family for out-of-network providers	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see a specialist within the Plan's exclusive provider network without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	Not Covered.	None.
	Specialist visit	$40 copayment	Not Covered.	None.
	Preventive care/screening/ immunization	$0 copayment	Not Covered.	With certain limitations. See Plan Document for details.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Depends on site of service; routine lab work: No charge	Not Covered.	*Out-of-Network labs paid in-network if no in-network provider within 50 miles/residence (balance billing applies to out-of-network provider claims); all non-pre-operative labs must be performed at a free-standing laboratory facility i.e. Labcorp, Quest
	Imaging (CT/PET scans, MRIs)	CT/MRI: $250 copay PET: $350 copay	Not Covered.	*May require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	$10 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Preferred brand drugs	$40 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Non-preferred brand drugs	$75 copayment 30-day supply	Not Covered.	*Plan does not coordinate prescription drug benefits. Single-source non-preferred brand.
	Specialty drugs	20% coinsurance	Not Covered.	*Covered only when ordered from Specialty pharmacy; limited to a 30-day supply; Some Specialty drugs require preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	Not Covered.	*Some services requires preauthorization.
	Physician/surgeon fees	PCP: $0 copay Specialist: $0 copay	Not Covered.	Primary Care or Specialty Office visit copay applies when services are performed in a physician's office.
If you need immediate medical attention	Emergency room care	$500 copayment	$500 copayment	Balance billing applies to out-of-network provider claims.
	Emergency medical transportation	$200 copayment (air) (air) plus amount exceeding 250% of	$200 copayment (air) plus amount exceeding 250% of Medicare allowable.	Balance billing for amounts exceeding 250% of Medicare allowable rate.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Medicare allowable. $150 copayment (ground)	$150 copayment (ground)	
	Urgent care	$50 copay /visit	$50 copayment	Balance billing applies to out-of-network provider claims.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not Covered.	Preauthorization required.
	Physician/surgeon fees	$0 copayment	Not Covered.	*Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay /visit	Not Covered.	*See plan document for details.
	Inpatient services	$500 copay/admission	Not Covered.	*Preauthorization required.
If you are pregnant	Office visits	$0 copay /visit	Not Covered.	Routine prenatal care obtained from a Plan provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab)
	Childbirth/delivery professional services	$0 copay/delivery	Not Covered.	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services.
	Childbirth/delivery facility services	$500 copay/admission	Not Covered.	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours.
If you need help recovering or have other special health needs	Home health care	$20 copay /visit	Not Covered.	Preauthorization required. Limited to 60 visits per person plan year.
	Rehabilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Habilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Skilled nursing care	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required and limited to 100 days per Plan Year. Outpatient: Preauthorization required; limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	$0 copay	Not Covered.	Preauthorization required for equipment over

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				$1,000.
	Hospice services	$500 copay/admission $0 copay /visit	Not Covered.	Maximum lifetime benefit limited to 185 days. Maximum 37 hours per Plan Year.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Limited to 1 routine preventive care/screening per plan year; $100 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Personal/custodial care
- Non-FDA approved drugs
- Orthodontia expenses

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Routine eye care (limited to one screening exam)
- Obesity Care Management Program
- Hearing aids
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthSCOPE Benefits Customer Service at 1-888-763-8232.

Does this plan provide Minimum Essential Coverage? Yes.
If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	*20%*

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$600**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,060
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-763-8232.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-763-8232.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-763-8232.

[PAUNAWA]: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.번으로 전화해 주십시오. 1-800-326-5496 (TTY: 1-800-545-8279).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279). (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279）まで、お電話にてご連絡ください。.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-800-326-5496 (TTY: 1-800-545-8279)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (1-800-545-8279).

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5.

5. Discussion and possible action regarding an update to PEBP's Voluntary Benefit Platform implementation, to include an update by the Nevada Division of Insurance on vendor compliance with insurance law requirements to offer voluntary benefits in Nevada. (Laura Rich, Operations Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: V

Title: Member Portal and Voluntary Benefit Platform Implementation

SUMMARY

This report will provide the Board, members, public and other stakeholders information on the Morneau Shepell Voluntary Benefits Platform and Benefits Selection portal.

REPORT

Member Portal

PEBP's implementation of the voluntary benefits platform is predicated on the launch of a new member portal, which is planned to be introduced and made available to members mid- April before the start of Open Enrollment. This will give members the opportunity to log in and familiarize themselves with the new site prior to making any open enrollment changes in May. Members will be able to access all plan documents, shop for, compare and enroll in medical plans, upload supporting documents, communicate securely with PEBP member services staff and shop for and enroll in voluntary products.

The system PEBP uses today is limited in functionality and as a result, the member tends to have a very segmented experience. Members today get bounced around the PEBP and vendor websites continually in order to obtain required forms or information, or to enroll in certain products. The new portal will improve the user experience by providing a one stop shop for all benefit related resources and enrollment. All relevant plan documents and notices will be easily accessible and the flow to enroll in a medical plan as well as voluntary products will be much simpler and user friendly than what members experience today.

Morneau Shepell/Corestream Regulatory Requirements

On November 29, 2018, the Board approved a list of voluntary products to be offered to all benefit eligible employees through a voluntary benefits platform, which would be integrated into the new member portal and enrollment tool. PEBP's enrollment and eligibility vendor, Morneau Shepell has subcontracted with Corestream to implement the platform and manage the elections, employee payroll deductions and customer service aspects of the voluntary benefit enrollments. Both Morneau Shepell and Corestream have worked diligently with the Division of Insurance (DOI) to ensure both entities have satisfied all the Nevada licensing requirements of producers which are regulated by the DOI. They have also coordinated with the DOI to ensure all carriers offering products on the platform meet all regulatory requirements. To date, Morneau Shepell reports that all the concerns brought to their attention by the DOI have been addressed and rectified. Additionally, Morneau Shepell is waiting on final confirmation regarding licensure requirements from one final state (Florida).

Voluntary Products and Schedule

In addition to the new Board approved carriers and products, PEBP has current contracts with The Standard and Unum to offer Voluntary Life, Short-Term Disability and Long-Term Care products which will also be featured on the voluntary benefits platform. Eight of the ten options will roll out at the start of Open Enrollment on May 1st. The remaining auto/home and pet insurance policies will be offered beginning July 1.

2019 Voluntary Benefits Rollout Schedule

Product	Carrier(s)	May 1	July 1
Accident	Aflac	X	
Critical Illness	Aflac	X	
Hospital Indemnity	Aflac	X	
Legal Plan	Legal Ease	X	
ID theft	ID Watchdog	X	
Buy-up Vision	VSP	X	
Voluntary Life	The Standard	X	
Short Term Disability	The Standard	X	
Auto/Home	Travelers, MetLife and Liberty Mutual		X
Pet Insurance	ASPCA and Nationwide		X

There were some challenges onboarding Unum, an existing Long-Term Care Insurance vendor, on to the platform. Initially, Unum reported they would not be able to accommodate electronic enrollments, however after working with Corestream on alternative solutions, Unum has discovered a way to participate on the portal and offer online enrollments. Unfortunately, this option will not be available by May 1, but Corestream will continue to coordinate with Unum to ensure they are onboarded as quickly as possible.

Members enrolled in PEBP voluntary products today have the option to have their premiums deducted through separate automatic payroll deductions. Most members who are currently participating in this process will be transitioned seamlessly and their payroll deductions will continue in a similar manner once these carriers move on to the platform. The process will go from being managed by each of the carriers and pay centers separately to one single deduction being managed by Corestream in coordination with the respective pay center. A small number of members will be moved to a direct bill status until PEBP and Corestream are able to establish similar interfaces with all of the pay centers.

Aflac Products for Retirees

When the Aflac products were first presented to the Board for approval, PEBP was under the assumption that these products would be available to all benefit eligible members, including retirees. It was later discovered that the Aflac products presented in November were group rated products that did not include retirees. Introducing the retiree risk pool would significantly impact the rates that were initially presented so Aflac explored and delivered an alternative solution that would enable PEBP to offer these types of products to retirees.

Retirees will be able to purchase individually rated Accident and Critical Care policies through Aflac. The policies are similar to the group policies being offered to active members (see Attachments A and B) with some minor differences. A retiree will see these options displayed on the voluntary benefits platform, however they will be required to enroll telephonically (rather than online) and will be enrolled in direct billing. Unlike actives, who will only be able to purchase these policies during open enrollment or any special enrollment periods offered by PEBP, retirees will be able to purchase these products without limitations throughout the year.

Retiree Example Monthly Premium Rates 2019

	Individual	Individual + Spouse	Individual + Child(ren)	Family
Accident Indemnity	$22.75	$31.98	$36.53	$49.40
Critical Care and Recovery				
Age 18-35	$12.74	$19.50	$14.30	$22.49
Age 36-45	$19.76	$32.63	$20.54	$36.01
Age 46-55	$27.30	$48.88	$28.21	$52.00
Age 55-64	$36.79	$71.63	$37.70	$74.49

PEBP plans to introduce these products alongside the Aflac benefits offered to actives in May, however, given the timing, any unforeseen issues may force PEBP to delay the rollout until July.

RECOMMENDATION

PEBP recommends the approval of the AFLAC Accident and Critical Care policies to be offered as a voluntary benefit to retirees on the Voluntary Benefit platform.

Aflac Accident Indemnity Advantage®

24-HOUR ACCIDENT-ONLY INSURANCE – ESSENTIALS PLAN

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac SmartClaim®
One Day Pay℠

ACCIDENT INDEMNITY ADVANTAGE®

24-HOUR ACCIDENT-ONLY INSURANCE

Policy Series A35000

Added Protection for You and Your Family

Even if you're well prepared, accidents happen. And they happen to all kinds of people every day. What's even more unexpected are the out-of-pocket expenses associated with them—even if you have major medical insurance.

That's how Aflac can help. Aflac pays cash benefits directly to you (unless otherwise assigned) to help with things like out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills. Helping you with the medical expenses that major medical doesn't cover—and much more.

The Aflac Accident Indemnity Advantage® insurance policy has:

- No deductibles and no copayments
- No lifetime limit—policy won't terminate based on the number of claims filed or the dollar amount of claims paid
- No network restrictions—you choose your own healthcare provider
- No coordination of benefits—we pay regardless of any other insurance

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

For over 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our Accident Indemnity Advantage® insurance policy is just another way to help make sure you're well protected.

Most accidents are unpredictable.
But their impact on your finances doesn't have to be.

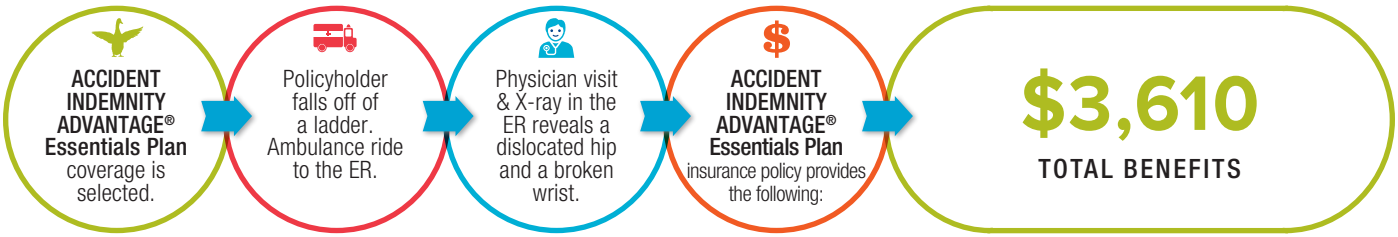
So, what would an injury or trip to the emergency room mean to your savings? Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.

Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

Policy Benefits Include:

- A wellness benefit payable for routine medical exams to encourage early detection and prevention.
- Daily hospitalization benefits payable for hospital stays.
- Benefits payable for emergency treatment, X-rays, and major diagnostic exams.
- Benefits payable for follow-up treatments and physical therapy.
- Transportation and lodging benefits payable for travel to receive treatment.

How it works



The above example is based on a scenario for Accident Indemnity Advantage® – Essentials Plan that includes the following benefit conditions: Ground ambulance transportation (Ambulance Benefit) of $120, physician visit (Accident Emergency Treatment Benefit) of $100, x-ray (X-Ray Benefit) of $25, dislocated hip – open reduction under general anesthesia (Accident Specific-Sum Injuries Benefit) of $1,500, broken wrist – closed reduction (Accident Specific-Sum Injuries Benefit) of $190, Initial Accident Hospitalization Benefit of $500, Accident Hospital Confinement Benefit (hospitalized for 5 days) of $750, Major Diagnostic Exams Benefit (CT scan) of $100, Physical Therapy Benefit (8 treatments) of $200, Appliances Benefit (wheelchair) of $50, Accident Follow-Up Treatment Benefit (3 days) of $75.

Benefits and/or premiums may vary based on the state and coverage option selected. The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Essentials Plan Accident Indemnity Advantage® Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
WELLNESS BENEFIT	$40 once per 12-month period
ACCIDENT EMERGENCY TREATMENT BENEFIT	Payable once per 24-hour period, per covered accident, per covered person. Hospital emergency room: $100 Office or facility (other than hospital emergency room): $75
X-RAY BENEFIT	$25 once per covered accident, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$25 for one treatment per day, per covered accident, per covered person
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$500 once per period of hospital confinement or $750 once when a covered person is admitted directly to an intensive care unit per year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$150 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	Additional $300 per day, per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFIT	Pays (according to the policy) for the treatments below: DISLOCATIONS.....$40-$1,500 BURNS .....$75-$7,500 SKIN GRAFTS.....50% of the burn benefit amount paid for the burn involved LACERATIONS Not requiring sutures ..... $20 Less than 5 centimeters ..... $40 At least 5 cm but not more than 15 cm . $150 Over 15 centimeters .....$300 CONCUSSION (brain)..... $50 PARALYSIS Quadriplegia .....$7,500 Paraplegia..... $3,750 Hemiplegia.....$3,000 EMERGENCY DENTAL WORK Broken tooth repaired with crown ..... $75 Broken tooth resulting in extraction..... $25 EYE INJURIES Surgical repair..... $250 Removal of foreign body by a physician .. $50 FRACTURES .....$75-$1,500 COMA .....$7,500 SURGICAL PROCEDURES .....$185-$750 MISCELLANEOUS SURGICAL PROCEDURES Miscellaneous surgery with general anesthesia..... $190 Other miscellaneous surgery with conscious sedation..... $80
MAJOR DIAGNOSTIC EXAMS BENEFIT	$100 per year, per covered person
EPIDURAL PAIN MANAGEMENT BENEFIT	$100 paid no more than twice per covered accident, per covered person
PHYSICAL THERAPY BENEFIT	$25 per treatment, per covered accident, per covered person
REHABILITATION UNIT BENEFIT	$75 per day
APPLIANCES BENEFIT	$50 once per covered accident, per covered person
PROSTHESIS BENEFIT	$250 once per covered accident, per covered person
BLOOD/PLASMA/PLATELETS BENEFIT	$100 once per covered accident, per covered person
AMBULANCE BENEFIT	$120 ground or $800 air
TRANSPORTATION BENEFIT	$200 per round trip, up to 3 trips per year, per covered person
FAMILY LODGING BENEFIT	$75 per night, up to 30 days per covered accident
ACCIDENTAL-DEATH BENEFIT	Common-Carrier Accident / Other Accident / Hazardous Activity Accident
INSURED	$80,000 / $20,000 / $5,000
SPOUSE	$80,000 / $20,000 / $5,000
CHILD	$12,000 / $6,000 / $1,500
ACCIDENTAL-DISMEMBERMENT BENEFIT	$400–$20,000
CONTINUATION OF COVERAGE BENEFIT	Waives all monthly premiums for up to two months

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

ACCIDENT-ONLY COVERAGE

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
1.800.99.AFLAC (1.800.992.3522)

ACCIDENT-ONLY COVERAGE
Policy Series A35B24

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

1. **Read Your Policy Carefully.** This document provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Accident-Only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. **Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.**

3. **Benefits.** Benefit A is a preventive benefit; the Accidental-Death, Dismemberment, or Injury of a Covered Person is not required for this benefit to be payable.

   A. **WELLNESS BENEFIT:** After the policy has been in force for 12 months, Aflac will pay $40 if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the Dependent Children of either you or your spouse. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

   Aflac will pay the following benefits as applicable if a Covered Person's Accidental-Death, Dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Accidental-Death, Dismemberment, or Injury must be independent of Sickness or the medical or surgical treatment of Sickness, or of any cause other than a covered accident. A covered Accidental-Death, Dismemberment, or Injury must also occur while coverage is in force and is subject to the Limitations and Exclusions. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

   B. **ACCIDENT EMERGENCY TREATMENT BENEFIT:** Aflac will pay the applicable amount shown below when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment received under the care of a Physician at a(n):

Hospital Emergency Room	$100
Office or facility (other than a Hospital Emergency Room)	$75

   Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per Covered Person.

   C. **X-RAY BENEFIT:** Aflac will pay $25 when a Covered Person requires an X-ray while receiving emergency treatment for Injuries sustained in a covered accident. This benefit is limited to one payment per covered accident, per Covered Person. **The X-Ray Benefit (C) is not payable for exams listed in the Major Diagnostic Exams Benefit (I).**

   D. **ACCIDENT FOLLOW-UP TREATMENT BENEFIT:** Aflac will pay $25 per day when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. Aflac will pay for one treatment per day for up to a maximum of six treatments per covered accident, per Covered Person. The treatment must begin within 30 days of the covered accident or discharge from the Hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed certified acupuncturist. **The Accident Follow-Up Benefit (D) is not payable for the same days that the Physical Therapy Benefit (K) is paid.**

   E. **INITIAL ACCIDENT HOSPITALIZATION BENEFIT:** Aflac will pay $500 when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment for Injuries sustained in a covered accident or Aflac will pay $750 if a Covered Person is admitted directly to an Intensive Care Unit of a Hospital for treatment for Injuries sustained in a covered accident. This benefit is payable only once per Period of Hospital Confinement (including Intensive Care Unit confinement) and only once per Calendar Year, per Covered Person. Hospital Confinements must start within 30 days of the accident.

   F. **ACCIDENT HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay $150 per day when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Aflac will pay this benefit up to 365 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident. **The Accident Hospital Confinement Benefit (F) and the Rehabilitation Unit Benefit (L) will not be paid on the same day. The highest eligible benefit will be paid.**

G. **INTENSIVE CARE UNIT CONFINEMENT BENEFIT:** Aflac will pay an additional $300 for each day a Covered Person receives the Accident Hospital Confinement Benefit and is confined and charged for a room in an Intensive Care Unit for treatment of Injuries sustained in a covered accident. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident.

H. **ACCIDENT SPECIFIC-SUM INJURIES BENEFITS:** When a Covered Person receives treatment for Injuries sustained in a covered accident, Aflac will pay specified benefits ranging from $20–$7,500 for dislocations, burns, skin grafts, eye injuries, lacerations, fractures, concussion, emergency dental work, coma, paralysis, and miscellaneous surgical procedures. See policy for specific amounts payable.

I. **MAJOR DIAGNOSTIC EXAMS:** Aflac will pay $100 when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a Hospital or a Physician's office. This benefit is limited to one payment per Calendar Year, per Covered Person. No lifetime maximum. **Exams listed in the Major Diagnostic Exams Benefit (I) are not payable under the X-Ray Benefit (C).**

J. **EPIDURAL PAIN MANAGEMENT BENEFIT:** Aflac will pay $100 when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a Hospital or a Physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure. This benefit is payable no more than twice per covered accident, per Covered Person.

K. **PHYSICAL THERAPY BENEFIT:** Aflac will pay $25 per treatment when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a Physician advises the Covered Person to seek treatment from a licensed Physical Therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the Hospital. Aflac will pay for one treatment per day for up to a maximum of ten treatments per covered accident, per Covered Person. The treatment must take place within six months after the accident. **The Physical Therapy Benefit (K) is not payable for the same days that the Accident Follow-Up Treatment Benefit (D) is paid.**

L. **REHABILITATION UNIT BENEFIT:** Aflac will pay $75 per day when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a Rehabilitation Unit of a Hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. This benefit is limited to 30 days for each Covered Person per Period of Hospital Confinement and is limited to a Calendar Year maximum of 60 days. No lifetime maximum. **The Rehabilitation Unit Benefit (L) will not be payable for the same days that the Accident Hospital Confinement Benefit (F) is paid. The highest eligible benefit will be paid.**

M. **APPLIANCES BENEFIT:** Aflac will pay $50 when a Covered Person receives a medical appliance, prescribed by a Physician, as an aid in personal locomotion, for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: wheelchair, leg brace, back brace, walker, and a pair of crutches. This benefit is payable once per covered accident, per Covered Person.

N. **PROSTHESIS BENEFIT:** Aflac will pay $250 when a Covered Person requires use of a Prosthetic Device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of Prosthetic Devices, hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per covered accident, per Covered Person.

O. **BLOOD/PLASMA/PLATELETS BENEFIT:** Aflac will pay $100 when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins and is payable only one time per covered accident, per Covered Person.

P. **AMBULANCE BENEFIT:** Aflac will pay $120 when a Covered Person requires ambulance transportation to a Hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. Aflac will pay $800 when a Covered Person requires transportation provided by an air ambulance for Injuries sustained in a covered accident. A licensed professional ambulance company must provide the ambulance service.

Q. **TRANSPORTATION BENEFIT:** Aflac will pay $200 per round trip to a Hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident.

Aflac will also pay $200 per round trip when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any Immediate Family Member.

This benefit is not payable for transportation to any Hospital located within a 50-mile radius of the site of the accident or residence of the Covered Person. The local attending Physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is payable for up to three round trips per Calendar Year, per Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital.

R. **FAMILY LODGING BENEFIT:** Aflac will pay $75 per night for one motel/hotel room for a member(s) of the Immediate Family that accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the Hospital. The Hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person. This benefit is limited to one motel/hotel room per night and is payable up to 30 days per covered accident.

S. **ACCIDENTAL-DEATH BENEFIT:** Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	Insured	Spouse	Child
Common-Carrier Accident	$80,000	$80,000	$12,000
Other Accident	20,000	20,000	6,000
Hazardous Activity Accident	5,000	5,000	1,500

In the event of the Accidental-Death of a covered spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

T. **ACCIDENTAL-DISMEMBERMENT BENEFIT:** Aflac will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident.

Dismemberment or complete loss of, with or without reattachment:

	Insured	Spouse	Child
Both arms and both legs	$20,000	$20,000	$6,000
Two eyes, feet, hands, arms, or legs	20,000	20,000	6,000
One eye, foot, hand, arm, or leg	5,000	5,000	1,500
One or more fingers and/or one or more toes	1,000	1,000	400

Only the highest single benefit per Covered Person will be paid for Dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and Dismemberment result from the same accident, only the Accidental-Death Benefit will be paid.

U. **CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction and you leave your employer for any reason;
4. You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and
5. You re-establish premium payments through:
   (a) your new employer's payroll deduction process or
   (b) direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

4. Optional Benefits

A. Off-the-Job Accident Disability Benefit Rider: (Series A35050) Applied For: ☐Yes ☐No

The rider does not apply to the spouse or dependents. It applies to the Named Insured only, as shown in the Policy Schedule.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE OFF-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER: Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States. Refer to your policy for additional Limitations and Exclusions.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

1. **TOTAL OR PARTIAL DISABILITY BENEFIT (through age 69):** If you have a Full-Time Job at the time of your Off-the-Job Injury, we will insure you as follows while coverage is in force:

   a. **Total Disability:** If your covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Off-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This

benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

b. **Partial Disability:** If your covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Off-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings of your Full-Time Job at the time you became disabled.

2. **DISABILITY BENEFIT (without a Full-Time Job or at age 70 and above):** If you do not have a Full-Time Job at the time of your Off-the-Job Injury or if you are age 70 or above, we will insure you as follows while coverage is in force:

If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Off-the-Job Accident Disability Benefit Rider multiplied by three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

B. **On-the-Job Accident Disability Benefit Rider: (Series A35051) Applied For: ☐Yes ☐No**

The rider does not apply to the spouse or dependents. It applies to the Named Insured only, as shown in the Policy Schedule.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE ON-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER: Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States. Refer to your policy for additional Limitations and Exclusions.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

1. **TOTAL OR PARTIAL DISABILITY BENEFIT (through age 69):** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

a. **Total Disability:** If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

b. **Partial Disability:** If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings of your Full-Time Job at the time you became disabled.

2. **DISABILITY BENEFIT (without a Full-Time Job or at age 70 and above):** If you do not have a Full-Time Job at the time of your On-the-Job Injury or if you are age 70 or above, we will insure you as follows while coverage is in force:

If you require Hospital Confinement within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job

Accident Disability Benefit Rider multiplied by three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

C. Sickness Disability Benefit Rider:
(Series A35052) Applied For: ☐Yes ☐No

The rider does not apply to the spouse or dependents. It applies to the Named Insured only, as shown in the Policy Schedule.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, condition, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE SICKNESS DISABILITY BENEFIT RIDER: (The Limitations and Exclusions listed in the policy do not apply to the rider unless they are listed below) Aflac will not pay benefits for services rendered by a member of the Immediate Family of a Covered Person. Aflac will not pay benefits whenever coverage provided by the rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such Disability will be covered to the same extent as a Disability due to Sickness. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of your: (1) Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The rider will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force; (2) Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness); or (3) Donating an organ within the first 12 months of the Effective Date of the rider.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after the rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

1. **TOTAL OR PARTIAL DISABILITY BENEFIT (through age 69):** If you have a Full-Time Job at the time of your Sickness, we will insure you as follows while coverage is in force:

   a. **Total Disability:** If your covered Sickness causes your Total Disability within 90 days of your last treatment for your covered Sickness, we will pay you the Daily Disability Benefit for the Sickness Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

   You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

   b. **Partial Disability:** If your covered Sickness causes your Partial Disability within 90 days of your last treatment for your covered Sickness, we will pay you the Daily Disability Benefit for the Sickness Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

   You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings of your Full-Time Job at the time you became disabled.

2. **DISABILITY BENEFIT (without a Full-Time Job or at age 70 and above):** If you do not have a Full-Time Job at the time of your Sickness or if you are age 70 or above, we will insure you as follows while coverage is in force:

   If you require Hospital Confinement within 90 days of your last treatment for your covered Sickness, we will pay you the Daily Disability Benefit for the Sickness Disability Benefit Rider multiplied by three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

D. Spouse Off-the-Job Accident Disability Benefit Rider: (Series A35053) Applied For: ☐Yes ☐No

The rider applies to the Named Insured's spouse only, as shown in the Policy Schedule.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE SPOUSE OFF-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER: Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States. Refer to your policy for additional Limitations and Exclusions.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

1. **TOTAL OR PARTIAL DISABILITY BENEFIT (through age 69):** If you have a Full-Time Job at the time of your Off-the-Job Injury, we will insure you as follows while coverage is in force:

   a. **Total Disability:** If your covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Spouse Off-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

      You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

   b. **Partial Disability:** If your covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Spouse Off-the-Job Accident Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

      You will no longer be qualified to receive this benefit upon the earlier of your (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings of your Full-Time Job at the time you became disabled.

2. **DISABILITY BENEFIT (without a Full-Time Job or at age 70 and above):** If you do not have a Full-Time Job at the time of your Off-the-Job Injury or if you are age 70 or above, we will insure you as follows while coverage is in force:

   If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Spouse Off-the-Job Accident Disability Benefit Rider multiplied by three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

E. Additional Accidental-Death Benefit Rider: (Series A35054) Applied For: ☐Yes ☐No

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE ADDITIONAL ACCIDENTAL-DEATH BENEFIT RIDER: Aflac will not pay benefits under the rider for an Accidental-Death that is caused by or occurs as a result of a Hazardous Activity Accident. Refer to your policy for additional Limitations and Exclusions.

ACCIDENTAL-DEATH BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for your Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	Insured	Spouse	Child
Common-Carrier Accident	$35,000	$35,000	$7,000
Other Accident	35,000	35,000	7,000

In the event of the Accidental-Death of a covered spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until a guardian for the financial estate of the minor is appointed by the

court or such beneficiary reaches the age of majority as defined by applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

5. **Exceptions, Reductions and Limitations of the Policy:**

   A. **Aflac will not pay benefits for services rendered by you or a member of the Immediate Family of a Covered Person.**

   B. **Aflac will not pay benefits for treatment or loss due to Sickness including (1) any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness.**

   C. **Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.**

   D. **Aflac will not pay benefits for an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person's:**

      1. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
      2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
      3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
      4. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
      5. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
      6. Having dental treatment except as a result of Injury;
      7. Being exposed to war or any act of war, declared or undeclared; or
      8. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

6. **Renewability.** The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

THE POLICY HAS LIMITATIONS THAT MAY AFFECT BENEFITS PAYABLE.
THIS BROCHURE IS FOR ILLUSTRATION PURPOSES ONLY.
REFER TO THE POLICY AND RIDERS FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

ACCIDENTAL-DEATH: Death caused by a covered injury. See the Limitations and Exclusions section for injuries not covered by the policy.

COMMON-CARRIER ACCIDENT: An accident, occurring on or after the effective date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a covered person is a passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A passenger is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A common-carrier accident does not include any hazardous activity accident or any accident directly involving private, on demand, or chartered transportation in which a covered person is a passenger at the time of the accident.

COVERED PERSON: Any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

EFFECTIVE DATE: The date(s) coverage begins as shown in the Policy Schedule. The effective date of the policy is not the date you signed the application for coverage.

HAZARDOUS ACTIVITY ACCIDENT: An accident, occurring on or after the effective date of coverage and while coverage is in force, while a covered person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing. A hazardous activity accident does not include any common-carrier accidents.

HOSPITAL CONFINEMENT: A stay of a covered person confined to a bed in a hospital for which a room charge is made. The hospital confinement must be on the advice of a physician, medically necessary, and the result of a covered injury. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

INJURY: A bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by the policy.

OTHER ACCIDENT: An accident that occurs on or after the effective date of coverage and while coverage is in force that is not classified as either a common-carrier accident or a hazardous activity accident and that is not specifically excluded in the Limitations and Exclusions section.

SICKNESS: An illness, disease, infection, or any other abnormal physical condition, independent of injury, occurring on or after the effective date of coverage and while coverage is in force.

ADDITIONAL INFORMATION

An Ambulatory Surgical Center does not include a physician's or dentist's office, clinic, or other such location.

The term hospital does not include any institution or part thereof used as a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

The term hospital emergency room does not include urgent care centers.

A physician or physical therapist does not include you or a member of your immediate family.

Dislocations must be diagnosed by a physician within 72 hours after the date of the injury and require correction by a physician. We will pay for no more than two dislocations per covered accident, per covered person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown in the policy for the closed reduction dislocation.

Burns must be treated by a physician within 72 hours after a covered accident.

If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burn benefit amount that we paid for the burn involved.

Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician.

Fractures must be diagnosed by a physician within 14 days after the date of the injury and require correction by a physician. We will pay for no more than two fractures per covered accident, per covered person. For the closed reduction for chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown in the policy.

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per covered person.

The duration of the paralysis must be a minimum of 30 days. This benefit will be payable once per covered person and must be confirmed by your attending physician.

Coma must last a minimum of seven days. The condition must require intubation for respiratory assistance. Coma does not include any medically induced coma.

Treatment for surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the most expensive procedure.

Miscellaneous surgery that is not covered by any other specific-sum injury benefit. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.

Aflac®

Aflac SmartClaim®

One Day Pay℠

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

One Day Pay℠ is available for certain individual claims submitted online through the Aflac SmartClaim® process. Claims may be eligible for One Day Pay processing if submitted online through Aflac SmartClaim®, including all required documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim® is available for claims on most individual Accident, Cancer, Hospital, Specified Health, and Intensive Care policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2018.

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

Aflac

Critical Care and Recovery

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

We've been dedicated to helping provide peace of mind and financial security for nearly 60 years.

Aflac®

We've got you under our wing.®

CRITICAL CARE AND RECOVERY

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

Policy Series A71000

CCR[1]

Added Protection for You and Your Family

Like many people, you probably have insurance to cover burglaries, fires, auto accidents, and standard hospital bills. But what would happen to your family's finances if you experienced a catastrophic event, such as a heart attack or stroke—an event that knocked you off your feet or even changed your life forever?

You may think you're already protected by major medical insurance. Think again. Major medical coverage pays doctor and hospital bills, not out-of-pocket expenses. Nor does it pay cash benefits that can be used to help with expenses, such as car payments, the mortgage or rent, and utility bills—bills that would be difficult, if not impossible to pay if your income suddenly stopped due to illness or injury. Aflac's specified health event insurance policy complements your major medical coverage and helps provide the peace of mind that comes from knowing you and your family are protected.

THE FACTS SAY YOU NEED THE PROTECTION OF THE AFLAC CRITICAL CARE AND RECOVERY PLAN:

FACT NO. 1

ABOUT EVERY **34** SECONDS

SOMEONE SUFFERS A HEART ATTACK.[1]

FACT NO. 2

ABOUT EVERY **40** SECONDS

SOMEONE SUFFERS A STROKE.[1]

[1]*Heart Disease and Stroke Statistics*, 2012 Update, American Heart Association.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Critical Care and Recovery is designed to provide you with cash benefits if you experience a catastrophic event, such as a heart attack or stroke. This means that you will have added financial resources to help with expenses incurred due to a serious health event, to help with ongoing living expenses, or to help with any purpose you choose.

An illness or injury can happen to anyone, anytime—and when it does, everyday expenses may suddenly seem insurmountable. Fortunately, Aflac's specified health event insurance policy can help with those everyday expenses, so all you have to focus on is getting well.

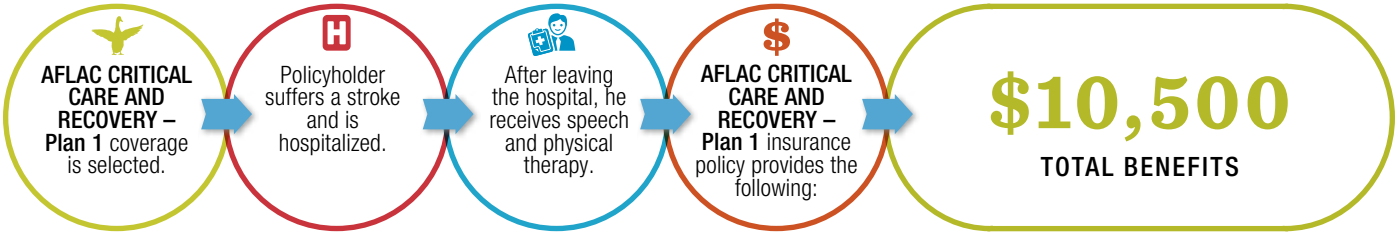
The Critical Care and Recovery insurance policy:

- Pays a lump-sum benefit upon diagnosis of having had a primary specified health event, which increases for dependent children.
- Pays benefits for hospital confinement, continuing care, transportation, and lodging.
- Is guaranteed-renewable—as long as premiums are paid, the policy cannot be canceled.
- Has no deductibles, copayments, or network restrictions–you choose your own medical treatment provider.

Primary specified health events covered by the Critical Care and Recovery policy include:

- Coma
- Paralysis
- End-Stage Renal Failure
- Persistent Vegetative State
- Major Human Organ Transplant
- Stroke
- Heart Attack
- Major Third-Degree Burns
- Coronary Artery Bypass Surgery
- Sudden Cardiac Arrest

HOW IT WORKS



The above example is based on a scenario for Aflac Critical Care and Recovery – Plan 1 that includes the following benefit conditions: Stroke (First-Occurrence Benefit) of $5,000, Hospital Confinement Benefit (5 days) of $1,500, Continuing Care Benefit (30 days) of $3,750, ground ambulance transportation (Ambulance Benefit) of $250.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer.
This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Plan 1 Critical Care and Recovery Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
FIRST-OCCURRENCE BENEFIT: • NAMED INSURED/SPOUSE • DEPENDENT CHILDREN	 $5,000; lifetime max $5,000 per covered person $7,500; lifetime max $7,500 per covered person
REOCCURRENCE BENEFIT	$2,500; no lifetime max
SECONDARY SPECIFIED HEALTH EVENT BENEFIT	$250; no lifetime max
HOSPITAL CONFINEMENT BENEFIT	$300 per day; no lifetime max
CONTINUING CARE BENEFIT	$125 each day for up to 75 days; no lifetime max
AMBULANCE BENEFIT	$250 ground or $2,000 air; no lifetime max
TRANSPORTATION BENEFIT	$.50 per mile; up to $1,500 per occurrence; no lifetime max
LODGING BENEFIT	Up to $75 per day; limited to 15 days per occurrence; no lifetime max

REFER TO THE FOLLOWING OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

SPECIFIED HEALTH EVENT INSURANCE POLICY

SUPPLEMENTAL HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE FOR POLICY FORM SERIES A71100

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* furnished by Aflac.

Should you have any questions about health insurance call: The Department of Business and Industry, Division of Insurance, Mondays through Fridays from eight am to five pm PST at 888-872-3234. In Carson City call 775-687-4270. In Las Vegas call 702-486-4009.

1. **Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

2. **Specified Health Event Insurance Coverage** is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

3. **Benefits:** Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.

   A. **FIRST-OCCURRENCE BENEFIT:** Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

   Named Insured/Spouse
   $5,000 (Lifetime maximum $5,000 per covered person)

   Dependent Children
   $7,500 (Lifetime maximum $7,500 per covered person)

   This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

   B. **REOCCURRENCE BENEFIT:** If benefits have been paid to a covered person under A above, Aflac will pay $2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

   For Benefit B to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit A or Benefit B became payable. No lifetime maximum.

   C. **HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay $300 (three hundred dollars) per day for each day a covered person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event.** No lifetime maximum.

   Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

   Benefits are not payable on the same day as the Continuing Care Benefit (D). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid.

Benefits D through G will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

   D. **CONTINUING CARE BENEFIT:** If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay $125 (one hundred twenty-five dollars) each day a covered person is charged:

1.	rehabilitation therapy	7.	home health care
2.	physical therapy	8.	dialysis
3.	speech therapy	9.	hospice care
4.	occupational therapy	10.	extended care
5.	respiratory therapy	11.	Physician visits
6.	dietary therapy/ consultation	12.	nursing home care

   Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is $125 (one hundred twenty-five dollars) regardless of the number of treatments received.

   Form A92397NV

   Benefits are not payable on the same day as the Hospital Confinement Benefit (C). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

   E. **AMBULANCE BENEFIT:** If, due to a covered Primary Specified Health Event, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event, we will pay $2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event. Payment will be made directly to the ambulance company, unless it received payment from another source. The Named Insured or the ambulance company may submit the claim. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

F. TRANSPORTATION BENEFIT: If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON.** No lifetime maximum.

G. LODGING BENEFIT: Aflac will pay the charges incurred up to $75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Primary Specified Health Event. **Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event**. No lifetime maximum.

H. SECONDARY SPECIFIED HEALTH EVENT BENEFIT: Aflac will pay $250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. **This benefit is limited to one Coronary Angioplasty per 30-day period.** No lifetime maximum.

I. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

Not Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

J. CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
5. You re-establish premium payments through:
   a. your new employer's payroll deduction process, or
   b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

4. Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER:
(Series A71050) Applied for: ☐ Yes ☐ No

The First-Occurrence Building Benefit as defined in the policy, will be increased by $500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person

on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051) Applied for: ☐ Yes ☐ No

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. "Primary Specified Health Event" includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

Aflac will pay $500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person's Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

PRE-EXISTING CONDITIONS: Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider. Any reoccurrence of a Primary Specified Health Event occurring more than 30 days after the Effective Date will be covered.

LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:

A. Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

B. This rider does not cover losses or confinements caused by or resulting from:

1. Participating in any sport or sporting activity for wage, compensation, or profit.
2. Intentionally self-inflicting bodily Injury or attempting suicide.
3. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

5. Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

B. The policy does not cover losses or confinements caused by or resulting from:

1. Participating in any sport or sporting activity for wage, compensation, or profit.
2. Intentionally self-inflicting bodily Injury or attempting suicide.
3. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Any reoccurrence of a Primary or Secondary Specified Health Event occurring more than 30 days after the Effective Date will be covered.

6. Renewability: The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

Associate/Agent's Name_____

Associate/Agent's Address_____

Associate/Agent's Telephone Number_____

RETAIN FOR YOUR RECORDS.

THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED. THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

COMA: a continuous state of profound unconsciousness, diagnosed or treated after the effective date of the policy, lasting for a period of seven or more consecutive days, characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance.

CORONARY ANGIOPLASTY: a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart (coronary arteries). A coronary angioplasty may be performed to treat persistent chest pain (angina) blockage of one or more coronary arteries, or residual obstruction in a coronary artery during or after a heart attack. These procedures may be performed with or without stents.

CORONARY ARTERY BYPASS SURGERY: open-heart surgery, performed after the effective date of the policy, to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, coronary angioplasty, laser relief, or other nonsurgical procedures. This does not include valve replacement surgery.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The effective date is not the date you signed the application for coverage.

END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

HEART ATTACK: a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the effective date of the policy. The attack must be positively diagnosed by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

MAJOR HUMAN ORGAN TRANSPLANT: a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. It does not include transplants involving mechanical or nonhuman organs.

MAJOR THIRD-DEGREE BURNS: an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis, and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals.

PARALYSIS: spinal cord injuries occurring after the effective date of coverage resulting in complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days. The paralysis must be confirmed by your attending physician.

PERSISTENT VEGETATIVE STATE: a state of severe mental impairment in which only involuntary bodily functions are present and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, shall certify in writing, based upon conditions found during the course of their examination, that:

1. The covered person's cognitive function has been substantially impaired, and
2. There exists no reasonable expectation that the covered person will regain significant cognitive function.

PRIMARY SPECIFIED HEALTH EVENT: heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, persistent vegetative state, coma, paralysis, or sudden cardiac arrest occurring after the effective date of coverage.

SECONDARY SPECIFIED HEALTH EVENT: coronary angioplasty, with or without stents, occurring after the effective date of coverage.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated after the effective date of the policy. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed by a physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

SUDDEN CARDIAC ARREST: sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the proximate cause of death shown on the death certificate is cardiovascular collapse, sudden cardiac arrest, cardiac arrest, or sudden cardiac death shall be deemed to be sudden cardiac arrest for purposes of the policy. Sudden cardiac arrest is not a heart attack.

ADDITIONAL INFORMATION

A hospital does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include a member of your immediate family.

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6.

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

   6.1 Amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor to coordinate payroll deductions for voluntary benefits;

   6.2 Amend the HealthSCOPE Benefits Third Party Administration (TPA) contract to reduce TPA collection of fees, subrogation recoveries, and provider refunds;

   6.3 Amend the Express Scripts, Inc. Pharmacy Benefits Manager contract to reduce administrative fees and implement greater drug discounts and guaranteed drug rebates;

   6.4 Extend and amend the Extend Health (Willis Towers Watson) Medicare Exchange contract to provide services for an additional 5 years through 2025 and eliminate administration fees beginning July 1, 2019.

   (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

6.1.

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

    6.1 Amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor to coordinate payroll deductions for voluntary benefits;

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Deonne Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: VI.I

Title: Contract Amendment Report – Morneau Shepell

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to add clarifying language to the contract.

REPORT

MORNEAU SHEPELL

The PEBP Board approved an amendment to the Morneau Shepell contract on September 27, 2018 that extended the contract through December 31, 2023 and added a new fully integrated voluntary benefit platform. PEBP staff now needs an amendment to add language to allow Morneau Shepell (or its PEBP approved subcontractors) to act on PEBP's behalf in executing the provisions of NRS 281.129(1)(c) and NRS 218F.510(3) to collect payroll deductions from participating pay centers for voluntary benefits.

NRS 281.129 Deductions from payroll for state officers and employees; regulations.

1. Any officer of the State, except the Legislative Fiscal Officer, who disburses money in payment of salaries and wages of officers and employees of the State:
   (c) Shall, upon receipt of information from the Public Employees' Benefits Program specifying amounts of premiums or contributions for coverage by the Program, withhold those amounts from the salaries or wages of officers and employees who participate in the Program and pay those amounts to the Program.

NRS 218F.510 Duties of Chief as Legislative Fiscal Officer.

3. The Chief shall, upon receipt of information from the Public Employees' Benefits Program specifying amounts of premiums or contributions for coverage by the Program:
   (a) Withhold from the pay of each employee of the Legislature and employee of the Legislative Counsel Bureau who participates in the Public Employees' Benefits Program those amounts; and
   (b) Pay those amounts to the Program. The salaries or wages of officers and employees who participate in the Program and pay those amounts to the Program.

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell for eligibility and enrollment services in contract # 15941 to add clarifying language to the contract.

6.2.

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

   6.2 Amend the HealthSCOPE Benefits Third Party Administration (TPA) contract to reduce TPA collection of fees, subrogation recoveries, and provider refunds;

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Governor

Deonne Contine
Board Chair

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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: VI.II

Title: Contract Amendment Report – HealthSCOPE Benefits

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for Third Party Administration (TPA) services for PEBP members at a reduced rate.

REPORT

HEALTHSCOPE BENEFITS TPA SERVICES

PEBP entered into a 5 year contract with HealthSCOPE Benefits for TPA services effective February 8, 2011 resulting from RFP # 1893. This contract has been extended through June 30, 2022. PEBP staff has negotiated a reduction to Medical Claims Admin fees from $14.50 PEPM to $13.95 PEPM; reduced Subrogation fees from 25% of recovery to 18% of recovery; and Enhanced Recovery fees from 25% of savings to 22% of savings. The reduction of fees will be effective July 1, 2019 through the contract term.

The total projected annual savings to PEBP is approximately $277,500 per year.

Fee Type	Pre-Amendment Projected Cost	Post-Amendment Projected Cost	Total Projected Savings
Medical Claims Admin Fees – Remainder of FY19	$1,590,452	$1,590,452	$0
Medical Claims Admin Fees – FY 20	$4,990,840	$4,829,371	$161,468
Medical Claims Admin Fees – FY 21	$5,226,879	$5,057,774	$169,105
Medical Claims Admin Fees – FY 22	$5,480,129	$5,302,831	$177,298
TOTAL	**$17,288,300**	**$16,780,428**	**$507,872**

Fee Type	Total Paid July – Dec 2018	25% Fee	Amended 18% Fee	Total Projected Savings (6 months)
Subrogation	$602,834	$150,708	$108,510	$42,198
TOTAL	**$602,834**	**$150,708**	**$108,510**	**$42,198**
ANNUAL TOTAL				**$84,396**

Fee Type	Total Paid July – Dec 2018	25% Fee	Amended 22% Fee	Total Projected Savings (6 months)
Enhanced Recoveries	$418,836	$104,057	$92,144	$11,913
TOTAL	**$418,836**	**$104,057**	**$92,144**	**$11,913**
ANNUAL TOTAL				**$23,826**

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for TPA services in contract # 11825 to reduce fees.

6.3.

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

    6.3 Amend the Express Scripts, Inc. Pharmacy Benefits Manager contract to reduce administrative fees and implement greater drug discounts and guaranteed drug rebates;

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Board Chair

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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: VI.III

Title: Contract Amendment Report – Express Scripts, Inc.

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and Express Scripts, Inc. to reduce fees and increase negotiated discounts and rebate guarantees through the contract term.

REPORT

EXPRESS SCRIPTS, INC.

PEBP contracted with Express Scripts Inc. (ESI) for Pharmacy Benefits Manager (PBM) Services which began July 1, 2016. Pursuant to the contract, PEBP may perform, or have performed on its behalf, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions.
AON Consulting performed a market check and based on the results, ESI has agreed to additional negotiated discounts, additional rebate guarantees, and reduced admin fees through the contract term. These reduced contract fees would begin July 1, 2019 and are anticipated to save the CDHP and EPO plans approximately $5.2 million per year.

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Express Scripts, Inc. for PBM services in contract # 17551 to reduce fees and increase negotiated discounts and rebate guarantees through the contract term.

6.4.

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

   6.4 Extend and amend the Extend Health (Willis Towers Watson) Medicare Exchange contract to provide services for an additional 5 years through 2025 and eliminate administration fees beginning July 1, 2019.

   (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

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Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: VI.IV

Title: Contract Amendment Report – Willis Towers Watson/Extend Health

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and Willis Towers Watson/Extend Health to provide individual Medicare Exchange and Health Reimbursement Arrangement Administration for eligible Medicare retirees of the program for an additional 5 years and eliminating all fees to PEBP.

REPORT

WILLIS TOWERS WATSON/EXTEND HEALTH MEDICARE EXCHANGE SERVICES

PEBP entered into a 5 year contract with Willis Towers Watson/Extend Health for Medicare Exchange services effective July 1, 2010 resulting from a solicitation waiver. PEBP later entered into another 5 year contract effective July 1, 2015 resulting from RFP # 3124 and is due to expire on June 30, 2020.

PEBP staff has negotiated to eliminate the current $1.50 PPPM HRA Admin fees and extend the contract 5 years through June 30, 2025.

The total projected annual savings to PEBP is approximately $241,000 per year.

Fee Type	Projected Medicare Exchange Enrollment	Pre-Amendment Projected Cost	Post-Amendment Projected Cost	Total Projected Savings
HRA Admin Fees – Remainder of FY19	12,505	$75,030	$75,030	$0
HRA Admin Fees – FY 20	12,755	$229,592	$0	$229,592
HRA Admin Fees – FY 21	13,010	$234,184	$0	$234,184
HRA Admin Fees – FY 22	13,270	$238,867	$0	$238,867
HRA Admin Fees – FY 23	13,536	$243,645	$0	$243,645
HRA Admin Fees – FY 24	13,807	$248,518	$0	$248,518
HRA Admin Fees – FY 25	14,083	$253,488	$0	$253,488
TOTAL		**$1,448,293**	**$75,030**	**$1,448,293**

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Willis Towers Watson/Extend Health for Medicare Exchange services in contract # 16468 to eliminate fees and extend through June 30, 2025.

7.

7. Discussion and possible action regarding changes to Plan Year 2020 Consumer Driven Health Plan (CDHP) plan design to include: reducing deductibles and out-of-pocket maximums; increasing dental benefit maximums; and eliminating annual vision exam copays. (Damon Haycock, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: VII

Title: Plan Year 2020 CDHP Plan Design Report

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on advocate group requests to evaluate additional CDHP plan design for Plan Year 2020.

BACKGROUND

At the January 24, 2019 PEBP Board meeting, PEBP presented a report on Plan Year 2020/2021 Plan Benefit Design Opportunities. In that report, PEBP provided a confirmation of previously approved Board actions at the November 29, 2018 Board meeting, updated available excess reserve calculations, and addressed additional opportunities to address Medicare Exchange retiree fees and premiums as well as alignment with Health Savings Account (HSA) / Health Reimbursement Arrangement (HRA) enhanced funding proposed in the Governor's Recommended Budget.

During that meeting, the Nevada Faculty Alliance submitted public comment requesting the Board direct PEBP to have Aon (PEBP's contracted actuaries) perform analysis enrichening the CDHP plan further by lowering deductibles and out-of-pocket maximums, eliminating copays for annual vision exams and increasing dental benefit maximums for Plan Year 2020.

REPORT

AON'S ANALYSIS

PEBP requested Aon perform the requested analysis above and they provided PEBP their results on February 28, 2019. Below is a table produced for this report:

Benefit Change	PY20 Cost Estimates
Reduce the deductible from $1,500/$3,000 to $1,350/$2,700 (individual/family)	$1,228,000
Reduce the out-of-pocket maximum from $3,900/$7,800 to $3,500/$7,000	$1,708,000
Raise the dental plan maximum from $1,500 to $1,800	$730,000
Reduce the annual vision plan co-pay from $25 to $0	$275,000
Total	**$3,941,000**

FACTORS TO CONSIDER

PEBP is confident the plan design options above can be funded for Plan Year 2020 utilizing existing excess reserves. However, PEBP has traveled this path before enhancing the plan design with excess reserves in 2014 for Plan Years 2015-2017 culminating in the planned elimination of these enhancements moving forward. The Board, Legislature, membership, and advocate groups unanimously expressed concerns over providing benefits to members and then taking them away after a period of time.

The following factors should be considered when evaluating the enhancement of benefits through excess reserves:

- Long-Term Sustainability
- Governor's Recommended Budget / Legislative Testimony
- Untested Rate Reductions and EPO Plan
- Plan Design Philosophy

PROPOSED SOLUTION

Today PEBP offers access to two plan designs that are designed to meet the budgetary needs of our members. PEBP offers the CDHP to members who want to pay low monthly premiums and are willing to pay more upfront when they seek services. PEBP also offers an HMO/EPO plan to members who want to pay higher monthly premiums but want to pay low copayments when they seek services. These plans are balanced on both ends of the spectrum.

However, if the Board would like to address the request to lower deductibles, out-of-pocket maximums, and eliminate/reduce copays on the CDHP, PEBP recommends the CDHP plan be left as-is and PEBP creates a middle tier plan that is designed to meet these proposed needs.

PEBP suggests the following:

1. Develop a statewide self-insured low-deductible PPO plan strategy at our annual strategic planning meeting in August 2019.
2. Provide the concept to the Board for approval by November 2019.
3. Develop the approved plan concept with our partners and stakeholders and build the plan in our next biennial budget in the summer of 2020.
4. Obtain Board final approval on the new plan November 2020.

5. Testify on the new plan at the Legislature and gain their buy-in/funding in February-June 2021.
6. Go live on the new plan July 1, 2021.

PEBP has listened to the Board and our stakeholders and recognizes sufficient time should be provided to make major changes to the Program.

RECOMMENDATION

PEBP recommends **not** enhancing the CHDP plan design further with excess reserves and direct PEBP (if desired) on a third plan option for implementation in 2021.

8.

8. Discussion regarding future Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plan in-state network strategies for improving access and choice to healthcare providers. (Damon Haycock, Executive Officer) (Information/Discussion)

Information / Discussion item, no report requested.

9.

9. Discussion and possible action to include approving Plan Year 2020 (July 1, 2019 – June 30, 2020) rates for State and Non-State employees, retirees, and their dependents for the Statewide Consumer Driven Health Plan (CDHP); southern Nevada Health Maintenance Organization (HMO) Plan; and the northern and rural Nevada PEBP Premier (Exclusive Provider Organization - EPO) Plan. (Damon Haycock, Executive Officer) **(For Possible Action)**.

PUBLIC EMPLOYEES' BENEFITS PROGRAM

Plan Year 2020 Rates

March 28, 2019

Executive Summary

PEBP continues to see low inflation on medical and dental costs but recently experienced very high pharmacy costs on the CDHP. This has led to an overall rate increase on that plan. The EPO plan is running better than projected and their overall rates have decreased. HPN provided PEBP with two rate renewal options to meet budgetary needs. The Board has a decision to make today on what level of employer contributions produce the desired employee/retiree premiums for Plan Year 2020.

Option 1: Return to 2016 Contribution Levels

- **93% employee / 64% retiree and premiums increase for all employees on all plans and an increase for retirees on the CDHP and a decrease on the HMO/EPO**

Option 2: Small Increase to 2018 Contribution Levels

- **95.1% employee / 66.4% retiree and premiums for employees and retirees stay flat on the CDHP and decrease on the HMO/EPO**

Option 3: Larger Employee Increase to 2018 Contribution Levels

- **96.3% employee / 66.4% retiree and premiums decrease for employees on all plans and stay flat for retirees on the CDHP while decreasing on the HMO/EPO.**

AGENDA

- Rate Development
  - Methodology
  - Inputs
  - Experience
  - Plan Tiers of Coverage
  - Projected Population
  - Optional Contribution Percentages

AGENDA (cont.)

- Overall Rates
- Optional State Employee Rates
- Optional State & Non-State Pre-Medicare Retiree Rates
- Board Approval

Rate Development

Methodology

1. Experience + Projected Trend = Base Rates
2. Base Rates + Administrative Costs = Overall Rates
3. Overall Rates – Employer Contributions (Subsidy) = Member Share (Premiums)

Rate Development

Inputs

- Legislatively Requested Employer Contribution (FY 2020)
  - Employees:
    - Agency Request: $772
    - Governor's Recommended: $757.83
    - Today's Rate Approval: $732.75 (Option 1), $747.75 (Option 2), $757.83 (Option 3)
  - Pre-Medicare Retirees:
    - Agency Request: $472
    - Governor's Recommended: $522.68
    - Today's Rate Approval: $529.68 (Option 1), $546.70 (Option 2 & 3)
- Updated Population (Point-in-Time Projected Forward)
- Experience (Through January, 2019)
- Plan Design (Approved at the November 29, 2018 Board Meeting)

Rate Development

Experience

- Aon provides PEBP with Base Rate Cards projecting claims experience and HPN provides PEBP with Medical/RX rate renewals:

State Employees and Retirees

CDHP	EPO	HPN
Medical: 1.63%	Medical: -2.18%	Medical/Rx: 0%/3.7%
Rx: 16.91%	Rx: 5.34%	Dental: 0.13%
Dental: 0.13%	Dental: 0.13%	Overall: 0.01%/3.47%
Overall: 4.35%	Overall: -0.29%	

Non-State Employees and Retirees

CDHP	EPO	HPN
Medical: 8.83%	Medical: 26.72%	Medical/Rx: 0%/3.7%
Rx: 28.14%	Rx: 7.46%	Dental: 0.62%
Dental: 0.62%	Dental: 0.62%	Overall: 0.04%/3.52
Overall: 12.66%	Overall: 17.74%	

Rate Development

Plan Tiers of Coverage

Established in July 2011 (PY 2012)

Participant Only =	$X
Participant + Spouse =	$2X
Participant + Child(ren) =	$X+$Y
Participant + Family =	$2X+$Y

$X = Average Cost of an Adult

$Y = Average Composite Cost of Children

Rate Development
Projected Population

Average enrollment based on past 48 month plus any known changes.

Projected Population is taken from plan experience on all plans offered by PEBP for Plan Year 2019 (as of March 2019).

There is an overall projected population increase of approximately 2.08% for PY20.

	FY 2018 (Actual)	FY 2019	FY 2020
State			
Actives	26,078	26,678	27,265
Early Retirees	4,034	4,072	4,117
Medicare Retirees	6,739	7,232	7,624
	36,852	37,982	39,006
Non-State			
Actives	8	8	8
Early Retirees	1,481	1,163	1,000
Medicare Retirees	5,221	5,284	5,367
	6,710	6,455	6,375
Total	**43,562**	**44,437**	**45,381**
Percent Change		**1.97%**	**2.08%**

Optional Employer Subsidy
Contribution Percentages

- **Board Policy Establishes:**
  - **Standardized differential for plans and dependents**
  - **Single blended "statewide" HMO/EPO rate**

Plan	Employees			Retirees	
	Option 1	Option 2	Option 3	Option 1	Option 2 & 3
Primary					
CDHP	93%	95.1%	96.3%	64%	66.4%
HMO/EPO	81%	82.6%	83.8%	52%	53.9%
Dependent					
CDHP	73%	75.1%	76.3%	44%	46.4%
HMO/EPO	61%	62.6%	63.8%	32%	33.9%

Overall Rates
Before Contributions and Premiums

State Employees		
Tier	CDHP	HMO/EPO
Employee Only	607.31	789.13
Employee + Spouse	1,123.53	1,533.34
Employee + Child(ren)	815.37	1,156.86
Employee + Family	1,331.61	1,901.07

State Retirees		
Tier	CDHP	HMO/EPO
Retiree Only	586.28	768.26
Retiree + Spouse	1,102.50	1,512.47
Retiree + Child(ren)	794.34	1,135.99
Retiree + Family	1,310.58	1,880.20

Non-State Retirees		
Tier	CDHP	HMO/EPO
Retiree Only	1,219.91	773.66
Retiree + Spouse	2,369.78	1,523.27
Retiree + Child(ren)	1,980.91	1,179.25
Retiree + Family	3,130.78	1,928.86

State Employee Premiums

State Active Employees	Statewide PPO				Statewide HMO/EPO			
	Consumer Driven Health Plan				PEBP Premier Plan and HPN Plan			
Tier	PY19	Option 1	Option 2	Option 3	PY19	Option 1	Option 2	Option3
Employee Only	31.73	42.45	31.73	22.71	142.43	151.52	137.31	128.15
Employee + Spouse	156.04	181.82	156.04	145.25	429.62	445.21	415.64	397.84
Employee + Child(ren)	82.41	98.62	82.41	72.10	284.89	297.41	274.84	261.41
Employee + Family	206.72	238.01	206.72	194.65	572.08	591.10	553.17	531.10

State/Non-State Retiree Premiums

State / Non-State Retirees	Statewide PPO			Statewide HMO/EPO		
	Consumer Driven Health Plan			PEBP Premier Plan and HPN Plan		
Tier	PY19	Option 1	Option 2 & 3	PY19	Option 1	Option 2 & 3
Retiree Only	199.56	210.72	199.56	379.06	372.74	354.17
Retiree + Spouse	470.33	499.80	470.33	896.26	884.81	846.09
Retiree + Child(ren)	309.96	327.23	309.96	635.63	627.11	597.24
Retiree + Family	580.72	616.33	580.72	1,152.83	1,139.19	1,089.16

Rates above reflect 15 years of service.

Board Approval

PEBP Recommends the following:

1. Approve Plan Year 2020 CDHP and HMO/EPO Rates as presented.
2. Select and approve the contribution levels and employee/retiree premiums
3. Allow staff to make technical adjustments as needed.

10.

10. Approval of the proposed changes to the CDHP and EPO Master Plan Documents for Plan Year 2020 (July 1, 2019 – June 30, 2020) for medical, dental, life, and long term disability benefits, for enrollment and eligibility rules, and for privacy and security requirements, to reflect previously approved plan design modifications, changes in legislative or regulatory requirements, and technical corrections or updates. (Nancy Spinelli, Quality Control Officer) **(For Possible Action)**

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 28, 2019

Item Number: X

Title: Approval of the proposed changes to the Master Plan Documents for Plan Year 2020

Summary

Updates to the Plan Year 2020 Master Plan Documents (MPD) including the Premier (EPO) Plan and the Consumer Driven Health Plan (CDHP).

Report

This report provides revisions to the Plan Year 2020 Master Plan Documents, including Board approved plan design changes and staff/vendor plan design recommendations to the CDHP and Premier EPO plans to standardize certain benefits across all plans.

No.	Description	Board Decision	Compliance audit, Federal and/or state laws	House - keeping	PEBP / Partner Recomm.
1.	Premier Plan	1	2	1	15
2.	Consumer Driven Health Plan	3	5	1	9
3.	PPO Dental Plan, Life and LTD			1	3
4.	Health and Welfare Wrap Document			1	1
5.	Medicare HRA SPD			1	2
6.	Flexible Spending Account SPD		1	2	
7.	Enrollment & Eligibility MPD		1	1	
Total		4	9	8	30

PREMIER EPO PLAN MPD

1. Board Approved Plan Design Changes

Premier EPO Plan			
Plan Feature		Current Plan Year (PY 2019)	Board Approved Benefit Design PY 2020
a.	Primary Care Physician (PCP) Visit	$25 copay	$20 copay
b.	Specialist Visit	$45 copay	$40 copay
c.	Emergency Room Visit	$300 copay	$500 copay
d.	Retail Pharmacy Preferred Generic:	$7 copay 30-day supply	$10 copay 30-day supply
e.	Specialty Pharmacy	30% coinsurance	20% coinsurance

2. ADDITIONAL RECOMMENDED PLAN DESIGN CHANGES

Premier EPO Plan			
	Plan Feature	Current Plan Year (PY 2019)	Staff/Vendor Recommendation
a.	Home Health Care, Outpatient Speech, Occupational and Physical Therapy visits	$25 copay	$20 copay to align with the standard $20 PCP copay per visit
b.	Chiropractic visits	Limited to 20 visits per Plan Year and 100 visits per lifetime	Align with HPN by eliminating lifetime maximum/retain 20 visits per Plan Year
c.	Doctor on Demand	Psychologist visit $25 copay Psychiatrist Visit: $25 copay	Amend Psychologist visit to $20 copay and Psychiatrist visit to $20 copay to align with the PCP copay
d.	Home Health Care	Limited to 30 visits per Plan Year	Increase HH care visits from 30 to 60 visits per Plan Year to align with the CDHP
e.	Hospice Services	$0 copay	Increase the Hospice copay per admission (inpatient or outpatient) from $0 to a $500 copay to align with HPN
f.	Hearing Aids	Excluded	Add hearing aid coverage for individuals with a 50% hearing loss in one ear. Benefits limited to $1,500 per ear, every three (3) years. Apply a $25 copay

Premier EPO Plan			
	Plan Feature	Current Plan Year (PY 2019)	Staff/Vendor Recommendation
			per device. This benefit is recommended to closely align with the CDHP and HPN hearing aid benefit
a.	OCM Weight-loss Medications	Coverage for preferred generic and brand name medications for both short-term and long-term term use	Exclude coverage for long-term weight loss medications; provide benefits for short-term preferred generic medications only
b.	Varicose Vein Treatment	Excluded	Add benefits for the medically necessary treatment for the removal, ablation, injection or destruction of varicose veins, including prior authorization requirement to align with the CDHP/HPN
c.	Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling	Coverage per USPSTF recommendation for adults 18 and older when the individual is referred by their PCP; for those with BMI of 30 or greater; and have additional cardiovascular disease factors. Current MPD does not include a visit limitation.	Incorporate a 3-visit limit for benefits paid at 100% under the wellness benefit; additional visits subject to a specialist visit copay
d.	Screening Colonoscopy	Plan currently covers the first colonoscopy of the Plan Year at 100% regardless of the diagnosis and/or USPSTF age/frequency guidelines	Align benefit with the American Cancer Society's age and frequency recommendation
e.	Screening Mammogram (2-D or 3-D)	Plan currently covers the first mammogram of the Plan Year at 100% regardless of the diagnosis, age and/or frequency guidelines	Align screening mammography benefit with the USPSTF age and frequency guidelines.

3. Other changes:

   a. Revised the list of services requiring precertification as recommended by American Health Holdings.

   b. Exclusions: Expanded the Marijuana exclusion language to include any derivative, including CBD, TCH, and edibles.

   c. For benefit clarification purposes, inserted Intensive Outpatient Program and Partial Hospitalization Services copayment with a $20 per each visit.

   d. 2018 Compliance review recommendation: Inserted Plan Sponsor Certification (45 CFR Section 164.504(f)(2)(ii)) certifying that the Plan Sponsor will appropriately safeguard and limit the use and disclosure of the Plan participants' protected health information that the Plan Sponsor may receive to perform the Plan administrative functions.

   e. Autism Spectrum Disorders and related terms: Updated the definitions pursuant to NRS 695G.1645 (effective January 1, 2019)

   f. Replaced member services email instructions with language on how to use the *Contact Us* feature in the E-PEBP Portal, including other revisions such as document formatting; plan year update; vendor contact information, etc.

CONSUMER DRIVEN HEALTH PLAN

1. Board approved plan design changes

Consumer Driven Health Plan (CDHP)			
Plan Feature		Current Plan Year (PY 2019)	Board Approved Benefit Design PY 2020
a.	HSA/HRA Contributions	Primary Base: $700; dependent(s) $200 per dependent, max 3 dependents	Primary Base: $700; dependent(s) $200 per dependent, max 3 dependents
b.	HSA/HRA supplemental contribution		Primary: $200
c.	HSA/HRA preventive program, Doctor on Demand (DoD) and Healthcare Bluebook (HCBB) enrollment (primary insured only)	$100 tied to preventive program $100 tied to DoD and HCBB enrollment	$100 tied to preventive program $100 tied to DoD and HCBB enrollment
d.	Smart90 Program	90-day supply available at any ESI network pharmacy	To receive coverage for maintenance medications, you must use the Smart90 Program. Maintenance medications obtained in a

Consumer Driven Health Plan (CDHP)			
Plan Feature		Current Plan Year (PY 2019)	Board Approved Benefit Design PY 2020
			30-day supply are not eligible for coverage under this Plan and you will be responsible for 100% of the prescription cost and will not receive Deductible and Out-of-Pocket credit.
e.	Copayment Assistance	Copay assistance dollars applied to accumulators.	Copayment assistance (manufacturer-funded patient assistance) for widely distributed specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

1. Additional plan design changes recommended by staff and/or vendor partners

Consumer Driven Health Plan (CDHP)			
Plan Feature		Current Plan Year (PY 2019)	Staff/Vendor Recommendations 2020
a.	Rehabilitation Services (Physical, Occupational and Speech Therapies)	Inpatient requires prior authorization; maintenance rehabilitation not covered.	Coverage for medically necessary ST, OT, and PT subject to a combined benefit of ninety (90) visits per Plan year to more closely align with the EPO and HPN
b.	Chiropractic Treatment Services	15 visits per Plan Year; Maintenance not covered, visits exceeding 15 require medical necessity review	Increase visits from 15 to 20 visits per Plan Year to align with the EPO and HPN plans
c.	Hospice Services	Life expectancy of 6 months or less; MPD does not have a hospice limit	Add a maximum lifetime benefit limited to 185 days to align with the EPO plan.
d.	OCM Weight Loss Medications	Coverage for preferred generic and brand name short and long-term weight loss medications.	Exclude coverage for long-term weight loss medications; exclude coverage for all medications except

			preferred generic as identified by the PBM. Recommended by staff as a cost containment measure
e.	Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling	USPSTF recommendation for adults 18 and older when the individual is referred by their PCP; for those with BMI of 30 or greater; and have additional cardiovascular disease factors. Current MPD does not include a visit limitation.	Incorporate a 3-visit limit for benefits paid at 100% under the wellness benefit (3 visit limit previously approved by the Board at their December 2011 meeting)
f.	Screening Colonoscopy	First colonoscopy of the Plan Year is paid at 100% regardless of the USPSTF age/frequency guidelines	Align benefit with the American Cancer Society's age and frequency recommendation.
g.	Screening Mammogram (2-D or 3-D)	First mammogram of the Plan Year paid at 100% regardless of the diagnosis, age and/or frequency guidelines.	Align screening mammography benefit with the USPSTF age and frequency guidelines.

2. Other changes

   a) Revised the 2019 IRS HSA contribution limits for individual from $3,450 to $3,500 and family from $6,850 to $7,000.

   b) Inserted the following out-of-network benefit clarification: If you receive services at an in-network facility, but the physician is out-of-network, the physician reimbursement will be subject to Usual and Customary.

   c) Colonoscopies: Inserted language to clarify Colonoscopy screening includes coverage for bowel preparation.

   d) Inserted revisions to the "summary" of the Subrogation provision in the CDHP with references pointing to the full "revised" subrogation language in the Health & Welfare Wrap document available on the PEBP website. See Premier EPO Plan *#3(e) Other Changes* for revised summary language.

   e) Inserted language stating the HRA may only be used to pay or reimburse qualified out of pocket health care expenses incurred by the Participant, Participant's spouse, Participant's dependents who could be claimed on the Participant's

annual tax return and enrolled in the CDHP or other non-HRA coverage. (2018 compliance review recommendation.)

f) Compliance Review Recommendation: Medical and Dental Claim Appeals: Inserted language stating adverse determinations for Health Reimbursement Arrangement (HRA) claims are subject to the internal appeals process. (2018 compliance review recommendation.)

g) Autism Spectrum Disorders and related terms: Updated the definitions pursuant to NRS 695G.1645 (effective January 1, 2019).

PPO DENTAL PLAN, BASIC LIFE, AND LTD MPD

1. Other changes

a) Inserted language regarding PEBP's provision requiring automatic dental premium reimbursement for retirees enrolled in the Medicare Exchange.

Medicare retirees enrolled in a medical plan through VIA Benefits (Medicare Exchange) and those retirees with Tricare for Life and Medicare Parts A and B who are eligible for a Medicare Exchange Health Reimbursement Arrangement (HRA) have the option to enroll in PEBP's PPO Dental Plan.

Enrollment in PEBP's PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

b) Revised the overview/summary of the Plan's Subrogation and Rights to Recovery provision, including a reference directing participants to the full subrogation language in the Health & Welfare Wrap document available on the PEBP website. See Premier EPO Plan *#3(e) Other Changes* for revised language.

c) Replaced member services email instructions with language on how to use the Contact Us feature in the E-PEBP Portal, including other revisions such as document formatting, plan year update, vendor contact information, etc.

PEBP HEALTH AND WELFARE WRAP PLAN DOCUMENT

1. Other changes

a) Revised the Subrogation and Rights to Recovery provision as recommended by HSB's legal subrogation team to address any new arguments from personal injury attorneys. The following language was also reviewed by PEBP's former Deputy Attorney General.

Subrogation applies to situations where the Participant is injured and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The other person or entity who may be responsible, liable, or contractually obligated for the payment of damages or claims may be an individual, a corporation or other business entity, an insurance company (including the Participant's own insurance company), or a public or private entity. By way of example only, and without limitation, automobile accident injuries or personal injury on another's property (i.e. a slip and fall) are examples of cases frequently subject to Subrogation.

Subrogation includes situations where the Injury is or may be covered by another insurance policy, including but not limited to the Participant's own first-party automobile insurance, any third-party automobile liability insurance, any applicable no-fault insurance or medical payments coverage, and premises medical payments coverage (including homeowner's insurance), irrespective of fault, negligence, or wrongdoing.

The Subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, negligence, or wrongdoing. ~~The Subrogation and Rights of Recovery provision allows for the right of recovery for certain payments made by the Plan, irrespective of fault, wrongdoing, or negligence.~~ *Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict, or settlement obtained by the Participant in relation to the Injury. "Injury" means any harm or damage sustained to the person of a Participant ~~body part~~ resulting ~~from trauma from an external source~~ in some form of medical treatment.*

Subrogation. By accepting coverage under the Plan, the Participant automatically assigns to the Plan or its Board any and all rights the Participant may have to recover damages or payments from any other person or entity arising from or relating in any way to the Injury, with regard to any and all tort, contractual or other ~~legal~~ liability or obligation on the part of a person or entity other than the Participant. This includes payments made, or to be made, to or for the Participant from another insurance company, including the Participant's own insurance policy (~~-~~a "first-party" insurance policy). The Board~~Plan Administrator~~ may, but is not required to, act as the substitute for the Participant in the event any payment made by th~~is~~e Plan for health care or other benefits,

including any payment for a known or discovered pre-existing condition, may be the responsibility or contractual liability of another person. Such payments shall be referred to as Reimbursable Paymentsor entity. This express assignment allows the Plan or its Board to directly pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. The Plan or its Board Plan Administrator may pursue any such claims on behalf of the Participant and/or in the Participant's own name, as if the Participant were pursuing the claim on his/her own behalf. This includes the right to sue the other person or entity in order to recover any and all payments made by the Plan relating in any way to the Injury. This also includes the right to pursue and/or make a claim against an insurance policy, on behalf of the Participant and/or in the Participant's own name.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation and rights of Recovery of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation;
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first-party insurance policy or another person's or entity's insurance policy.

(a)(b) Right of Reimbursement and Recovery. By accepting coverage under the Plan, the Participant agrees that if he/she they or someone else receives a recovery of any kind in the form or a judgment, verdict, settlement, payment, or other compensation, irrespective of fault, wrongdoing, or negligence, and irrespective of how the recovery is classified, the Plan or its Board has the unequivocal right to recover its Subrogated Payments from the Participant and/or from any other person or entity, including but not limited to the Participant's estate, survivors, or family members. This also includes, but is not limited to, the right of recovery from the following:

(1) Tortfeasor;
(2) Tortfeasor's insurance company; and/or
(3) Any other source, including but not limited to: any form of first-party insurance coverage carried by, or insuring, the Participant; uninsured or underinsured motorist coverage; any medical payments coverage; no-fault coverage; school insurance coverage; sports insurance coverage;

workers' compensation coverage; premises liability coverage, including homeowner's and boating coverage; any medical malpractice recovery; or any other form of insurance coverage, of whatever kind.

The Plan and its Board haves an equitable lien against the ~~Recovery~~ recovery rights of the Participant. The Plan and its Board~~, and has~~ have the legal right to be paid from any such recovery~~Recovery~~, or potential recovery ~~Recovery~~, an amount not to exceed the total amount of benefits paid or to be paid by the Plan, irrespective of whether or not the Participant has been "made whole" for the injuries received. ~~In its sole discretion, the Executive Officer has the right (but is not required) to consider reducing the subrogated amount (lien) by any attorney's fees or costs incurred (e.g. deductible or co-insurance) by the Participant in the collection of damages.~~

The Plan's right to Subrogation applies on a first-dollar basis, and has priority over all other rights or claims, including the Participant's attorney fees. The Plan's right of Subrogation applies irrespective of whether the funds paid to (or for the benefit of) the Participant constitute a full or partial recovery and applies to recovered funds paid for non-health care charges or attorney fees, or other costs and expenses, including lost wages. The Plan's first priority right of Subrogation in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any other person or entity attempts to designate or characterize the Recovery, including but not limited to claims for loss of consortium or wrongful death, and irrespective of whether the Recovery itemizes or identifies an amount recovered, adjudicated, or characterized specifically as medical expenses, or is specifically linked to certain kinds of damages or payments.

The Plan's first priority right of Subrogation extends to any and all recoveries arising from or relating in any way to the Injury, including but not limited to any recovery obtained by the Participant's estate, or obtained by the Participant's heirs, survivors, successors, assigns, dependents, and/or the like, and/or irrespective of whether the claim is characterized as a wrongful death claim or a survivorship claim.

The Plan's first priority right of Subrogation extends to the Participant's attorney and/or to other agents, successors, and assigns of the Participant.

Payment of ~~the~~ Subrogated ~~Amount to the Plan~~ Payments shall be made without reduction, set-off, or abatement for attorney ~~attorney's~~ fees or costs incurred by the Participant in the collection of a Recovery.

The Plan or its Board shall be entitled to seek any equitable ~~remedy~~ or ~~any~~ legal remedy to recover money damages or claims against any person or entity ~~party~~ possessing or controlling such monies or properties, including but not limited to the Participant and/or his/her attorney. At the sole discretion of the Plan and/or ~~the Plan Administrator~~its Board, the Plan may reduce any and all eligible medical expenses, or deny any and all claims, otherwise available to the Participant under the Plan by an amount up to the total Subrogated ~~Amount that~~Payments which are ~~is~~ subject to the Plan's right of Subrogation. The Plan's right to reduce eligible medical expenses and to deny claims applies to all eligible medical expenses and claims, irrespective of whether such eligible medical expenses and claims bear any relation to the Injury. All rights of the Plan's recovery will be limited to the amount of payments made under this Plan, plus the Plan's reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan.

The Plan or its Board shall be entitled to payment of reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan. This may include, but is not limited to, situations in which: (i) the Plan or its Board commence litigation; (ii) the Plan or its Board intervene in existing litigation; (iii) the Participant or his/her attorney has not paid the Plan the full amount of Subrogated Payments within fifteen (15) days of recovery, as required by NRS 287.0465(3); and/or (iv) the Participant or his/her attorney is not fully cooperative with respect to the Plan's right of Subrogation.

The Plan's equitable lien shall also attach to any money or property that is obtained, held, or to be paid by any person or entity, including but not limited to the Participant, the Participant's attorney, an insurance company, and/or a trust for the direct or indirect benefit of the Participant or for his/her "special needs," as a result of an exercise of the Participant's rights of ~~Recovery~~recovery.

If the Participant attempts to assert that certain Subrogated Payments are not causally related to the Injury, it shall be the Participant's burden to prove the relatedness of the Subrogated Payments in question. If the Subrogated Payments in question are referred to, referenced, or included in any way by the Participant in any settlement negotiations or in any demand package tendered by the Participant to the person or entity from which a recovery is sought, it shall be deemed conclusive evidence that said Subrogated Payments are causally related to the Injury. At its sole discretion, the Plan or its Board may consider additional evidence concerning the causal relation of Subrogated Payments to the Injury.

The Plan or its Board may require the Participant or the Participant's attorney or substitute, as a pre-condition to receiving benefit payments, to sign a Subrogation agreement or acknowledgment and to agree in writing to assist the Plan and to protect the Plan's right to payment of the Subrogated Amount from any person ~~including the Participant. In the event that the Plan does not receive such~~

~~*agreement, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and creation of an equitable lien:*~~*or entity including the Participant.*

In addition to all Subrogation rights afforded to the Plan herein and by Nevada law, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and/or creation of an equitable lien:

"Pay and Pursue." The Plan ~~*Administrator*~~*, in its sole discretion, may elect to process claims under the "pay and pursue" option. If the Plan* ~~*Administrator*~~ *elects to "pay and pursue," benefit payments will be made prior to, or concurrently with, necessarily applying the Subrogation, reimbursement and lien rights under the Plan. This is at the sole discretion of the Plan* ~~*Administrator*~~*or its Board and remains subject to the Participant's required cooperation with and protection of the Plan's right of Subrogation.*

Scope of Subrogation, Reimbursement and Lien Rights. The Subrogation, reimbursement, and lien rights apply to any and all benefits paid by the Plan for or on behalf of the Participant arising from or related in any way to the ~~*injury*~~*Injury, and apply to all of the following, enumerated without limitation:*

- *Any no-fault insurance.*
- *Medical benefits/payments coverage under any automobile insurance coverage. This includes* ~~*the Participant's*~~ *any first-party insurance plan under which the Participant is covered or an insured, or any third person's insurance policy under which the Participant may be entitled to benefits.*
- ~~*Under-insured*~~*Underinsured and uninsured motorist coverage, and any other first-party insurance coverage.*
- *Any automobile medical payments and personal injury protection ("PIP'') benefits.*
- *Any third person's liability insurance, whether automobile coverage or other.*
- *Any premises/guest medical payments coverage, including homeowner's insurance.*
- *Any medical malpractice recovery or insurance policies covering medical malpractice.*
- *Any professional negligence or attorney malpractice recovery or insurance policies covering professional negligence.*
- *Workers' compensation benefits or claims.*
- *Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds), to the extent permitted by law.*
- *Restitution in a criminal matter.*

~~***Reimbursable***~~ *Subrogated Payments. The term "*~~*Reimbursable*~~ *Subrogated Payments" refers to any benefit payments made by the Plan that are eligible for*

recovery from any other person as described hereinabove and/or any benefits payments for which the Plan asserts a right of Subrogation.

"Make Whole" and "Common Fund" Rules Do Not Apply. The Plan's right of Subrogation, reimbursement, equitable liens, and other legal and equitable remedies are specifically intended to supersede the applicability of any and all common law doctrines and/or any and all local, state, and federal laws, including but not limited to the "make whole" rule and the "common fund" rule, to the extent permitted by law.

Role of the Executive Officer. PEBP has delegated to the Executive Officer its powers and its authority and discretion to enforce its rights under this Section 4.5.

A Subrogation lien of the~~The~~ Executive Officer ~~shall reduce~~ upon the proceeds of any recovery from an insurer providing first-party coverage to a member must be reduced by the applicable in-network or out-of-network out-of-pocket maximum balance of the member remaining at the time of the incident giving rise to the subrogation lien. If the subrogation lien includes medical claims from medical costs resulting from the incident giving rise to the subrogation lien which occurred over multiple plan years, the out-of-pocket maximum balances for each plan year must be used for purposes of reducing the subrogation lien amount. Notwithstanding the foregoing, the provisions of this paragraph do not apply to the coordination of benefits for coverage of the cost of medical services which may be provided under:

- *The plan of self-insurance established by PEBP; and*
- *Any other health insurance coverage.*

~~*The Executive Officer may collect less than the total cost of the medical services to which the Board is entitled to, including, without limitation, if the Executive Officer negotiated the amount to be collected in good faith with the Participant, the legal counsel of the Participant or the first-party insurance carrier of the Participant or the insurance carrier of a third party.*~~

A decision of the Executive Officer ~~made pursuant to this subsection~~ is final and not subject to judicial review.

Applicable Law. The Plan's right of Subrogation under Nevada law is set forth in part at NRS 287.0465. The Plan's Subrogation rights as set forth in this Section 4.5 are established, maintained, operated, and carried out in accordance with Nevada law, including but not limited to NRS 287.0465 and NAC 287.755, and in accordance with the statutory delegation to the Board of the powers and duties to establish and carry out PEBP.

b) Replaced member services email instructions with language on how to use the *Contact Us* feature in the E-PEBP Portal, including other revisions such as document formatting, plan year update, vendor contact information, etc.

MEDICARE HRA SUMMARY PLAN DESCRIPTION

1. Other changes

a) Inserted language regarding PEBP's provision to require automatic dental premium reimbursement for retirees enrolled in the Medicare Exchange and who elect PEBP's voluntary PPO Dental Plan.

Enrollment in PEBP's voluntary PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

b) Reimbursement Request Form Certification: Inserted language stating retirees who submit reimbursement requests online "certify" that the information is correct and complete and signed forms are not required for online submissions.

By submitting the reimbursement request, you certify that the information provided on the Reimbursement Request Form is correct and complete. You also certify that the expenses for which you are requesting reimbursement were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, the expenses have not been reimbursed in any other way from any other source, and the expenses will not be submitted for future reimbursement from any other source. (Refer to the back of the claim form for additional submission information (i.e. what documents or medical information is necessary to support the claim.)

c) Inserted language stating the specific information/documentation that VIA Benefits, in accordance with the IRS, requires to process a reimbursement request for medical, prescription drugs, Medicare Part B, Medicare supplemental plan, etc.

If you are submitting a reimbursement request for services provided by your physician, other health care practitioner, pharmacy or dentist, you must attach one or more documents from a third party containing all the following information.

- *provider name and professional information*
- *patient's name*
- *date eligible medical expense was incurred*
- *a brief description of the eligible medical expense*

- *amount that the patient paid or owed*

Reimbursement requests for prescription drugs must include an itemized receipt produced by the pharmacy that provides the following:

- *pharmacy name and address*
- *patient's name*
- *date the medication was dispensed*
- *name of medication*
- *amount that the patient paid*

This information may be included in one or more documents. A copy of the explanation of benefit provided by your health plan (e.g. Medicare or Medicare supplemental plan) indicating your financial responsibility may be the simplest document to provide.

Requests for premium reimbursements must be attached to a claim form. Claims may be submitted online at the VIA Benefits website https://my.viabenefits.com/PEBP. Claim forms may also be down loaded or mailed by calling (888) 598-7545.

If you are submitting a request for premium for a health plan (e.g. Medicare or Medicare supplemental plan) you must attach one or more documents from a third party containing all of the following information.

- *provider name*
- *covered participants name*
- *date of coverage*
- *type of coverage*
- *amount of the premium paid or incurred*

This information may be included in one or more documents. A copy of the premium statement from your insurance carrier (e.g. Medicare or Medicare supplemental plan) indicating your payments or financial responsibility may be the simplest document to provide. If the person is not the eligible retiree requesting reimbursement, please provide the relationship of the person to such eligible retiree.

d) Document formatting, plan year update, etc. Replaced member services email instructions with language on how to use the *Contact Us* feature in the E-PEBP Portal, including other revisions such as document formatting, plan year update, vendor contact information, etc.

FLEXIBLE SPENDING ACCOUNT SUMMARY PLAN DESCRIPTION

1. Other changes

a) Increased the Plan Year 2020 (July 1, 2019 – June 30, 2020) Health Care and Limited Purpose FSA contribution maximum from $2,650 to $2,700.

b) Document formatting, plan year update, etc. Replaced member services email instructions with language on how to use the *Contact Us* feature in the E-PEBP Portal, including other revisions such as document formatting, plan year update, vendor contact information, etc.

ENROLLMENT AND ELIGIBILITY MPD

1. Other changes

a) 2018 Compliance Review: Inserted Adverse Benefit Determination language stating the events allow and disallow retroactive termination or a rescission of coverage under the Plan.

> The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a covered person, unless the covered person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent. Providing however, that the prohibition shall not prohibit retroactive termination in the event:
>
> - Failure to timely pay premiums towards the cost of coverage;
> - the Plan erroneously covers an ex-spouse of a participant because the participant failed to timely report a divorce to the Plan Administrator;
> - the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage.
>
> The covered person may appeal the rescission of coverage as a denial of a post-service claim. In the event the Plan Administrator rescinds a covered person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

b) Document formatting, plan year update, etc. Document formatting, plan year update, etc. Replaced member services email instructions with language on how to use the *Contact Us* feature in the E-PEBP Portal, including other revisions such as document formatting, plan year update, vendor contact information, etc.

Recommendation

Staff requests Board approval for the amendments to the following documents, including plan design amendments for the Premier EPO and Consumer Driven Health Plan. Staff

also requests the ability to make any necessary technical adjustments as a result of Board action taken on March 28, 2019, and due to any changes in state or federal laws and regulations.

1. Premier Plan Master Plan Document
2. CDHP Medical, Vision and Prescription Drug Master Plan Document
3. Dental, Life and Long-Term Disability Master Plan Document
4. Health and Welfare Wrap Plan Document
5. Medicare Exchange HRA Summary Plan Description
6. Flexible Spending Account Summary Plan Description
7. PEBP Enrollment and Eligibility Master Plan Document

11.

11. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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ACCREDITED
CORE
Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: January 24, 2019

Item Number: XI

Title: Executive Officer Report

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the overall activities of PEBP.

REPORT

UNLV NUTRITION PILOT - POSTPONED

In November 2018, the PEBP Board approved earmarking $100,000 of excess reserves to partner with UNLV and implement a nutrition pilot program for CDHP members with diabetes or renal disease. At the time, PEBP and UNLV were able to make commitments for the program to include funding, time, and space requirements for a July 1, 2019 launch.

PEBP and UNLV have encountered logistical issues in the implementation of this program. Both of us are dedicated to seeing this program move forward and therefore request a postponement while we resolve the outstanding issues. PEBP will work with UNLV to develop an appropriate launch date and bring the results back for Board approval at a later Board meeting.

HEALTHCARE BLUEBOOK UPDATE

PEBP implemented Healthcare Bluebook, an online transparency vendor beginning July 1, 2018. As of February 28, 2019:

- Just under 58,000 online searches have occurred – just over 20,500 were on mobile devices.
- 260 members have received rewards checks ranging from $25 to $125 (totaling $13,225) in areas across the state (both rural and urban), as well as areas outside of the state of Nevada.

12.

12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bills

    * Senate Bills

    * Bill Draft Requests

    (Damon Haycock, Executive Officer) **(For Possible Action)**

PEBP Legislative Tracking
80th Legislative Session

Bill Number & Description	Impact to PEBP	Bill Status
SB200 (BDR 57-43) Requires health insurers to provide coverage for certain services and equipment. • Requires health insurers to provide coverage for various hearing screening tests, examinations, and devices. • Requires plan to replace hearing aid devices that are reported lost/broken every 12 months. **Effective Date:** January 1, 2020.	PEBP's CDHP and HMO plans Provide hearing aid devices. PEBP will recommend the EPO plan align as well. The current replacement schedule is 3 years. This bill reduces it to 1 increasing costs (see fiscal note below). **Board Position** Neutral **Fiscal Note** FY 18-19: $0 FY 19-20: $283,950 FY 20-21: $351,450 Effect on Future Biennia: $905,400	2/18/19: Read first time. Referred to Committee on Commerce and labor. To Printer 2/19/19: From printer. To committee. 3/18/19: Notice of eligibility for exemption.

Bill Number & Description	Impact to PEBP	Bill Status
SB226 (BDR 38-549) Makes various changes relating to health insurance. This bill proposes the following changes: • Requires an insurer or health benefit plan which provides prescription coverage to use the formulary developed by HHS and provide for prescription drugs to be obtained through the purchasing agreements negotiated by the Department	Requires the formulary developed by HHS to be followed and RX coupons to apply to copay and coinsurance. **Board Position** Neutral	2/18/19: Read first time. Referred to Committee on Commerce and labor. To Printer 2/19/19: From printer. To committee.

• Allow an insured to credit any amount saved by using a coupon for prescription drugs toward any copay or coinsurance that the insured is required to pay for the prescription drug. • Allows opt in to participate in a purchasing agreement negotiated by or pursuant to a contract with the Department. **Effective Date:** January 1, 2020.	**Fiscal Note** FY18-19: $2,000,000 FY 19-20: $2,200,000 FY 20-21: $2,400,000 Future Biennia: $5,400,000	3/18/19: Notice of eligibility for exemption.

Bill Number & Description	Impact to PEBP	Bill Status
SB276 (BDR 57-599) Revises provisions relating to prescription drugs. The bill proposes the following changes: • This bill prohibits a pharmacy benefit manager from accepting from the manufacturer of a prescription drug a rebate or reduction in price in connection with the sale of the prescription drug unless the full value of the rebate or reduction in price is applied to the price paid by the person to whom the drug is dispensed • Prohibits an insurer, including a local government employer, the Public Employee Benefits Program and the Medicaid program, from accepting: (1) a rebate or reduction in price from a manufacturer under similar circumstances as prohibited by section 1 for a pharmacy benefit manager; or (2) any other remuneration from a manufacturer. **Effective Date:** July 1, 2019	Not receiving RX rebates will create a major deficit in PEBP's budget resulting in increased rates, benefit reductions, or a combination of both. **Board Position** Neutral **Fiscal Note** FY18-19: $9,500,000 FY 19-20: $11,000,000 FY 20-21: $12,500,000 Future Biennia: $29,500,000	3/14/19: Read first time. Referred to Committee on Commerce and Labor. 3/15/19: From printer. To committee.

Bill Number & Description	Impact to PEBP	Bill Status
SB287 (BDR 19-648) Revises provisions governing public records. • Defines "public record" to mean any of several types of records and information prepared, created, used, owned, retained or received in connection with the transaction of official business or the provision of a public service. • Makes changes to conform with existing law which provides that, in addition to the right to inspect and copy a public record, members of the public have the right to receive a copy of a public record upon request. • Clarifies that the actual cost to a governmental entity: includes such direct costs as the cost of ink, toner, paper, media and postage; and does not include overhead and labor costs that a governmental entity incurs regardless of the request. • Eliminates the authority of a governmental entity to charge an additional fee for providing a copy of a public record when extraordinary use of personnel or resources is required. • Authorizes a requester of a public record to apply to a district court for a similar order if a request for inspection, copying or copies of a public record is unreasonably delayed or if a person who requests a copy of a public record believes that the fee charged by the governmental entity for providing the copy of the public record is excessive or improper. Section 7 additionally provides that if the requester prevails in a proceeding involving an unreasonable delay in the provision of a public record or the imposition of an excessive or improper fee for the public record, the requester is entitled to recover from the governmental entity his or her costs and	This bill prohibits the collection of money from public records requestors regardless if there are significant resources expended to meet the request. This could result in a significant increase in high cost generic requests. **Board Position** Neutral **Fiscal Note** Cannot be determined.	3/15/19: Read first time. Referred to Committee on Government Affairs. To Printer 3/18/19: From printer. To committee.

reasonable attorney's fees and $100 per day for each day that the requester was denied the right to inspect, copy or receive a copy of the public record. **Effective Date:** October 1, 2019.		

Bill Number & Description	Impact to PEBP	Bill Status
SB359 (BDR 57-627) Provides for continued coverage for health care for certain chronic conditions. This bill proposes the following changes: • An insurer, pursuant to a policy of health insurance, approves coverage for a procedure, device, medication or any other treatment for a condition for an insured, and the provider of health care for the insured determines that the condition of the insured is a chronic condition, the insurer shall not: Deny continued coverage for the treatment; or 2. Require that the insured obtain prior authorization or fulfill any other preconditions before continuing coverage for the treatment. • The present insurer of an insured must not require approval of the coverage for a procedure, device, medication or any other treatment for a chronic condition of the insured, and for all purposes shall deem the procedure, device, medication or other treatment to be approved if: The policy of health insurance of the present insurer covers the procedure, device, medication or other treatment; 2. The former insurer from which the insured received coverage immediately preceding the present insurer approved the procedure, device,	This bill forces PEBP to accept the risk and liability of another health plan's pre-certification decision that could result in increased costs. **Board Position** Neutral **Fiscal Note** Cannot be determined.	3/19/19: Read first time. Referred to Committee on Commerce and Labor. To Printer. 3/20/19: From printer. To committee.

medication or other treatment; 3. The insured delivers to the present insurer reasonable evidence of the approval from the former insurer as described in subsection 2; and 4. The present insurer does not have credible evidence that the chronic condition does not exist, no longer exists or, if applicable, is in remission. • An insurer subject to the provisions of section 11 or 12 of this act may deny continued coverage or require prior authorization or other precondition for continuing coverage if, before the denial or imposition of the required precondition, the insurer obtains credible evidence that the chronic condition does not exist, no longer exists or, if applicable, is in remission. **Effective Date:** July 1, 2019.		

Bill Number & Description	Impact to PEBP	Bill Status
SB361 (BDR 54-921) Provides for the prescribing, ordering and dispensing of contraceptive supplies by pharmacists. The bill proposes the following changes: • Authorizes a pharmacist to prescribe or order and to dispense contraceptives or their therapeutic equivalent and certain contraceptive devices to a patient and establishes the procedures the pharmacist must follow to do so. • Requires such a pharmacist to: (1) complete a program related to prescribing or ordering contraceptive supplies; (2) provide a self-screening risk assessment tool that the patient must complete before the pharmacist prescribes or	This bill is silent on in-network versus out-of-network pharmacists. PEBP does not allow out-of-network pharmacy benefits. Pending utilization of out-of-network pharmacists prescribing contraceptives, the costs could increase to PEBP as there are no contracts with required discounts. **Board Position** Neutral	3/19/19: Read first time. Referred to Committee on Commerce and Labor. To printer. 3/20/19: From printer. To committee.

orders any contraceptive supplies; (3) advise the patient to consult with the primary care provider of the patient upon prescribing or ordering and dispensing the contraceptive supplies or to consult a provider of health care if the patient does not have a primary care provider; (4) provide the patient with a written record of the contraceptive supplies prescribed or ordered and dispensed; and (5) dispense the contraceptive supplies as soon as practicable after the pharmacist issues the prescription or order • Prohibits such a pharmacist from requiring a patient to schedule an appointment with the pharmacist for the prescribing or ordering or the dispensing of contraceptive supplies. • Requires health insurance plans to cover contraceptive supplies prescribed or ordered and dispensed by a pharmacist. **Effective Date:** January 1, 2020.	**Fiscal Note** Cannot be determined.	

13.

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.

14. Adjournment