STEVE SISOLAK
Governor

LAURA FREED
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

LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	March 25, 2021 9:00 a.m.
Place of Meeting:	Pursuant to the Governor's Emergency Directives 006, and 029, this meeting will be conducted via video- and tele-conference only. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/TEY9iGlo_Ic

Members of the public are encouraged to submit public comment in writing by emailing wlunz@peb.nv.gov at least two business days prior to the meeting.

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

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

Option #1 **Join the webinar as an attendee https://zoom.us/j/99009408078 . This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.**

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 990 0940 8078 then press #. When prompted for a Participant ID, please enter #.**

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

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

Meeting materials can be accessed here: https://pebp.state.nv.us/meetings-events/board-meetings/

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting by telephone and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@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 (Laura Freed, 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 8 and January 19, 2021 PEBP Board Subcommittee Meetings

   4.2 Approval of Action Minutes from the January 28, 2021 PEBP Board Meeting

   4.3 Receipt of quarterly staff reports for the period ending December 31, 2020:

   4.3.1 Budget Report

   4.3.2 Utilization Report

   4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

   4.4.1 HealthSCOPE Benefits – Obesity Care Management

   4.4.2 HealthSCOPE Benefits – Diabetes Care Management

   4.4.3 American Health Holdings – Utilization and Large Case Management

   4.4.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

   4.4.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report Q2 2021

   4.4.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

   4.4.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.4.8 Doctor on Demand Engagement Report through December 2020

4.5 Morneau Shepell/Corestream Voluntary Benefits Report

4.6 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2021 for individual coverage and family coverage for PEBP's Consumer Driven Health (CDHP) plan, Exclusive Provider Organization (EPO) plan and Low Deductible (LD) plan.

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

6. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) **(For Possible Action)**

6.1 Contract Overview

6.2 New Contracts

6.2.1 Claim Technologies Inc.

6.2.2 Clifton Larson Allen LLP

6.3 Contract Amendments

6.4 Contract Solicitations

6.4.1 Actuarial Consultants

6.4.2 Group Basic Life Insurance and Long-Term Disability

6.5 Status of Current Solicitations

7. Discussion and possible action regarding (1) PEBP's Voluntary Benefit Platform implementation, and (2) selection of voluntary benefits for implementation on January 1, 2022. (Nik Proper, Operations Officer) (**For Possible Action)**

8. Discussion and possible action to include approving Plan Year 22 (July 1, 2021 – June 30, 2022) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

9. 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.

10. 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/meetings-events/board-/meetings (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.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 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 Wendi Lunz at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, and also posted to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

4. Consent Agenda (Laura Freed, 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.

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4.6 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2021 for individual coverage and family coverage for PEBP's Consumer Driven Health (CDHP) plan, Exclusive Provider Organization (EPO) plan and Low Deductible (LD) plan

4.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the January 8 and January 19, 2021 PEBP Board Subcommittee Meetings

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD SUBCOMMITTEE MEETING

Video/Telephonic Open Meeting
Carson City, NV

ACTION MINUTES (Subject to Board Approval)
January 8, 2021

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Michelle Kelley, Member Ms. Betsy Aiello, Member Mr. Tim Lindley, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Ms. Cari Eaton, Chief Financial Officer Ms. Michelle Weyland, Admin Services Officer II Ms. Wendi Lunz, Executive Assistant

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 1:04 p.m.

2. Public Comment

    - Kent Ervin – Nevada Faculty Alliance

3. Approval of Action Minutes from the December 11, 2020 PEBP Board Subcommittee Meeting (Laura Freed, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 3
MOTION: Motion to approve item 3
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

4. Discussion and possible action on changes to Board policies and procedures related to PEBP's corrective action plan submitted to the Legislative Counsel Bureau Audit Division. (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 4
No action taken. Request for PEBP Staff to make proposed changes as discussed and bring back to subcommittee for approval prior to the January 28, 2021 Board meeting.

5. Public Comment

    - No Public Comment

6. Adjournment

    - Board Chair Freed adjourned the meeting at 2:38 p.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD SUBCOMMITTEE MEETING

Video/Telephonic Open Meeting
Carson City, NV

ACTION MINUTES (Subject to Board Approval)
January 19, 2021

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Michelle Kelley, Member Ms. Betsy Aiello, Member Mr. Tim Lindley, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Ms. Cari Eaton, Chief Financial Officer Ms. Wendi Lunz, Executive Assistant Ms. Michelle Weyland, Admin Services Officer

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 10:01 a.m.

2. Public Comment

    - Kent Ervin – Nevada Faculty Alliance

3. Discussion and possible action on changes to Board policies and procedures related to PEBP's corrective action plan submitted to the Legislative Counsel Bureau Audit Division. (Laura Rich, Executive Officer) (**For Possible Action**)

    3.1 Board and Agency Duties, Policies and Procedures

BOARD ACTION ON ITEM 3.1

MOTION:	Motion to take to the full Board, the sections on contracts and the changes discussed today.
BY:	Member Betsy Aiello
SECOND:	Member Tim Lindley
VOTE:	Unanimous; the motion carried

    3.2 Checklist for RFP's Solicitations and Contracts

BOARD ACTION ON ITEM 3.2

MOTION:	Motion to approve the checklist with authority for staff to make changes to the checklist as circumstances dictate.
BY:	Member Betsy Aiello
SECOND:	Member Michelle Kelley
VOTE:	Unanimous; the motion carried

4. Public Comment

    - No Public Comment

5. Adjournment

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

4.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.1 Approval of Action Minutes from the January 8 and January 19, 2021 PEBP Board Subcommittee Meetings

    4.2 Approval of Action Minutes from the January 28, 2021 PEBP Board Meeting

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
January 28, 2021

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Jennifer Krupp, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Mr. Tim Lindley, Member Dr. Marsha Urban, Member
MEMBERS EXCUSED:	Mr. Don Bailey, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Steven Martin, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	Ms. Stephanie Messier, AON Ms. Amy Williams, Express Scripts

1. Open Meeting; Roll Call

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

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Marlene Lockard – RPEN
    - Diane Swords – Active State Employee
    - Cameron Hopkins – Active State Employee
    - Jacob Bakke – NSHE Faculty
    - Kevin Ranft - AFSCME
    - Matt Leathen – NSHE Faculty
    - Serrochia Sherfield – Active State Employee
    - Unidentified Speaker – Active State Employee
    - Doug Unger – UNLV Employee Benefits Advisory Committee
    - Priscilla Maloney – AFSCME

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

4. Consent Agenda (Laura Freed, 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 November 23, 2020 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending September 30, 2020:

        4.2.1 Budget Report

        4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending September 30, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

        4.3.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

        4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand Engagement Report through September 2020

4.4 Revised Financial Statement for the Self Insurance Trust Fund

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

BOARD ACTION ON ITEM 4

MOTION: Motion to approve or accept all the reports on the consent agenda, except 4.1, 4.3.6 and 4.5
BY: Vice Chair Linda Fox
SECOND: Member Tim Lindley
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.1, 4.3.6 and 4.5

MOTION: Motion to approve action minutes (future minutes will list any other parties presenting), 4.3.6 and 4.5
BY: Vice Chair Linda Fox
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

5. Presentation and possible action on Governor's Recommended Budget and approval of PY22 Plan Benefit Design (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 5

MOTION: Motion to approve the staff recommendation so that PEBP staff can go forward planning for a rate structure predicated on the recommended budget by the Governor.
BY: Board Chair Freed
SECOND: Member Tim Lindley
VOTE: Yes - 6, No - 3; the motion carried

Members voting yes: Chair Freed, Vice Chair Linda Fox, Betsy Aiello, April Caughron, Jennifer Krupp, Tim Lindley

Members voting no: Michelle Kelley, Marsha Urban, Tom Verducci

SUPPLEMENTAL BOARD ACTION ON ITEM 5

MOTION: Motion that staff price out the long-term disability plan that the Board approved in the November meeting, so the reduction, and bring that back to the March meeting, showing us how much to continue the LTD at the reduced amount would cost for the premiums.
BY: Member Michelle Kelley
SECOND: Member Marsha Urban
VOTE: Yes - 8, No - 1; the motion carried

Members voting yes: Vice Chair Linda Fox, Betsy Aiello, April Caughron, Jennifer Krupp, Tim Lindley, Michelle Kelley, Marsha Urban, Tom Verducci

Members voting no: Chair Freed

6. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

    6.1 Contract Overview

    6.2 New Contracts

        6.2.1 Aetna Signature Administrators - Statewide PPO/EPO Network (pursuant to Request for Proposal No. 95PEBP-S1289)

        6.2.2 Health Plan of Nevada – Statewide HMO Plan (pursuant to Request for Proposal No. 95PEBP-S1291)

        6.2.3 Diversified Dental – Dental Network (pursuant to Request for Proposal No. 95PEBP-S1299

    11:50 a.m. – 1:03 p.m. MEETING CLOSED PURSUANT TO NRS 287.04.45(4) FOR BOARD TO REVIEW THE RESULTS OF EVALUATIN OF PROPOSALS FOR CONTRACTS

BOARD ACTION ON ITEM 6.2
MOTION: Motion to approve all three contracts to move forward in the process and accept the evaluation committee's recommendations in all three cases.
BY: Member Michelle Kelley
SECOND: Member Tim Lindley
VOTE: Unanimous; the motion carried

    6.3 Contract Amendments

        6.3.1 Hometown Health - Statewide PPO - increases contract maximum to allow sufficient authority through remainder of contract

        6.3.2 The Standard – Life insurance and Long Term Disability – decreases contract to reflect changes in plan benefit design

        6.3.3 Aon Consulting – Consulting Services – increases contract authority for consulting services

BOARD ACTION ON ITEM 6.3
MOTION: Motion to complete the contract amendments for 6.3.1 and 6.3.3 and not take any action at this time on 6.3.2
BY: Member Tom Verducci
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

    6.4 Contract Solicitations

        6.4.1 Website hosting

        6.4.2 Third Party Administrator and associated services

        6.4.3 Pharmacy Benefit Manager

BOARD ACTION ON ITEM 6.4.1
MOTION: Motion to authorize PEBP staff to complete an informal solicitation for web hosting under 6.4.1
BY: Member Marsha Urban
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6.4.3
MOTION: Motion to authorize PEBP to move forward with a request for proposal for a new pharmacy benefit manager.
BY: Member April Caughron
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6.4.2
MOTION: Motion to accept staff recommendation except on subrogation. The preference is to include it in the TPA solicitation rather than having yet another separate solicitation.
BY: Board Chair Freed
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

6.5 Status of Current Solicitations

7 Discussion and possible action on rate setting and rate development (Stephanie Messier, Aon) (**For Possible Action**)

NO ACTION TAKEN ON ITEM 7

8 Discussion and possible action on Legislative Counsel Bureau Information Technology Audit Report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to approve the Corrective Action Plan.
BY: Member Tim Lindley
SECOND: Board Chair Freed
VOTE: Unanimous; the motion carried

9 Discussion and possible action on updates to Board policies and procedures to include edits reflecting (1) Board policy decisions and (2) Subcommittee recommendations relating to the Legislative Counsel Bureau contract audit report (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9 (2)

MOTION: Motion to approve the changes recommended by the subcommittee. This is a vote to approve the redline version of the policies and procedures as it pertains to the contract Section 3.
BY: Member Tim Lindley
SECOND: Board Chair Freed
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 9 (1)

MOTION: Motion to approve the changes to the Board duties, policies and procedures based on the July 23, 2020 policy decisions approved at that meeting by the Board.
BY: Vice Chair Linda Fox
SECOND: Board Chair Freed
VOTE: Unanimous; the motion carried

10 Discussion and possible action regarding the withdrawal of funds from the Retirement Benefits Investment Fund (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10

MOTION: Motion that the Board transfer immediately whatever is in the retirement benefits investment fund into the State retirees' health and benefits fund in order to pay for current year retiree healthcare costs.
BY: Board Chair Freed
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

11 Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

12 Public Comment

- Unidentified Speaker – State Retiree

13 Adjournment

- Board Chair Freed adjourned the meeting at 4:11 p.m.

4.3

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly staff reports for the period ending December 31, 2020:

        4.3.1 Budget Report

        4.3.2 Utilization Report

4.3.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly staff reports for the period ending December 31, 2020:

4.3.1 Budget Report

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 25, 2021

Item Number: IV.III.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of December 31, 2020 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, 2020 with comparisons to the same period in Fiscal Year 2020. 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 $202.1 million as of December 31, 2020 compared to $195.7 million as of December 31, 2020 or an increase of 3.3%. Total expenses for the period have decreased by $12.2 million or 6.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $167.6 million. This compares to $144.4 million for last year. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2021			FISCAL YEAR 2020		
	Actual as of 12/31/2020	Work Program	Percent	Actual as of 12/31/2019	Fiscal Year 2020 Close	Percent
Beginning Cash	154,541,329	154,541,329	100%	150,276,433	150,276,433	100%
Premium Income	194,503,274	375,455,443	52%	187,733,763	378,746,198	50%
All Other Income	7,632,569	20,863,995	37%	7,959,417	17,070,199	47%
Total Income	202,135,843	396,319,438	51%	195,693,181	395,816,398	49%
Personnel Services	1,089,420	2,896,914	38%	1,244,900	2,603,314	48%
Operating - Other than Personnel	1,158,070	2,383,918	49%	967,249	2,073,172	47%
Insurance Program Expenses	186,569,016	418,644,286	45%	199,101,863	386,256,172	52%
All Other Expenses	262,068	647,864	40%	299,417	618,845	48%
Total Expenses	189,078,574	424,572,982	45%	201,613,428	391,551,503	51%
Change in Cash	13,057,269	(28,253,544)		(5,920,248)	4,264,895	
REALIZED FUNDING AVAILABLE	167,598,598	126,287,785	133%	144,356,185	154,541,328	93%
Incurred But Not Reported Liability	(51,514,000)	(51,514,000)		(58,790,000)	(58,790,000)	
Catastrophic Reserve	(34,835,000)	(34,835,000)		(24,201,541)	(24,201,541)	
HRA Reserve	(30,550,651)	(30,550,651)		(36,204,203)	(36,204,203)	
NET REALIZED FUNDING AVAILABLE	50,698,947	9,388,134		25,160,441	35,345,584	

Current Budget Projections

The following table represents projections for FY 2021. The projection reflects total income to be less than budgeted by 1.6% ($542.1 million vs $550.9 million), total expenditures are projected to be less than budgeted by 7.9% ($391.0 million vs $424.7 million); total reserves are projected to be more than budgeted by 19.8% ($151.1 million vs $126.1 million).

State Subsidies are projected to be less than the budgeted amount by $7.7 million (2.8%), Non-State Subsidies are projected to be less than budgeted by $4.5 million (15.4%), and Premium Income is projected to be more than budgeted by $3.8 million (5.6%). This overall decrease in budgeted revenue is due in part to a reduction in State Subsidies as a result of average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 3.14% fewer state actives,
- 0.85% fewer state non-Medicare retirees,
- 6.25% fewer non-state actives,
- 1.73% fewer non-state, non-Medicare retirees
- 5.28% fewer state Medicare retirees, and
- 6.69% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/20**	**Projected**	**Difference**	
Carryforward	154,541,329	154,541,329	154,541,329	0	0.0%
State Subsidies	278,042,182	145,792,777	270,353,502	(7,688,680)	-2.8%
Non-State Subsidies	29,075,407	12,314,777	24,592,004	(4,483,403)	-15.4%
Premium	68,337,854	36,395,720	72,177,190	3,839,336	5.6%
All Other	20,863,995	7,632,569	20,428,055	(435,940)	-2.1%
Total	550,860,767	356,677,172	542,092,080	(8,768,687)	-1.6%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/20**	**Projected**	**Difference**	
Operating	5,928,696	2,509,558	5,715,178	213,518	3.6%
State Employee Ins Cost	308,157,770	137,811,194	276,863,494	31,294,276	10.2%
State Retirees Ins Cost	53,659,367	24,498,232	57,514,721	(3,855,354)	-7.2%
Non-State Employees Ins Cost	142,871	47,351	143,703	(832)	-0.6%
Non-State Retirees Ins Cost	13,453,450	5,385,446	11,746,686	1,706,764	12.7%
State Medicare Ret Ins Cost	25,382,152	11,827,074	22,561,978	2,820,174	11.1%
Non-State Medicare Ret Ins Cost	17,991,547	6,999,719	16,418,092	1,573,455	8.7%
Total Insurance Costs	418,787,157	186,569,016	385,248,673	33,538,484	8.0%
Total Expenses	424,715,853	189,078,574	390,963,851	33,752,002	7.9%
Restricted Reserves	116,899,651	116,899,651	111,395,726	5,503,925	4.7%
Differential Cash Available	9,245,263	50,698,947	39,732,503	(30,487,240)	-329.8%
Total Reserves	126,144,914	167,598,598	151,128,229	(24,983,315)	-19.8%
Total of Expenses and Reserves	550,860,767	356,677,172	542,092,080	8,768,687	1.6%

Expenses for Fiscal Year 2021 are projected to be $33.8 million (7.9%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.2 million (3.6%). Employee and Retiree insurances costs are projected to be less than budgeted by $33.5 million (8.0%) when taken in total (see table above for specific information). The significant reduction in projected expenditures compared to the budget is substantially due to the claims suppression experienced between July and December during the COVID-19 shutdown.

Recommendations

None.

4.3.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly staff reports for the period ending December 31, 2020:

        4.3.1 Budget Report

        4.3.2 Utilization Report

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 25, 2021

Item Number: IV.III.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending December 31, 2020

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2021 period ending December 31, 2020. 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 C for Q2 Plan Year 2021 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2021 compared to Q2 of Plan Year 2020 is summarized below.

- Population:
  - 1.1% decrease for primary participants
  - 0.9% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 12.6% decrease for primary participants
  - 12.7% decrease for primary participants plus dependents (members)
- High Cost Claims:
  - There were 72 High Cost Claimants accounting for 24.8% of the total plan paid for Q2 in Plan Year 2021
  - 15.5% decrease in High Cost Claimants per 1,000 members
  - 5.3% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($2.2 million) – 14.9% of paid claims
  - Diseases of the Digestive System ($2.0 million) – 13.7% of paid claims
  - Diseases of the Circulatory System ($1.7 million) – 11.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased 21.8%
  - Average paid per ER visit increased 5.9%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 20.8%
  - Average paid per Urgent Care visit increased 172.2% (increase from $36 to $98)
- Network Utilization:
  - 95.8% of claims are from In-Network providers
  - Q2 of Plan Year 2021 In-Network utilization decreased 0.1% over PY 2020
  - Q2 of Plan Year 2021 In-Network discounts increased 2.1% over PY 2020
- Preventive Services:
  - Overall Preventive Services Compliance Rates decreased in 8 out of 9 categories from Plan Year 2020 between 0.7% - 4.2%.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 7.1%
    - Total Gross Claims Costs increased 14.1% ($3.4 million)
    - Average Total Cost per Claim increased 14.9%
      - From $91.05 to $104.65
  - Member:
    - Total Member Cost decreased 9.0%
    - Average Participant Share per Claim decreased 6.4%
    - Net Member PMPM decreased 6.3%
      - From $29.55 to $27.68

- Plan
  - Total Plan Cost increased 24.0%
  - Average Plan Share per Claim increased 24.9%
  - Net Plan PMPM increased 25.1%
    - From $63.21 to $79.05
  - Net Plan PMPM factoring rebates increase 39.7%
    - From $42.80 to $59.77

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2021 compared to the Q2 of Plan Year 2020 is summarized below.

- Population:
  - 2.6% decrease for primary participants
  - 2.2% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 5.8% increase for primary participants
  - 5.5% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 29 High Cost Claimants accounting for 22.7% of the total plan paid for Q2 in Plan Year 2021
  - 97.6% increase in High Cost Claimants per 1,000 members (increase from 1.7 to 3.4)
  - 7.0% increase in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($1.3 million) – 22.0% of paid claims
  - Diseases of the Blood ($0.9 million) – 15.7% of paid claims
  - Endocrine, Nutritional and Metabolic Diseases ($0.6 million) – 10.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 19.1%
  - Average paid per ER visit decreased by 1.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 28.7%
  - Average paid per Urgent Care visit increased 12.5%
- Network Utilization:
  - 97.5% of claims are from In-Network providers
  - In-Network utilization increased 0.1%
  - In-Network discounts decreased 0.1%
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased from Plan Year 2020 in 6 out of 9 categories.

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 1.5%
    - Total Gross Claims Costs increased 10.7% ($1.1 million)
    - Average Total Cost per Claim increased 12.4%
      - From $113.03 to $127.09
  - Member:
    - Total Member Cost increased 18.4%
    - Average Participant Share per Claim increased 20.2%
    - Net Member PMPM increased 21.0%
      - From $28.69 to $34.72
  - Plan
    - Total Plan Cost increased 9.3%
    - Average Plan Share per Claim increased 11.0%
    - Net Plan PMPM increased 11.7%
      - From $156.70 to $175.10
    - Net Plan PMPM factoring rebates increased 10.5%
      - From $122.62 to $135.45

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2021 is summarized below.

- Dental Cost:
  - Total of $12,715,391 paid for Dental claims
    - Preventative claims account for 42.2% ($5.4 million)
    - Basic claims account for 30.0% ($3.8 million)
    - Major claims account for 21.5% ($2.7 million)
    - Periodontal claims account for 6.3% ($0.8 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2020.

HRA Account Balances as of December 31, 2020			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	971	0	0
$.01 - $500.00	1,995	409,058	205
$500.01 - $1,000	2,279	1,641,446	720
$1,000.01 - $1,500	1,079	1,325,289	1,228
$1,500.01 - $2,000	766	1,342,714	1,753
$2,000.01 - $2,500	551	1,246,580	2,262
$2,500.01 - $3,000	377	1,032,178	2,738
$3,000.01 - $3,500	278	892,780	3,211
$3,500.01 - $4,000	188	702,149	3,735
$4,000.01 - $4,500	172	731,630	4,254
$4,500.01 - $5,000	125	594,024	4,752
$5,000.01 +	**844**	**6,749,617**	**224,025**
Total	**9,625**	**$ 16,667,465**	**$ 1,732**

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 2021. The CDHP total plan paid costs decreased 13.5% over the same time for Plan Year 2020. The EPO total plan paid costs increased 3.1% over the second quarter of Plan Year 2020. 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, 2020 – December 31, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July – December 2020

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q21 was $59,567,516 of which 74.5% was spent in the State Active population. When compared to 2Q20, this quarter reflected a decrease of 13.5% in plan spend, with State Actives having a decrease of 10.7%.
  - When compared to 2Q19, 2Q21 reflected an increase of 3.5% in plan spend, with State Actives having an increase of 3.9%.
- On a PEPY basis, 2Q21 reflected an decrease of 12.5% when compared to 2Q20. The largest group, State Actives, decreased 9.7%.
  - When compared to 2Q19, 2Q21 reflected an increase in PEPY of 3.9%, with State Actives increasing by 3.6%.
- 93.6% of the Average Membership had paid Medical claims less than $2,500, with 43.0% of those having no claims paid at all during the reporting period.
- There were 72 High Cost Claimants (HCC's) over $100K, that accounted for 24.8% of the total spend. HCC's accounted for 27.1% of total spend during 2Q20, with 86 members hitting the $100K threshold. The largest diagnosis grouper was Neoplasms accounting for 14.9% of high cost claimant dollars.
- IP Paid per Admit was $19,695 which is a decrease of 1.5% compared to 2Q20.
- ER Paid per Visit is $2,168, which is an increase of 5.9% compared to 2Q20.
- 95.8% of all Medical spend dollars were to In Network providers. The average In Network discount was 67.4%, which is 3.2% higher than the PY20 average discount of 67.4%.

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

Paid Claims by Age Group										
	2Q20									
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 3,125,930	$ 1,476	$ 4,958	$ 2	$ 9,126	$ 3	$ 3,140,014	$ 1,481
1	$ 405,172	$ 171	$ 8,214	$ 3	$ 25,737	$ 8	$ 439,123	$ 183
2 - 4	$ 627,536	$ 78	$ 138,668	$ 17	$ 205,909	$ 19	$ 972,113	$ 115
5 - 9	$ 854,517	$ 56	$ 71,289	$ 5	$ 661,689	$ 31	$ 1,587,495	$ 92
10 - 14	$ 1,812,800	$ 106	$ 223,825	$ 13	$ 641,514	$ 27	$ 2,678,139	$ 146
15 - 19	$ 1,834,410	$ 101	$ 391,533	$ 22	$ 776,827	$ 31	$ 3,002,771	$ 154
20 - 24	$ 2,927,770	$ 143	$ 423,423	$ 21	$ 524,971	$ 19	$ 3,876,164	$ 183
25 - 29	$ 2,583,979	$ 154	$ 462,009	$ 28	$ 528,795	$ 25	$ 3,574,783	$ 207
30 - 34	$ 3,924,676	$ 220	$ 827,755	$ 46	$ 612,847	$ 26	$ 5,365,279	$ 292
35 - 39	$ 3,370,512	$ 170	$ 1,301,560	$ 66	$ 742,642	$ 29	$ 5,414,714	$ 264
40 - 44	$ 3,236,736	$ 180	$ 875,944	$ 49	$ 725,414	$ 30	$ 4,838,095	$ 258
45 - 49	$ 5,042,049	$ 259	$ 1,605,357	$ 82	$ 886,480	$ 32	$ 7,533,887	$ 373
50 - 54	$ 6,211,742	$ 306	$ 1,934,321	$ 95	$ 972,069	$ 34	$ 9,118,132	$ 435
55 - 59	$ 8,096,492	$ 361	$ 2,821,175	$ 126	$ 1,178,205	$ 37	$ 12,095,872	$ 524
60 - 64	$ 16,905,310	$ 669	$ 3,469,129	$ 137	$ 1,435,524	$ 40	$ 21,809,963	$ 847
65+	$ 7,892,651	$ 575	$ 2,050,922	$ 149	$ 3,421,967	$ 43	$ 13,365,540	$ 768
Total	**$ 68,852,282**	**$ 268**	**$ 16,610,084**	**$ 65**	**$ 13,349,718**	**$ 32**	**$ 98,812,083**	**$ 365**

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

Paid Claims by Age Group																
	2Q21														% 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	$	1,971,150	$	944	$	11,666	$	6	$	5,915	$	2	$	1,988,731	$	952	-36.7%	-35.8%
1	$	384,894	$	162	$	93,095	$	39	$	25,092	$	7	$	503,081	$	209	14.6%	14.3%
2 - 4	$	608,391	$	76	$	152,536	$	19	$	185,442	$	17	$	946,369	$	112	-2.6%	-2.3%
5 - 9	$	952,603	$	64	$	209,508	$	14	$	604,397	$	30	$	1,766,508	$	108	11.3%	17.3%
10 - 14	$	1,192,118	$	70	$	222,874	$	13	$	664,155	$	28	$	2,079,147	$	111	-22.4%	-23.6%
15 - 19	$	1,513,141	$	85	$	326,386	$	18	$	833,988	$	33	$	2,673,515	$	136	-11.0%	-11.5%
20 - 24	$	2,402,666	$	120	$	638,417	$	32	$	495,420	$	18	$	3,536,503	$	170	-8.8%	-7.0%
25 - 29	$	3,403,240	$	215	$	746,614	$	47	$	503,991	$	24	$	4,653,845	$	286	30.2%	38.1%
30 - 34	$	3,025,186	$	165	$	1,299,860	$	71	$	616,734	$	26	$	4,941,780	$	262	-7.9%	-10.6%
35 - 39	$	3,101,725	$	156	$	2,172,938	$	109	$	719,288	$	27	$	5,993,951	$	292	10.7%	10.6%
40 - 44	$	3,323,267	$	178	$	1,201,565	$	64	$	694,249	$	28	$	5,219,081	$	270	7.9%	4.7%
45 - 49	$	4,059,468	$	212	$	1,708,128	$	89	$	774,557	$	29	$	6,542,153	$	331	-13.2%	-11.4%
50 - 54	$	7,136,700	$	354	$	2,570,181	$	127	$	878,427	$	30	$	10,585,308	$	512	16.1%	17.7%
55 - 59	$	7,837,772	$	358	$	3,096,424	$	141	$	1,065,686	$	35	$	11,999,882	$	534	-0.8%	1.8%
60 - 64	$	12,490,962	$	511	$	3,837,310	$	157	$	1,317,511	$	38	$	17,645,783	$	706	-19.1%	-16.6%
65+	$	6,164,234	$	434	$	2,675,079	$	189	$	3,330,539	$	41	$	12,169,852	$	664	-8.9%	-13.5%
Total	**$**	**59,567,516**	**$**	**234**	**$**	**20,962,581**	**$**	**82**	**$**	**12,715,391**	**$**	**31**	**$**	**93,245,489**	**$**	**347**	**-5.6%**	**-4.9%**

Financial Summary - (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,482	23,652	23,391	-1.1%	19,494	19,761	19,545	-1.1%	4	4	4	-8.3%
Avg # Members	42,703	42,850	42,479	-0.9%	37,031	37,257	36,879	-1.0%	7	7	8	14.3%
Ratio	1.8	1.8	1.8	1.1%	1.9	1.9	1.9	-0.5%	1.8	1.8	2.2	21.1%
Financial Summary												
Gross Cost	$79,638,308	$94,029,865	$81,146,482	-13.7%	$60,229,544	$69,915,428	$61,683,401	-11.8%	$10,236	$32,755	$4,863	-85.2%
Client Paid	$57,576,958	$68,852,282	$59,567,516	-13.5%	$42,715,160	$49,660,887	$44,364,510	-10.7%	$7,062	$23,556	$2,263	-90.4%
Employee Paid	$22,061,195	$25,177,583	$21,578,966	-14.3%	$17,514,229	$20,254,541	$17,318,891	-14.5%	$3,174	$9,198	$2,600	-71.7%
Client Paid-PEPY	$4,904	$5,822	$5,093	-12.5%	$4,382	$5,026	$4,540	-9.7%	$3,531	$11,778	$1,234	-89.5%
Client Paid-PMPY	$2,697	$3,214	$2,805	-12.7%	$2,307	$2,666	$2,406	-9.8%	$2,018	$6,730	$566	-91.6%
Client Paid-PEPM	$409	$485	$424	-12.6%	$365	$419	$378	-9.8%	$294	$982	$103	-89.5%
Client Paid-PMPM	$225	$268	$234	-12.7%	$192	$222	$200	-9.9%	$168	$561	$47	-91.6%
High Cost Claimants (HCC's) > $100k												
# of HCC's	75	86	72	-16.3%	52	59	50	-15.3%	0	0	0	0.0%
HCC's / 1,000	1.8	2.0	1.7	-15.5%	1.4	1.6	1.4	-15.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$182,390	$216,669	$205,168	-5.3%	$183,935	$175,311	$178,470	1.8%	$0	$0	$0	0.0%
HCC's % of Plan Paid	23.8%	27.1%	24.8%	-8.5%	22.4%	20.8%	20.1%	-3.4%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$878	$1,133	$854	-24.6%	$740	$846	$685	-19.0%	$0	$0	$32	0.0%
Facility Outpatient	$827	$981	$923	-5.9%	$683	$819	$770	-6.0%	$333	$2,975	$121	-95.9%
Physician	$928	$1,023	$970	-5.2%	$836	$938	$901	-3.9%	$1,563	$3,470	$413	-88.1%
Other	$64	$76	$58	-23.7%	$48	$63	$50	-20.6%	$121	$285	$0	0.0%
Total	$2,697	$3,214	$2,805	-12.7%	$2,307	$2,666	$2,406	-9.8%	$2,018	$6,730	$566	-91.6%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary - (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,222	3,245	3,298	1.6%	762	642	546	-15.0%	
Avg # Members	4,800	4,848	4,950	2.1%	865	739	642	-13.1%	
Ratio	1.5	1.5	1.5	0.0%	1.1	1.2	1.2	-1.7%	1.8
Financial Summary									
Gross Cost	$14,750,103	$20,854,519	$16,039,320	-23.1%	$4,648,425	$3,227,164	$3,418,899	5.9%	
Client Paid	$10,981,049	$16,734,691	$12,420,150	-25.8%	$3,873,687	$2,433,148	$2,780,594	14.3%	
Employee Paid	$3,769,054	$4,119,828	$3,619,170	-12.2%	$774,738	$794,016	$638,305	-19.6%	
Client Paid-PEPY	$6,816	$10,313	$7,533	-27.0%	$10,167	$7,582	$10,195	34.5%	$6,209
Client Paid-PMPY	$4,575	$6,904	$5,018	-27.3%	$8,960	$6,588	$8,662	31.5%	$3,437
Client Paid-PEPM	$568	$859	$628	-26.9%	$847	$632	$850	34.5%	$517
Client Paid-PMPM	$381	$575	$418	-27.3%	$747	$549	$722	31.5%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	18	27	19	-29.6%	8	4	4	0.0%	
HCC's / 1,000	3.8	5.6	3.8	-31.4%	9.3	5.4	6.2	15.4%	
Avg HCC Paid	$129,001	$287,451	$247,107	-14.0%	$224,076	$132,243	$288,394	118.1%	
HCC's % of Plan Paid	21.1%	46.4%	37.8%	-18.5%	46.3%	21.7%	41.5%	91.2%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,262	$3,063	$1,615	-47.3%	$4,647	$2,962	$4,695	58.5%	$1,057
Facility Outpatient	$1,641	$2,062	$1,941	-5.9%	$2,467	$2,058	$1,840	-10.6%	$1,145
Physician	$1,514	$1,597	$1,358	-15.0%	$1,621	$1,480	$1,990	34.5%	$1,122
Other	$159	$182	$104	-42.9%	$225	$88	$138	56.8%	$113
Total	$4,575	$6,904	$5,018	-27.3%	$8,960	$6,588	$8,662	31.5%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Financial Summary - Prior Year comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,569	23,673	23,391	-1.2%	19,612	19,809	19,545	-1.3%	4	4	4	-4.2%
Avg # Members	42,776	42,865	42,479	-0.9%	37,138	37,291	36,879	-1.1%	7	7	8	17.1%
Ratio	1.8	1.8	1.8	0.6%	1.9	1.9	1.9	0.5%	1.8	1.8	2.2	22.5%
Financial Summary												
Gross Cost	$172,993,213	$185,251,114	$81,146,482	-56.2%	$129,947,874	$139,774,757	$61,683,401	-55.9%	$105,325	$46,064	$4,863	-89.4%
Client Paid	$133,179,670	$143,667,208	$59,567,516	-58.5%	$97,851,639	$106,095,205	$44,364,510	-58.2%	$96,469	$35,053	$2,263	-93.5%
Employee Paid	$39,813,543	$41,583,906	$21,578,966	-48.1%	$32,096,235	$33,679,553	$17,318,891	-48.6%	$8,857	$11,011	$2,600	-76.4%
Client Paid-PEPY	$5,651	$6,069	$5,093	-16.1%	$4,989	$5,356	$4,540	-15.2%	$24,117	$9,144	$1,234	-86.5%
Client Paid-PMPY	$3,113	$3,352	$2,805	-16.3%	$2,635	$2,845	$2,406	-15.4%	$13,781	$5,130	$566	-89.0%
Client Paid-PEPM	$471	$506	$424	-16.2%	$416	$446	$378	-15.2%	$2,010	$762	$103	-86.5%
Client Paid-PMPM	$259	$279	$234	-16.1%	$220	$237	$200	-15.6%	$1,148	$427	$47	-89.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	198	206	72		124	151	50		0	0	0	
HCC's / 1,000	4.6	4.8	1.7		3.3	4.1	1.4		0.0	0.0	0.0	
Avg HCC Paid	$219,374	$236,642	$205,168	-13.3%	$218,720	$206,591	$178,470	-13.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	32.6%	33.9%	24.8%	-26.8%	27.7%	29.4%	20.1%	-31.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,071	$1,139	$854	-25.0%	$847	$883	$685	-22.4%	$3,087	$0	$32	0.0%
Facility Outpatient	$925	$1,040	$923	-11.3%	$782	$880	$770	-12.5%	$6,561	$2,087	$121	-94.2%
Physician	$1,045	$1,093	$970	-11.3%	$948	$1,014	$901	-11.1%	$4,006	$2,777	$413	-85.1%
Other	$72	$80	$58	-27.5%	$58	$68	$50	-26.5%	$129	$266	$0	0.0%
Total	$3,113	$3,352	$2,805	-16.3%	$2,635	$2,845	$2,406	-15.4%	$13,781	$5,130	$566	-89.0%
			Annualized				Annualized				Annualized	

Financial Summary - Prior Year comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,224	3,246	3,298	1.6%	729	615	546	-11.3%	
Avg # Members	4,799	4,858	4,950	1.9%	832	710	642	-9.6%	
Ratio	1.5	1.5	1.5	0.0%	1.1	1.2	1.2	1.7%	1.8
Financial Summary									
Gross Cost	$34,175,219	$39,350,569	$16,039,320	-59.2%	$8,764,794	$6,079,723	$3,418,899	-43.8%	
Client Paid	$27,761,940	$32,691,908	$12,420,150	-62.0%	$7,469,622	$4,845,042	$2,780,594	-42.6%	
Employee Paid	$6,413,280	$6,658,661	$3,619,170	-45.6%	$1,295,172	$1,234,681	$638,305	-48.3%	
Client Paid-PEPY	$8,612	$10,070	$7,533	-25.2%	$10,246	$7,882	$10,195	29.3%	$6,209
Client Paid-PMPY	$5,785	$6,730	$5,018	-25.4%	$8,983	$6,821	$8,662	27.0%	$3,437
Client Paid-PEPM	$718	$839	$628	-25.1%	$854	$657	$850	29.4%	$517
Client Paid-PMPM	$482	$561	$418	-25.5%	$749	$568	$722	27.1%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	58	60	19		16	8	4		
HCC's / 1,000	12.1	12.4	3.8		19.2	11.3	6.2		
Avg HCC Paid	$220,380	$271,721	$247,107	-9.1%	$220,793	$156,233	$288,394	84.6%	
HCC's % of Plan Paid	46.0%	49.9%	37.8%	-24.2%	47.3%	25.8%	41.5%	60.9%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,155	$2,853	$1,615	-43.4%	$4,794	$2,835	$4,695	65.6%	$1,057
Facility Outpatient	$1,787	$2,107	$1,941	-7.9%	$2,295	$2,143	$1,840	-14.1%	$1,145
Physician	$1,677	$1,600	$1,358	-15.1%	$1,732	$1,745	$1,990	14.0%	$1,122
Other	$166	$170	$104	-38.8%	$163	$98	$138	40.8%	$113
Total	$5,785	$6,730	$5,018	-25.4%	$8,983	$6,821	$8,662	27.0%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 18,568,451	$ 6,456,930	$ 1,752,662	$ 26,778,043	$ 14,876,766	$ 2,928,106	$ 1,578,041	$ 19,382,914	-27.6%
Outpatient	$ 31,092,436	$ 7,623,448	$ 901,651	$ 39,617,535	$ 29,487,744	$ 6,949,375	$ 964,627	$ 37,401,746	-5.6%
Total - Medical	$ 49,660,887	$ 14,080,379	$ 2,654,313	$ 66,395,578	$ 44,364,510	$ 9,877,481	$ 2,542,669	$ 56,784,660	-14.5%
Dental	$ 9,090,617	$ 1,071,864	$ 298,172	$ 10,460,654	$ 8,645,923	$ 1,017,552	$ 274,399	$ 9,937,874	-5.0%
Dental Exchange	$ -	$ -	$ 1,616,736	$ 1,616,736	$ -	$ -	$ 1,615,026	$ 1,615,026	-0.1%
Total	**$ 58,751,504**	**$ 15,152,243**	**$ 4,569,221**	**$ 78,472,968**	**$ 53,010,433**	**$ 10,895,033**	**$ 4,432,093**	**$ 68,337,559**	**-12.9%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 419	$ 891	$ 724	$ 481	$ 378	$ 619	$ 664	$ 414	-13.9%
Dental	$ 56	$ 53	$ 67	$ 56	$ 53	$ 50	$ 60	$ 53	-4.2%
Dental Exchange	$ -	$ -	$ 51	$ 51	$ -	$ -	$ 49	$ 49	-4.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 204	$ 568,876	$ 591,343	$ 1,160,423	$ 126	$ 1,113,031	$ 496,882	$ 1,610,039	38.7%
Outpatient	$ 23,352	$ 972,837	$ 300,091	$ 1,296,281	$ 2,137	$ 888,545	$ 282,135	$ 1,172,817	-9.5%
Total - Medical	$ 23,556	$ 1,541,713	$ 891,435	$ 2,456,704	$ 2,263	$ 2,001,576	$ 779,017	$ 2,782,857	13.3%
Dental	$ 1,300	$ 162,757	$ 123,500	$ 287,557	$ 2,188	$ 117,318	$ 112,403	$ 231,909	-19.4%
Dental Exchange	$ -	$ -	$ 984,771	$ 984,771	$ -	$ -	$ 930,582	$ 930,582	-5.5%
Total	**$ 24,856**	**$ 1,704,470**	**$ 1,999,706**	**$ 3,729,032**	**$ 4,451**	**$ 2,118,895**	**$ 1,822,003**	**$ 3,945,348**	**5.8%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 982	$ 673	$ 571	$ 634	$ 103	$ 1,193	$ 488	$ 845	33.2%
Dental	$ 27	$ 43	$ 49	$ 45	$ 48	$ 42	$ 45	$ 43	-4.1%
Dental Exchange	$ -	$ -	$ 45	$ 45	$ -	$ -	$ 44	$ 44	-3.4%

Paid Claims by Claim Type – Total

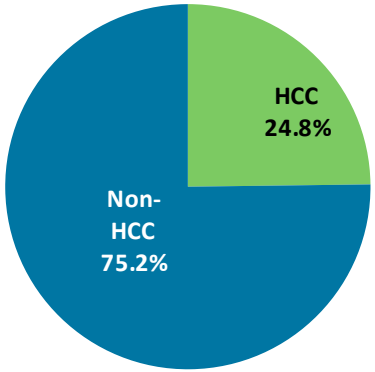
Net Paid Claims - Total Total Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 18,568,655	$ 7,025,807	$ 2,344,005	$ 27,938,466	$ 14,876,892	$ 4,041,137	$ 2,074,924	$ 20,992,953	-24.9%
Outpatient	$ 31,115,789	$ 8,596,285	$ 1,201,742	$ 40,913,816	$ 29,489,881	$ 7,837,920	$ 1,246,762	$ 38,574,563	-5.7%
Total - Medical	$ 49,684,443	$ 15,622,092	$ 3,545,747	$ 68,852,282	$ 44,366,773	$ 11,879,057	$ 3,321,686	$ 59,567,516	-13.5%
Dental	$ 9,091,917	$ 1,234,621	$ 421,673	$ 10,748,211	$ 8,648,111	$ 1,134,870	$ 386,802	$ 10,169,783	-5.4%
Dental Exchange	$ -	$ -	$ 2,601,507	$ 2,601,507	$ -	$ -	$ 2,545,608	$ 2,545,608	-2.1%
Total	**$ 58,776,360**	**$ 16,856,713**	**$ 6,568,926**	**$ 82,201,999**	**$ 53,014,884**	**$ 13,013,928**	**$ 6,254,096**	**$ 72,282,907**	**-12.1%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 419	$ 863	$ 678	$ 485	$ 378	$ 673	$ 613	$ 424	-12.5%
Dental	$ 56	$ 51	$ 61	$ 55	$ 53	$ 49	$ 55	$ 53	-4.2%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 47	$ 47	-3.8%

Cost Distribution – Medical Claims

2Q20							2Q21					
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
74	0.2%	$18,633,518	27.1%	$506,733	2.0%	$100,000.01 Plus	62	0.1%	$14,757,845	24.8%	$438,323	2.0%
109	0.3%	$8,454,203	12.3%	$613,144	2.4%	$50,000.01-$100,000.00	112	0.3%	$8,205,997	13.8%	$629,846	2.9%
256	0.6%	$9,512,393	13.8%	$1,245,066	4.9%	$25,000.01-$50,000.00	225	0.5%	$8,149,864	13.7%	$1,123,566	5.2%
665	1.6%	$11,037,796	16.0%	$2,936,073	11.7%	$10,000.01-$25,000.00	586	1.4%	$9,619,497	16.1%	$2,567,045	11.9%
946	2.2%	$7,060,747	10.3%	$3,009,034	12.0%	$5,000.01-$10,000.00	748	1.8%	$5,538,987	9.3%	$2,412,521	11.2%
1,257	2.9%	$4,721,615	6.9%	$2,851,639	11.3%	$2,500.01-$5,000.00	1,017	2.4%	$3,843,670	6.5%	$2,234,603	10.4%
20,477	47.8%	$9,432,010	13.7%	$11,212,169	44.6%	$0.01-$2,500.00	21,490	50.6%	$9,451,659	15.9%	$10,046,762	46.6%
7,152	16.7%	$0	0.0%	$2,803,725	11.1%	$0.00	5,595	13.2%	$0	0.0%	$2,126,300	9.9%
11,914	27.8%	$0	0.0%	$0	0.0%	No Claims	12,645	29.8%	$0	0.0%	$0	0.0%
42,850	**100.0%**	**$68,852,282**	**100.0%**	**$25,177,583**	**100.0%**		**42,479**	**100.0%**	**$59,567,516**	**100.0%**	**$21,578,966**	**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 NEO) Neoplasms	29	$2,196,114	14.9%
(CCS DIG) Diseases of the Digestive System	29	$2,023,881	13.7%
(CCS CIR) Diseases of the Circulatory System	45	$1,675,410	11.3%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	65	$1,247,048	8.4%
(CCS NVS) Diseases of the Nervous System	39	$1,064,778	7.2%
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	36	$996,320	6.7%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	15	$971,876	6.6%
(CCS GEN) Diseases of the Genitourinary System	33	$921,308	6.2%
(CCS INF) Certain Infectious and Parasitic Diseases	24	$910,928	6.2%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	41	$756,180	5.1%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	4	$658,124	4.5%
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalities	7	$427,980	2.9%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	34	$396,025	2.7%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere	54	$210,743	1.4%
(CCS RSP) Diseases of the Respiratory System	32	$189,746	1.3%
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	24	$102,139	0.7%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	20	$16,005	0.1%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	8	$4,705	0.0%
(CCS EYE) Diseases of the Eye and Adnexa	12	$1,791	0.0%
(CCS EAR) Diseases of the Ear and Mastoid Process	3	$554	0.0%
(CCS EXT) External Causes of Morbidity	1	$441	0.0%
Overall	**----**	**$14,772,096**	**100.0%**

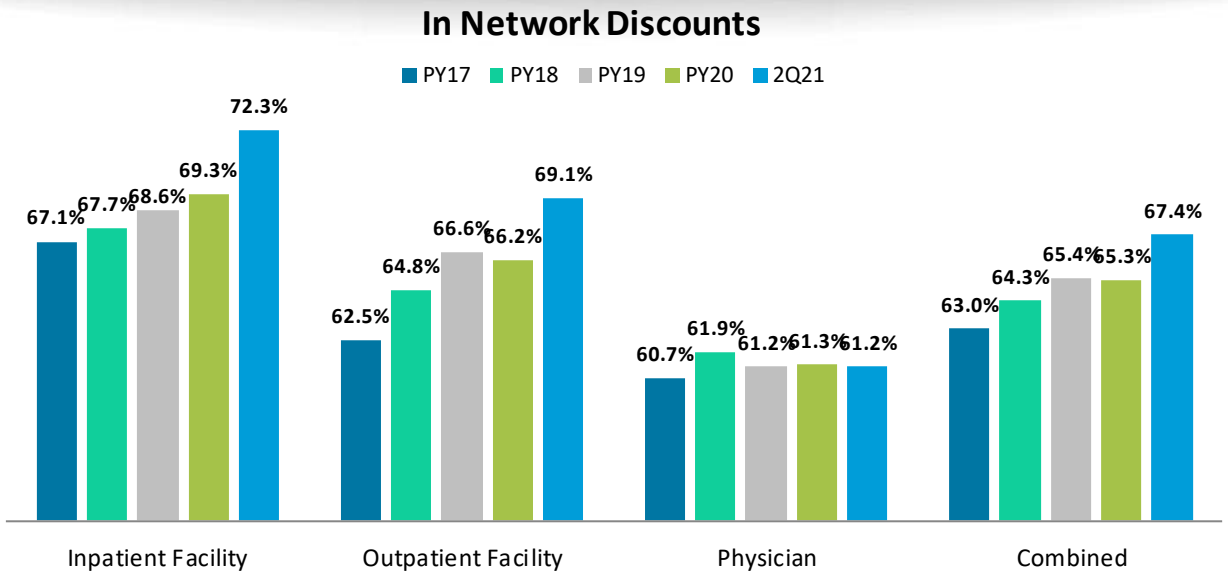
Utilization Summary (p. 1 of 2)

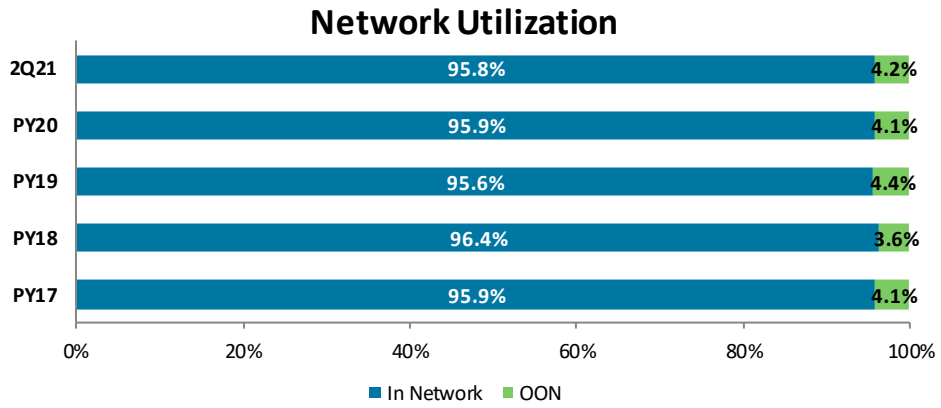
	Total				State Active				Non-State Active			
Summary	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	1,078	1,239	950		841	970	764		0	0	1	
# of Bed Days	7,353	6,314	5,094		4,000	4,723	4,126		0	0	2	
Paid Per Admit	$18,364	$19,991	$19,695	-1.5%	$17,473	$16,727	$17,243	3.1%	$0	$0	$2,186	0.0%
Paid Per Day	$2,702	$3,923	$3,673	-6.4%	$3,674	$3,435	$3,193	-7.0%	$0	$0	$1,093	0.0%
Admits Per 1,000	51	58	45	-22.4%	45	52	41	-21.2%	0	0	250	0.0%
Days Per 1,000	344	295	240	-18.6%	216	254	224	-11.8%	0	0	500	0.0%
Avg LOS	6.8	5.1	5.4	5.9%	4.8	4.9	5.4	10.2%	0	0	2	0.0%
Physician Office												
OV Utilization per Member	3.4	3.8	3.3	-13.2%	3.2	3.6	3.1	-13.9%	3.7	8.3	3.8	-54.2%
Avg Paid per OV	$40	$41	$44	7.3%	$40	$41	$44	7.3%	$73	$66	$43	-34.8%
Avg OV Paid per Member	$136	$156	$146	-6.4%	$127	$146	$139	-4.8%	$271	$548	$161	-70.6%
DX&L Utilization per Member	7.3	8.4	7.8	-7.1%	6.8	7.8	7.3	-6.4%	0	0	0	0.0%
Avg Paid per DX&L	$59	$55	$58	5.5%	$54	$52	$53	1.9%	$0	$0	$0	0.0%
Avg DX&L Paid per Member	$432	$461	$453	-1.7%	$363	$410	$391	-4.6%	$0	$0	$0	0.0%
Emergency Room												
# of Visits	3,232	3,635	2,835		2,610	2,972	2,381		0	2	0	
# of Admits	499	517	443		369	384	338		0	0	0	
Visits Per Member	0.15	0.17	0.13	-23.5%	0.14	0.16	0.13	-18.8%	0	0.57	0.00	0.0%
Visits Per 1,000	151	170	133	-21.8%	141	160	129	-19.4%	0	571	0	0.0%
Avg Paid per Visit	$1,825	$2,047	$2,168	5.9%	$1,755	$2,055	$2,169	5.5%	$0	$1,803	$0	0.0%
Admits Per Visit	0.15	0.14	0.16	14.3%	0.14	0.13	0.14	7.7%	0.00	0.00	0.00	0.0%
Urgent Care												
# of Visits	4,466	5,683	4,450		4,001	5,123	3,989		0	1	0	
Visits Per Member	0.21	0.27	0.21	-22.2%	0.22	0.28	0.22	-21.4%	0.00	0.29	0.00	0.0%
Visits Per 1,000	209	265	210	-20.8%	216	275	216	-21.5%	0	286	0	0.0%
Avg Paid per Visit	$29	$36	$98	172.2%	$28	$34	$99	191.2%	$0	$170	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**2Q19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	179	212	135		58	57	50		
# of Bed Days	914	1,302	737		2,439	289	229		
Paid Per Admit	$17,608	$34,625	$29,547	-14.7%	$34,692	$21,100	$30,894	46.4%	$16,173
Paid Per Day	$3,448	$5,638	$5,412	-4.0%	$825	$4,162	$6,745	62.1%	$3,708
Admits Per 1,000	75	87	55	-36.8%	134	154	156	1.3%	61
Days Per 1,000	381	537	298	-44.5%	5,641	782	713	-8.8%	264
Avg LOS	5.1	6.1	5.5	-9.8%	42.1	5.1	4.6	-9.8%	4.3
Physician Office									
OV Utilization per Member	4.7	5.3	4.4	-17.0%	6.3	7.3	6.3	-13.7%	3.3
Avg Paid per OV	$42	$41	$44	7.3%	$34	$30	$30	0.0%	$50
Avg OV Paid per Member	$198	$221	$198	-10.4%	$216	$221	$192	-13.1%	$167
DX&L Utilization per Member	10.6	12.1	10.5	-13.2%	13.4	14.4	12.7	-11.8%	8.3
Avg Paid per DX&L	$79	$66	$81	22.7%	$85	$58	$74	27.6%	$67
Avg DX&L Paid per Member	$836	$799	$852	6.6%	$1,133	$835	$934	11.9%	$554
Emergency Room									
# of Visits	476	513	384		146	148	70		
# of Admits	98	103	83		32	30	22		
Visits Per Member	0.20	0.21	0.16	-23.8%	0.34	0.40	0.22	-45.0%	0.17
Visits Per 1,000	198	212	155	-26.9%	338	401	218	-45.6%	174
Avg Paid per Visit	$2,136	$2,159	$2,008	-7.0%	$2,052	$1,489	$2,995	101.1%	$1,684
Admits Per Visit	0.21	0.20	0.22	10.0%	0.22	0.20	0.31	55.0%	0.14
Urgent Care									
# of Visits	373	467	402		92	92	59		
Visits Per Member	0.16	0.19	0.16	-15.8%	0.21	0.25	0.18	-28.0%	0.24
Visits Per 1,000	155	193	162	-16.1%	213	249	184	-26.1%	242
Avg Paid per Visit	$35	$53	$89	67.9%	$33	$36	$81	125.0%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary



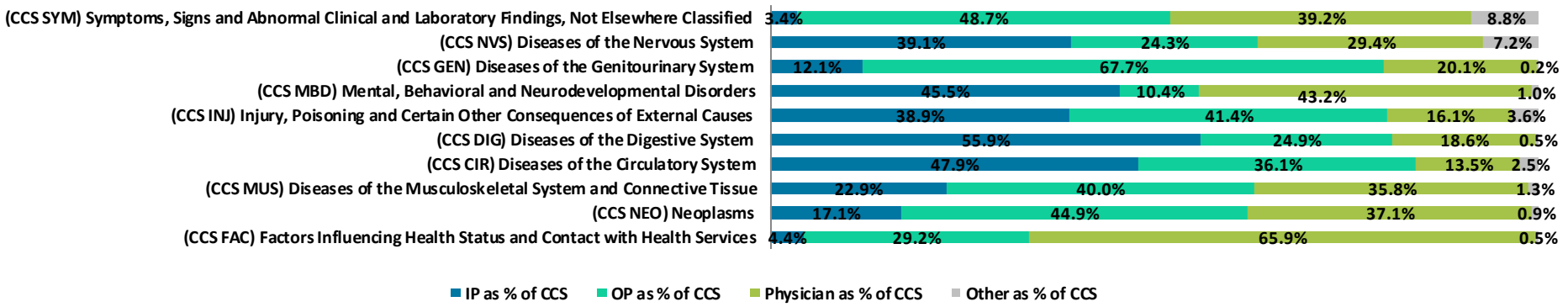


AHRQ* Clinical Classifications Summary

*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.

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$8,988,220	15.1%	$5,682,071	$1,379,469	$1,926,680	$2,997,383	$5,990,837
(CCS NEO) Neoplasms	$6,111,256	10.3%	$4,886,754	$1,142,850	$81,652	$2,462,197	$3,649,059
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$6,077,963	10.2%	$4,011,286	$1,636,607	$430,070	$2,131,502	$3,946,461
(CCS CIR) Diseases of the Circulatory System	$5,736,069	9.6%	$4,293,939	$1,309,296	$132,833	$3,151,408	$2,584,661
(CCS DIG) Diseases of the Digestive System	$4,716,727	7.9%	$2,862,855	$1,482,184	$371,688	$2,209,294	$2,507,433
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$4,318,144	7.2%	$2,584,744	$973,325	$760,075	$2,255,729	$2,062,414
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$3,294,969	5.5%	$1,379,522	$338,727	$1,576,721	$1,538,328	$1,756,642
(CCS GEN) Diseases of the Genitourinary System	$3,213,945	5.4%	$2,478,168	$520,985	$214,793	$1,551,548	$1,662,397
(CCS NVS) Diseases of the Nervous System	$2,918,343	4.9%	$1,986,144	$546,311	$385,888	$735,547	$2,182,796
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$2,688,480	4.5%	$1,798,051	$505,583	$384,846	$1,049,741	$1,638,740
(CCS INF) Certain Infectious and Parasitic Diseases	$2,485,483	4.2%	$2,082,453	$221,576	$181,454	$1,110,458	$1,375,025
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$1,855,544	3.1%	$1,295,737	$518,516	$41,290	$266	$1,855,278
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$1,759,378	3.0%	$1,146,107	$398,984	$214,288	$870,865	$888,514
(CCS RSP) Diseases of the Respiratory System	$1,401,041	2.4%	$952,120	$123,744	$325,178	$647,399	$753,642
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$1,260,218	2.1%	$4,779	$1,014	$1,254,425	$1,001,221	$258,997
(CCS EYE) Diseases of the Eye and Adnexa	$1,006,047	1.7%	$627,950	$236,919	$141,178	$394,705	$611,342
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormaliti	$708,901	1.2%	$57,546	$1,876	$649,480	$154,323	$554,579
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$435,132	0.7%	$275,339	$74,321	$85,472	$247,840	$187,291
(CCS EAR) Diseases of the Ear and Mastoid Process	$264,416	0.4%	$150,800	$19,955	$93,661	$140,275	$124,141
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$259,524	0.4%	$188,445	$40,710	$30,369	$89,075	$170,449
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$67,062	0.1%	$47,054	$9,098	$10,911	$18,287	$48,775
(CCS EXT) External Causes of Morbidity	$654	0.0%	$88	$566	$0	$461	$193
Total	**$59,567,516**	**100.0%**	**$38,791,950**	**$11,482,616**	**$9,292,950**	**$24,757,850**	**$34,809,666**

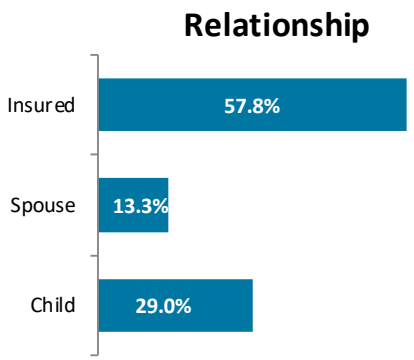
Top 10 Categories by Claim Type

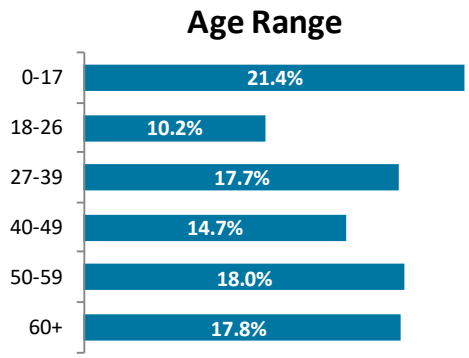


AHRQ Category – Factors Influencing Health Status and Contact with Health Services

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Exposure, Encounters, Screening Or Contact With Infectious Disease	12,487	22,244	$2,301,820	25.6%
Medical Examination/Evaluation	10,645	18,626	$1,798,891	20.0%
Encounter For Antineoplastic Therapies	90	462	$1,688,035	18.8%
Neoplasm-Related Encounters	3,995	7,386	$1,390,866	15.5%
Other Aftercare Encounter	442	1,179	$537,947	6.0%
Contraceptive And Procreative Management	852	1507	$377,872	4.2%
Implant, Device Or Graft Related Encounter	441	1,118	$275,666	3.1%
Personal/Family History Of Disease	613	1,089	$193,661	2.2%
Other Specified Status	1,179	2,424	$138,832	1.5%
Encounter For Prophylactic Or Other Procedures	87	109	$127,939	1.4%
Encounter For Observation And Examination For Conditions Ruled Out (Excl	1,423	1,903	$46,129	0.5%
Organ Transplant Status	36	286	$37,636	0.4%
Acquired Absence Of Limb Or Organ	32	56	$31,526	0.4%
Other Specified Encounters And Counseling	292	552	$27,211	0.3%
Encounter For Administrative Purposes	137	166	$7,340	0.1%
Encounter For Prophylactic Measures (Excludes Immunization)	25	40	$1,790	0.0%
Lifestyle/Life Management Factors	50	81	$1,648	0.0%
Screening For Neurocognitive Or Neurodevelopmental Condition	38	38	$1,220	0.0%
Socioeconomic/Psychosocial Factors	23	49	$1,027	0.0%
Encounter For Mental Health Conditions	142	150	$683	0.0%
No Immunization Or Underimmunization	18	21	$369	0.0%
Carrier Status	6	8	$110	0.0%
Counseling Related To Sexual Behavior Or Orientation	2	2	$0	0.0%
Overall	**----**	**----**	**$8,988,220**	**100.0%**

*Patient and claim counts are unique only within the category

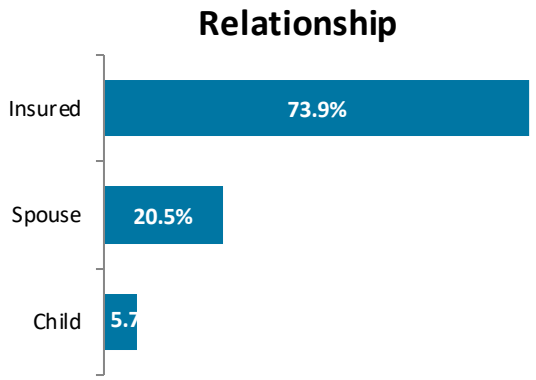


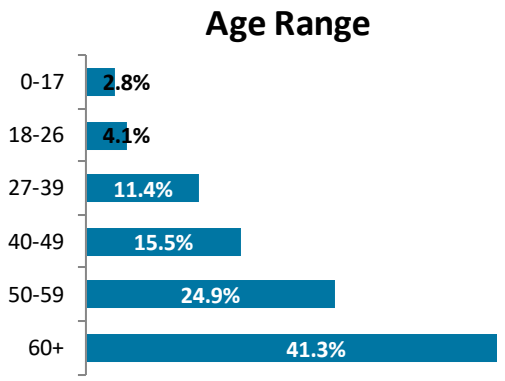


AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Breast Cancer - All Other Types	249	1,841	$1,024,865	16.8%
Benign Neoplasms	1497	2,562	$704,060	11.5%
Male Reproductive System Cancers - Prostate	108	909	$605,593	9.9%
Secondary Malignancies	62	317	$573,809	9.4%
Nervous System Cancers - Brain	18	280	$321,497	5.3%
Urinary System Cancers - Bladder	20	319	$316,496	5.2%
Female Reproductive System Cancers - Ovary	24	179	$271,218	4.4%
Head And Neck Cancers - Lip And Oral Cavity	16	166	$225,736	3.7%
Malignant Neuroendocrine Tumors	12	81	$219,179	3.6%
Gastrointestinal Cancers - Colorectal	46	310	$200,426	3.3%
Respiratory Cancers	24	275	$176,116	2.9%
Neoplasms Of Unspecified Nature Or Uncertain Behavior	1,039	1,659	$152,451	2.5%
Multiple Myeloma	17	208	$124,907	2.0%
Skin Cancers - Melanoma	52	193	$123,339	2.0%
Gastrointestinal Cancers - Liver	6	25	$102,841	1.7%
Female Reproductive System Cancers - Endometrium	28	217	$88,577	1.4%
Sarcoma	8	109	$68,577	1.1%
Head And Neck Cancers - Eye	6	50	$67,794	1.1%
Gastrointestinal Cancers - All Other Types	3	34	$65,996	1.1%
Gastrointestinal Cancers - Esophagus	5	99	$60,963	1.0%
Skin Cancers - Basal Cell Carcinoma	173	351	$59,592	1.0%
Female Reproductive System Cancers - Cervix	17	52	$55,648	0.9%
Female Reproductive System Cancers - All Other Types	1	8	$52,781	0.9%
Female Reproductive System Cancers - Vulva	8	25	$52,635	0.9%
Endocrine System Cancers - Thyroid	70	227	$49,530	0.8%
Head And Neck Cancers - All Other Types	8	59	$49,520	0.8%
Non-Hodgkin Lymphoma	45	245	$42,786	0.7%
Breast Cancer - Ductal Carcinoma In Situ (Dcis)	32	119	$38,124	0.6%
Female Reproductive System Cancers - Fallopian Tube	1	15	$36,768	0.6%
Conditions Due To Neoplasm Or The Treatment Of Neoplasm	23	64	$24,701	0.4%
All Others	243	858	$154,733	2.4%
Overall	**----**	**----**	**$6,111,256**	**100.0%**

*Patient and claim counts are unique only within the category

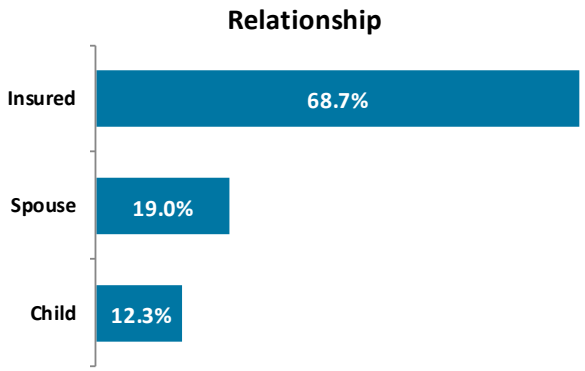


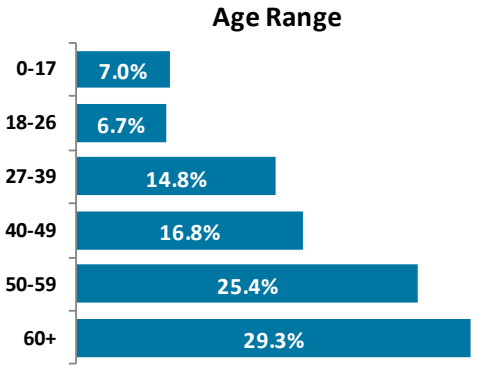


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylopathies/Spondyloarthropathy (Including Infective)	1,852	9,162	$2,136,801	35.2%
Osteoarthritis	771	2,099	$1,188,081	19.5%
Musculoskeletal Pain, Not Low Back Pain	3,011	11,703	$518,066	8.5%
Tendon And Synovial Disorders	606	2,069	$506,353	8.3%
Other Specified Joint Disorders	436	1,329	$273,780	4.5%
Scoliosis And Other Postural Dorsopathic Deformities	71	322	$198,906	3.3%
Other Specified Connective Tissue Disease	810	2,021	$173,857	2.9%
Osteomyelitis	21	264	$164,005	2.7%
Postprocedural Or Postoperative Musculoskeletal System Complication	52	155	$142,737	2.3%
Low Back Pain	897	3,410	$139,279	2.3%
Acquired Foot Deformities	178	538	$120,770	2.0%
Rheumatoid Arthritis And Related Disease	148	418	$108,407	1.8%
Systemic Lupus Erythematosus And Connective Tissue Disorders	129	365	$65,625	1.1%
Other Specified Bone Disease And Musculoskeletal Deformities	236	403	$48,180	0.8%
Pathological Fracture, Subsequent Encounter	2	5	$39,270	0.6%
Muscle Disorders	108	577	$39,164	0.6%
Acquired Deformities (Excluding Foot)	49	126	$36,527	0.6%
Biomechanical Lesions	1,029	3,915	$30,182	0.5%
Osteoporosis	151	258	$24,872	0.4%
Pathological Fracture, Initial Encounter	2	6	$24,317	0.4%
Stress Fracture, Initial Encounter	23	52	$17,912	0.3%
Aseptic Necrosis And Osteonecrosis	7	32	$17,734	0.3%
Juvenile Arthritis	6	26	$14,196	0.2%
Traumatic Arthropathy	21	80	$13,136	0.2%
Neurogenic/Neuropathic Arthropathy	3	17	$8,572	0.1%
Disorders Of Jaw	47	128	$7,537	0.1%
Musculoskeletal Abscess	2	3	$6,825	0.1%
Infective Arthritis	4	26	$6,271	0.1%
Gout	140	218	$4,995	0.1%
Stress Fracture, Subsequent Encounter	8	59	$1,379	0.0%
Immune-Mediated/Reactive Arthropathies	2	3	$145	0.0%
Pathological, Stress And Atypical Fractures, Sequela	1	2	$42	0.0%
Autoinflammatory Syndromes	3	4	$40	0.0%
Other Bone Disease And Musculoskeletal Deformities [212.]	2	2	$0	0.0%
Crystal Arthropathies (Excluding Gout)	1	2	$0	0.0%
	----	----	$6,077,963	100.0%

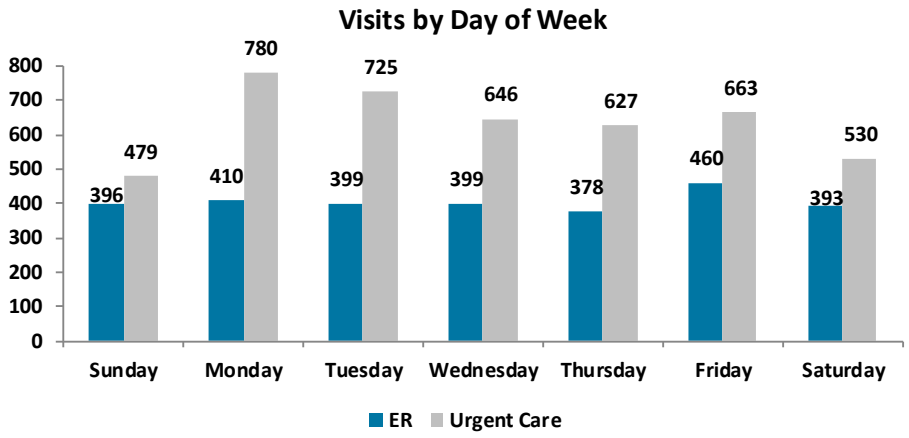
*Patient and claim counts are unique only within the category

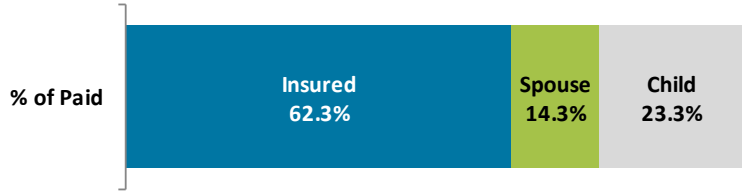




Emergency Room / Urgent Care Summary

	2Q20		2Q21		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	3,635	5,683	2,835	4,450		
Number of Admits	517	----	443	----		
Visits Per Member	0.17	0.27	0.13	0.21	0.17	0.24
Visits/1000 Members	170	265	133	210	174	242
Avg Paid Per Visit	$2,047	$36	$2,166	$98	$1,684	$74
Admits per Visit	0.14	----	0.16	----	0.14	
% of Visits with HSB ER Dx	76.2%	----	77.5%	----		
% of Visits with a Physician OV*	76.9%	73.2%	77.6%	71.6%		
Total Plan Paid	**$7,436,737**	**$203,082**	**$6,141,336**	**$434,608**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



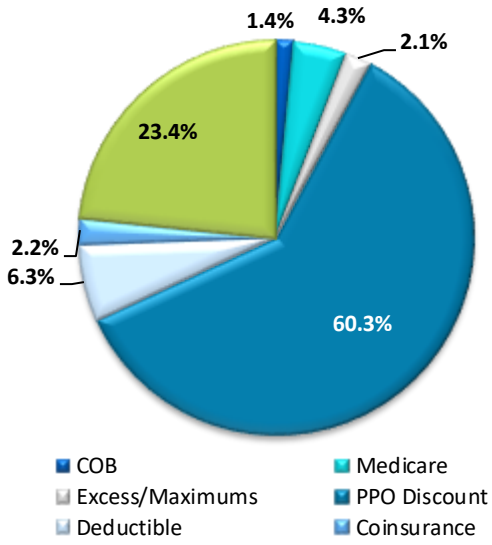


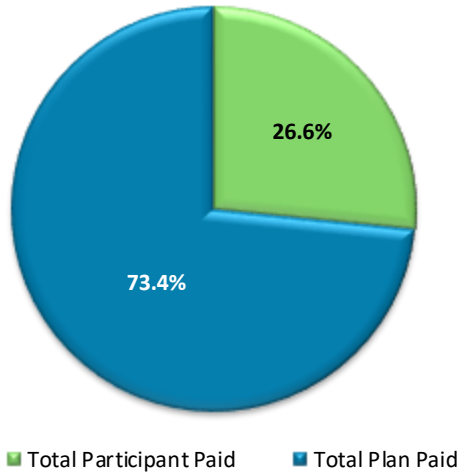
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,748	75	2,794	119	4,542	194
Spouse	485	88	558	101	1,043	189
Child	602	44	1,098	81	1,700	125
Total	**2,835**	**67**	**4,450**	**105**	**7,285**	**171**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$254,998,902	$1,817	100.0%
COB	$3,691,828	$26	1.4%
Medicare	$11,016,046	$78	4.3%
Excess/Maximums	$5,439,384	$39	2.1%
PPO Discount	$153,705,162	$1,095	60.3%
Deductible	$15,980,583	$114	6.3%
Coinsurance	$5,598,383	$40	2.2%
Total Participant Paid	**$21,578,966**	**$154**	**8.5%**
Total Plan Paid	**$59,567,516**	**$424**	**23.4%**

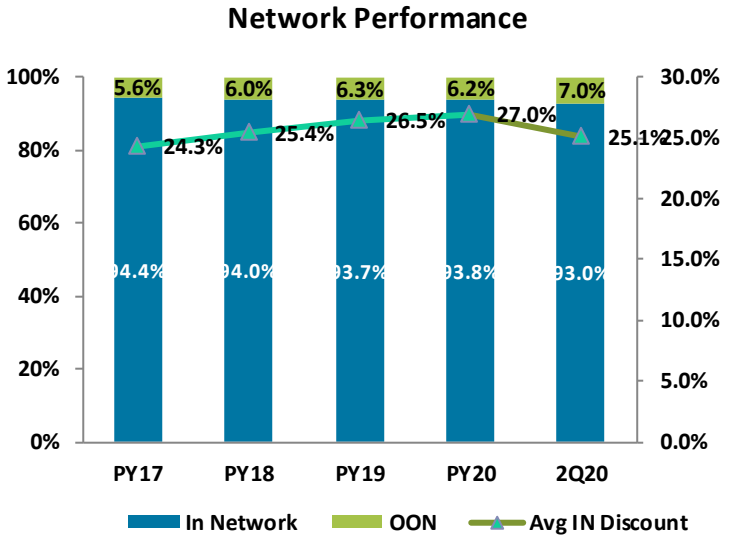
Total Participant Paid - PY20	**$146**
Total Plan Paid - PY20	**$506**



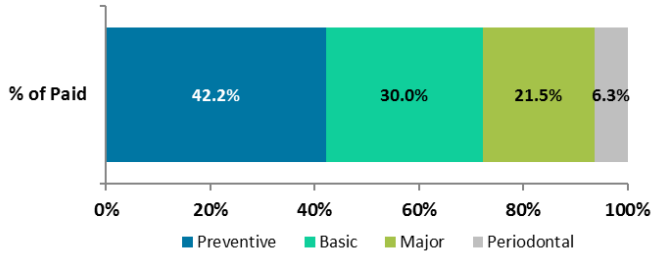


Dental Claims Analysis

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	3,203	4.7%	37,511	20.6%	$4,680,987	36.8%	$3,160,141	49.5%
$750.01-$1,000.00	1,293	1.9%	11,189	6.2%	$1,141,551	9.0%	$682,326	10.7%
$500.01-$750.00	2,484	3.6%	18,508	10.2%	$1,554,317	12.2%	$908,785	14.2%
$250.01-$500.00	6,035	8.8%	37,638	20.7%	$2,078,562	16.3%	$719,893	11.3%
$0.01-$250.00	22,100	32.3%	75,999	41.8%	$3,259,974	25.6%	$879,619	13.8%
$0.00	592	0.9%	1,077	0.6%	$0	0.0%	$37,510	0.6%
No Claims	32,765	47.9%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,471**	**100.0%**	**181,922**	**100.0%**	**$12,715,391**	**100.0%**	**$6,388,274**	**100.0%**



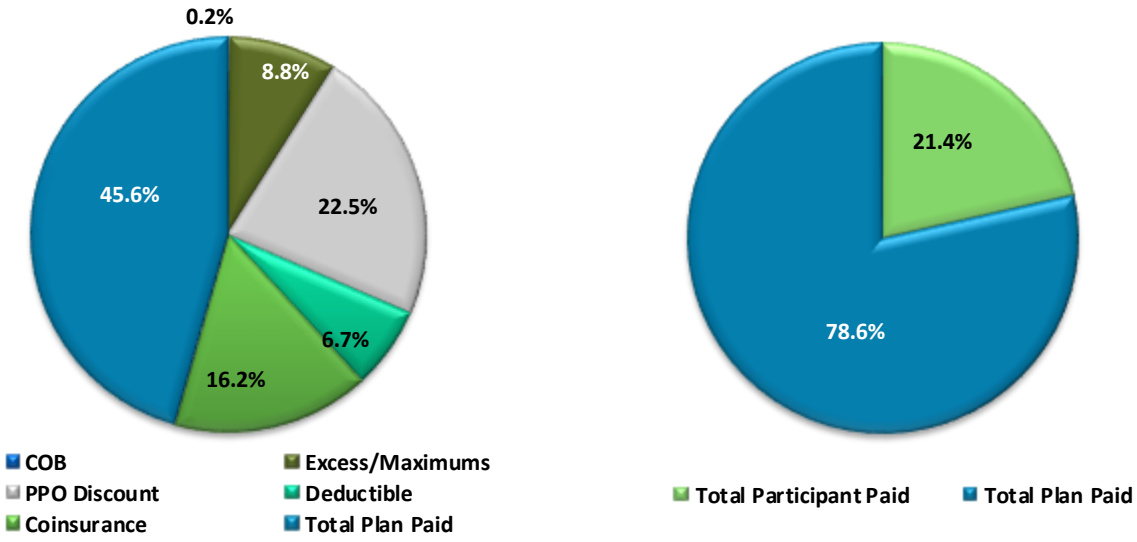
Claim Category	Total Paid	% of Paid
Preventive	$5,368,295	42.2%
Basic	$3,810,806	30.0%
Major	$2,726,972	21.5%
Periodontal	$806,072	6.3%
Total	**$12,712,145**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$27,880,331	$113	100.0%
COB	$60,999	$0	0.2%
Excess/Maximums	$2,441,699	$10	8.8%
PPO Discount	$6,273,969	$25	22.5%
Deductible	$1,876,855	$8	6.7%
Coinsurance	$4,511,419	$18	16.2%
Total Participant Paid	**$3,471,268**	**$14**	**12.5%**
Total Plan Paid	**$12,715,391**	**$52**	**45.6%**

Total Participant Paid - PY20	**$22**
Total Plan Paid - PY20	**$46**

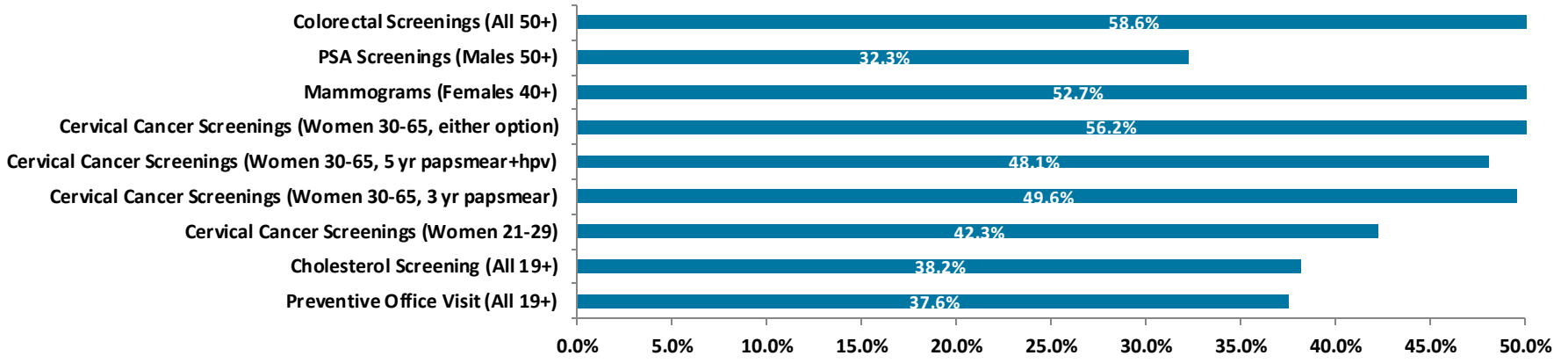


Preventive Services Compliance

*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+)	17,449	8,358	47.9%	15,292	3,945	25.8%	32,741	12,303	37.6%
Cholesterol Screening (All 19+)	17,449	7,224	41.4%	15,292	5,276	34.5%	32,741	12,500	38.2%
Cervical Cancer Screenings (Women 21-29)	2,733	1,156	42.3%	----	----	----	2,733	1,156	42.3%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	13,136	6,515	49.6%	----	----	----	13,136	6,515	49.6%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	13,136	6,318	48.1%	----	----	----	13,136	6,318	48.1%
Cervical Cancer Screenings (Women 30-65, either option)	13,136	7,382	56.2%	----	----	----	13,136	7,382	56.2%
Mammograms (Females 40+)	10,709	5,644	52.7%	----	----	----	10,709	5,644	52.7%
PSA Screenings (Males 50+)	----	----	----	6,435	2,079	32.3%	6,435	2,079	32.3%
Colorectal Screenings (All 50+)	7,350	4,461	60.7%	6,435	3,616	56.2%	13,785	8,078	58.6%

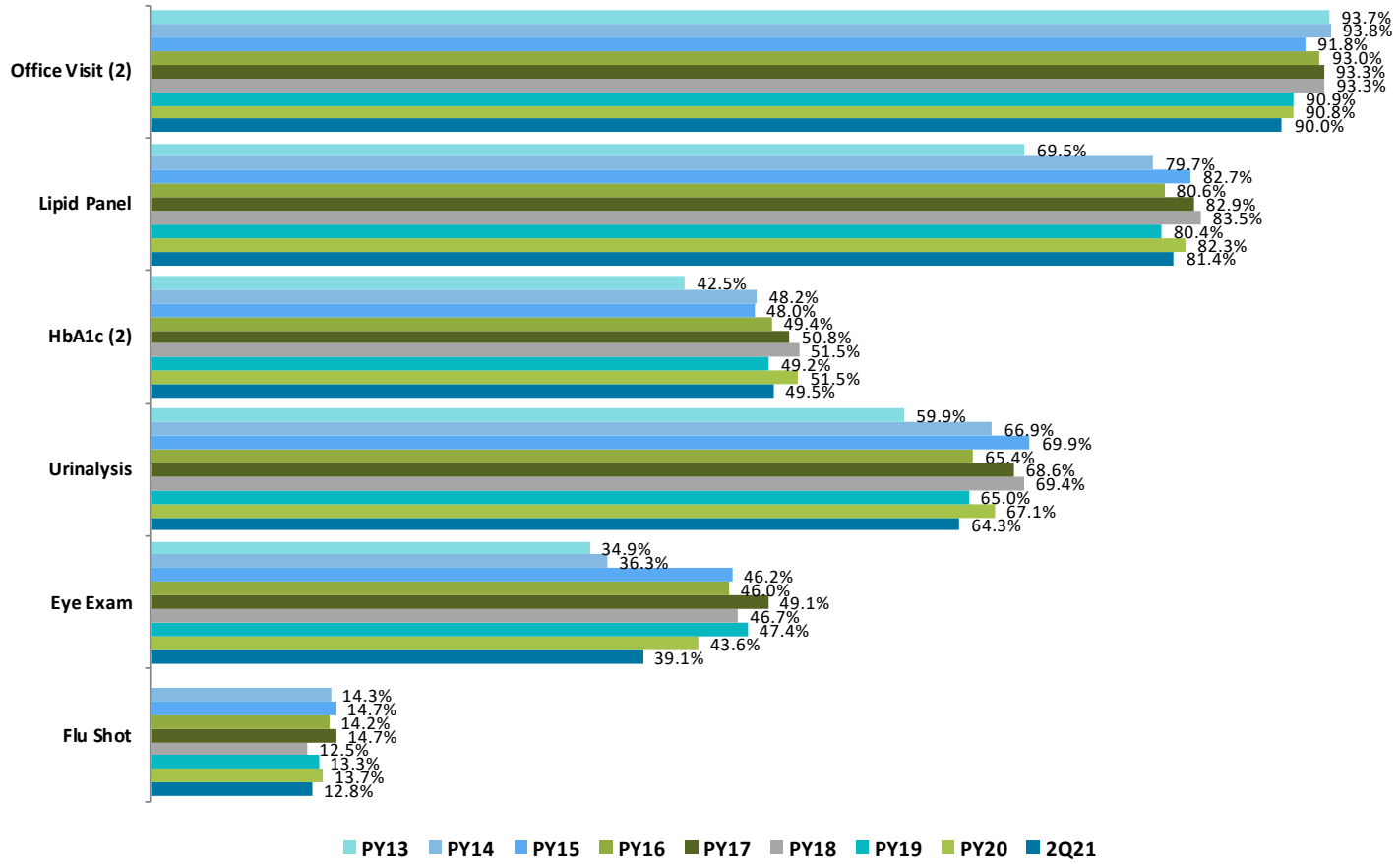
Overall Preventive Services Compliance Rates



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	PY13	PY14	PY15	PY16	PY17	PY18	PY19	PY20	2Q21
Members	1,643	1,555	1,676	1,693	1,704	1,747	1,838	1,876	1,862

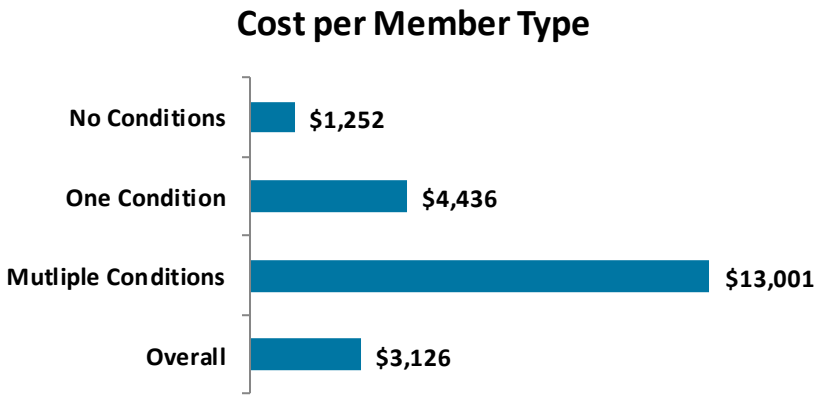


Chronic Conditions Summary

*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	1,103	1,051	26	40	$5,820,901	$5,277	99.2%	1 Office Visit
Cancer	1,298	1,228	30	59	$27,971,913	$21,550	----	----
Chronic Kidney Disease	313	295	7	60	$7,509,892	$23,993	----	----
Chronic Obstructive Pulmonary Disease (COPD)	230	214	5	60	$7,432,806	$32,317	98.7%	1 Office Visit
Congestive Heart Failure (CHF)	140	127	3	63	$7,846,569	$56,047	11.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	591	564	14	62	$9,163,019	$15,504	21.3%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,538	1,441	36	40	$14,926,230	$9,705	95.1%	1 Office Visit
Diabetes	1,862	1,766	44	56	$15,547,518	$8,350	17.0%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,180	3,070	74	54	$17,452,933	$5,488	39.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,545	3,390	83	57	$32,194,104	$9,082	26.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	784	751	18	43	$4,568,146	$5,827	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	29,737	32	47.6%	11.9%	40.5%
One Condition	8,504	47	70.6%	16.5%	12.9%
Multiple Conditions	4,515	56	77.8%	19.4%	2.8%
Overall	**42,755**	**37**	**54.7%**	**13.5%**	**31.8%**



Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending December 31, 2020

Express Scripts

Membership Summary	2Q FY2021	2Q FY2020	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,487	42,842	(355)	-0.8%
Utilizing Member Count (Patients)	24,695	26,119	(1,424)	-5.5%
Percent Utilizing (Utilization)	58.1%	61.0%	(0.03)	-4.7%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	259,996	261,881	(1,885)	-0.7%
Claims per Elig Member per Month (Claims PMPM)	1.02	1.02	-	0.0%
Total Claims for Generic (Generic Rx)	222,498	225,394	(2,896.00)	-1.3%
Total Claims for Brand (Brand Rx)	37,498	36,487	1,011.00	2.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	4,032	3,920	112.00	2.9%
Total Non-Specialty Claims	256,894	258,830	(1,936.00)	-0.7%
Total Specialty Claims	3,102	3,051	51.00	1.7%
Generic % of Total Claims (GFR)	**85.6%**	**86.1%**	(0.00)	-0.6%
Generic Effective Rate (GCR)	**98.2%**	**98.3%**	(0.00)	-0.1%
Mail Order Claims	55,846	44,008	11,838.00	26.9%
Mail Penetration Rate*	24.4%	19.4%	0.05	5.0%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$27,207,938.00	$23,845,030.00	$3,362,908.00	14.1%
Total Generic Gross Cost	$4,323,132.00	$3,912,121.00	$411,011.00	10.5%
Total Brand Gross Cost	$22,884,806.00	$19,932,909.00	$2,951,897.00	14.8%
Total MSB Gross Cost	$1,003,015.00	$819,768.00	$183,247.00	22.4%
Total Ingredient Cost	$26,968,933.00	$23,622,012.00	$3,346,921.00	14.2%
Total Dispensing Fee	$227,355.00	$214,157.00	$13,198.00	6.2%
Total Other (e.g. tax)	$11,650.00	$8,861.00	$2,789.00	31.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$104.65**	**$91.05**	$13.59	14.9%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$19.43	$17.36	$2.07	11.9%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$610.29	$546.30	$63.99	11.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$248.76	$209.12	$39.64	19.0%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$7,056,541.00**	**$7,596,347.00**	($539,806.00)	-7.1%
Total Copay	$4,705,342.00	$3,339,488.00	$1,365,854.00	40.9%
Total Deductible	$2,351,198.00	$4,256,859.00	($1,905,661.00)	-44.8%
Avg Copay per Claim (Copay/Rx)	$18.10	$12.75	$5.35	41.9%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$27.14**	**$29.01**	**($1.87)**	**-6.4%**
Avg Copay for Generic (Copay/Generic Rx)	$10.00	$10.11	($0.11)	-1.1%
Avg Copay for Brand (Copay/Brand Rx)	$128.85	$145.76	($16.91)	-11.6%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$75.24	$80.21	($4.97)	-6.2%
Net PMPM (Participant Cost PMPM)	**$27.68**	**$29.55**	($1.87)	-6.3%
Copay % of Total Prescription Cost (Member Cost Share %)	25.9%	31.9%	-5.9%	-18.6%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$20,151,397.00**	**$16,248,683.00**	**$3,902,714.00**	**24.0%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,943,790.00	$5,968,516.00	$975,274.00	16.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$13,207,607.00	$10,280,167.00	$2,927,440.00	28.5%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$77.51**	**$62.05**	$15.46	24.9%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$9.43	$7.25	$2.18	30.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$481.45	$400.55	$80.90	20.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$173.52	$128.91	$44.61	34.6%
Net PMPM (Plan Cost PMPM)	**$79.05**	**$63.21**	**$15.84**	**25.1%**
PMPM for Specialty Only (Specialty PMPM)	$51.81	$39.99	$11.82	29.6%
PMPM without Specialty (Non-Specialty PMPM)	$27.24	$23.22	$4.02	17.3%
Rebates (Q1-Q2 FY2021 actual)	$4,915,767.49	$5,248,066.35	($332,298.86)	-6.3%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$59.77**	**$42.80**	**$16.97**	**39.7%**
PMPM for Specialty Only (Specialty PMPM)	$44.62	$33.98	$10.64	31.3%
PMPM without Specialty (Non-Specialty PMPM)	$14.11	$11.51	$2.60	22.6%

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2020 – December 31, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July – December 2020

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q21 was $24,992,892 with an annualized plan cost per employee per year of $10,644. This is an increase of 5.9% when compared to 2Q20.
  - IP Cost per Admit is $16,338 which is 29.7% higher than 2Q20.
  - ER Cost per Visit is $2,576 which is 1.7% lower than 2Q20.
- Employees shared in 6.1% of the medical cost.
- Inpatient facility costs were 19.1% of the plan spend.
- 83.8% of the Average Membership had paid Medical claims less than $2,500, with 18.5% of those having no claims paid at all during the reporting period.
- 29 members exceeded the $100k high cost threshold during the reporting period, which accounted for 22.7% of the plan spend. The highest diagnosis category was Neoplasms, accounting for 22.0% of the high cost claimant dollars.
- Total spending with in-network providers was 97.5%. The overall in-network discount was 57.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q20						2Q21						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,046,671	$ 1,544	$ 9,366	$ 14	$ 1,056,037	$ 1,558	$ 755,466	$ 1,298	$ 8,243	$ 14	$ 763,709	$ 1,312	-27.7%	-15.8%
1	$ 181,130	$ 332	$ 5,393	$ 10	$ 186,523	$ 342	$ 92,724	$ 147	$ 1,175	$ 2	$ 93,899	$ 149	-49.7%	-56.4%
2 - 4	$ 309,366	$ 176	$ 7,602	$ 4	$ 316,968	$ 180	$ 166,045	$ 100	$ 6,299	$ 4	$ 172,344	$ 103	-45.6%	-42.7%
5 - 9	$ 398,927	$ 127	$ 55,969	$ 18	$ 454,896	$ 144	$ 255,835	$ 84	$ 40,755	$ 13	$ 296,590	$ 97	-34.8%	-32.5%
10 - 14	$ 754,875	$ 191	$ 125,494	$ 32	$ 880,369	$ 223	$ 501,931	$ 136	$ 107,041	$ 29	$ 608,972	$ 164	-30.8%	-26.2%
15 - 19	$ 1,388,355	$ 321	$ 189,229	$ 44	$ 1,577,584	$ 365	$ 1,153,196	$ 268	$ 216,715	$ 50	$ 1,369,911	$ 319	-13.2%	-12.7%
20 - 24	$ 856,924	$ 233	$ 254,799	$ 69	$ 1,111,723	$ 303	$ 997,822	$ 252	$ 347,621	$ 88	$ 1,345,443	$ 339	21.0%	12.1%
25 - 29	$ 662,698	$ 295	$ 196,674	$ 88	$ 859,372	$ 383	$ 625,083	$ 293	$ 555,437	$ 261	$ 1,180,520	$ 554	37.4%	44.7%
30 - 34	$ 1,245,650	$ 422	$ 165,854	$ 56	$ 1,411,504	$ 478	$ 1,922,273	$ 683	$ 393,850	$ 140	$ 2,316,123	$ 823	64.1%	72.1%
35 - 39	$ 1,810,197	$ 531	$ 374,946	$ 110	$ 2,185,143	$ 641	$ 1,967,049	$ 561	$ 427,343	$ 122	$ 2,394,392	$ 683	9.6%	6.6%
40 - 44	$ 1,521,462	$ 449	$ 626,476	$ 185	$ 2,147,938	$ 634	$ 1,426,392	$ 417	$ 719,424	$ 210	$ 2,145,816	$ 627	-0.1%	-1.0%
45 - 49	$ 2,167,308	$ 500	$ 727,893	$ 168	$ 2,895,201	$ 668	$ 2,274,793	$ 574	$ 580,217	$ 147	$ 2,855,010	$ 721	-1.4%	7.9%
50 - 54	$ 2,468,319	$ 520	$ 1,127,782	$ 238	$ 3,596,101	$ 758	$ 2,521,730	$ 513	$ 1,264,072	$ 257	$ 3,785,802	$ 770	5.3%	1.7%
55 - 59	$ 3,707,542	$ 688	$ 1,626,073	$ 302	$ 5,333,615	$ 990	$ 3,260,075	$ 641	$ 1,331,853	$ 262	$ 4,591,928	$ 904	-13.9%	-8.7%
60 - 64	$ 4,254,644	$ 712	$ 1,871,243	$ 313	$ 6,125,887	$ 1,025	$ 5,351,303	$ 952	$ 2,063,246	$ 367	$ 7,414,549	$ 1,319	21.0%	28.7%
65+	$ 1,475,677	$ 610	$ 731,274	$ 302	$ 2,206,951	$ 913	$ 1,721,176	$ 708	$ 921,919	$ 379	$ 2,643,095	$ 1,088	19.8%	19.2%
Total	**$ 24,249,744**	**$ 458**	**$ 8,096,067**	**$ 153**	**$32,345,812**	**$ 611**	**$ 24,992,892**	**$ 483**	**$ 8,985,212**	**$ 174**	**$ 33,978,105**	**$ 656**	**5.0%**	**7.4%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,653	4,823	4,696	-2.6%	3,878	4,074	3,986	-2.2%	4	4	4	0.0%
Avg # Members	8,488	8,819	8,627	-2.2%	7,445	7,808	7,666	-1.8%	5	5	5	-6.6%
Ratio	1.8	1.8	1.8	2.2%	1.9	1.9	1.9	1.1%	1.3	1.3	1.2	-10.0%
Financial Summary												
Gross Cost	$45,094,672	$26,998,382	$26,605,674	-1.5%	$35,711,039	$23,079,745	$22,398,978	-2.9%	$45,961	$38,573	$27,972	-27.5%
Client Paid	$40,764,731	$24,249,744	$24,992,892	3.1%	$32,097,283	$20,843,376	$21,045,129	1.0%	$40,931	$35,593	$26,079	-26.7%
Employee Paid	$4,329,941	$2,748,639	$1,612,781	-41.3%	$3,613,757	$2,236,369	$1,353,850	-39.5%	$5,030	$2,979	$1,893	-36.5%
Client Paid-PEPY	$8,745	$10,055	$10,644	5.9%	$8,277	$10,233	$10,560	3.2%	$10,233	$17,797	$13,039	-26.7%
Client Paid-PMPY	$4,794	$5,499	$5,794	5.4%	$4,311	$5,339	$5,491	2.8%	$8,186	$14,237	$11,177	-21.5%
Client Paid-PEPM	$729	$838	$887	5.8%	$690	$853	$880	3.2%	$853	$1,483	$1,087	-26.7%
Client Paid-PMPM	$400	$458	$483	5.5%	$359	$445	$458	2.9%	$682	$1,186	$931	-21.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	15	29	93.3%	27	14	23	64.3%	0	0	0	0.0%
HCC's / 1,000	4.6	1.7	3.4	97.6%	3.6	1.8	3.0	66.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$183,130	$195,921	7.0%	$246,453	$189,023	$201,553	6.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	11.3%	22.7%	100.9%	20.7%	12.7%	22.0%	73.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,218	$1,060	$1,106	4.3%	$944	$1,025	$1,108	8.1%	$3,360	$5,856	$0	0.0%
Facility Outpatient	$1,506	$1,727	$1,929	11.7%	$1,395	$1,674	$1,778	6.2%	$1,369	$1,978	$6,326	219.8%
Physician	$1,923	$2,534	$2,556	0.9%	$1,844	$2,480	$2,442	-1.5%	$3,030	$6,126	$4,050	-33.9%
Other	$148	$178	$203	14.0%	$127	$161	$163	1.2%	$427	$277	$801	189.2%
Total	$4,794	$5,499	$5,794	5.4%	$4,311	$5,339	$5,491	2.8%	$8,186	$14,237	$11,177	-21.5%
		Annualized	Annualized			Annualized	Annualized			Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	599	592	578	-2.4%	181	154	129	-16.4%	
Avg # Members	826	811	791	-2.5%	227	195	165	-15.2%	
Ratio	1.4	1.4	1.4	-2.1%	1.3	1.3	1.3	-1.5%	1.8
Financial Summary									
Gross Cost	$7,418,807	$3,433,058	$3,710,234	8.1%	$1,918,864	$447,006	$468,489	4.8%	
Client Paid	$6,863,148	$2,999,537	$3,499,564	16.7%	$1,763,370	$371,237	$422,121	13.7%	
Employee Paid	$555,659	$433,521	$210,670	-51.4%	$155,495	$75,769	$46,368	-38.8%	
Client Paid-PEPY	$11,461	$10,142	$12,113	19.4%	$9,769	$4,816	$6,561	36.2%	$6,209
Client Paid-PMPY	$8,313	$7,397	$8,848	19.6%	$7,777	$3,808	$5,106	34.1%	$3,437
Client Paid-PEPM	$955	$845	$1,009	19.4%	$814	$401	$547	36.4%	$517
Client Paid-PMPM	$693	$616	$737	19.6%	$648	$317	$426	34.4%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	1	7	0.0%	3	0	1	0.0%	
HCC's / 1,000	10.9	1.2	8.9	0.0%	13.2	0.0	6.1	0.0%	
Avg HCC Paid	$339,256	$100,633	$131,142	0.0%	$334,114	$0	$127,984	0.0%	
HCC's % of Plan Paid	44.5%	3.4%	26.2%	0.0%	56.8%	0.0%	30.3%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,028	$1,510	$1,151	-23.8%	$3,554	$465	$831	78.7%	$1,057
Facility Outpatient	$2,243	$2,401	$3,520	46.6%	$2,477	$1,064	$1,198	12.6%	$1,145
Physician	$2,713	$3,160	$3,637	15.1%	$1,587	$2,028	$2,633	29.8%	$1,122
Other	$328	$326	$540	65.6%	$158	$250	$444	77.6%	$113
Total	$8,313	$7,397	$8,848	19.6%	$7,777	$3,808	$5,106	34.1%	$3,437
		Annualized	Annualized			Annualized	Annualized		

Financial Summary – Prior Year Comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,653	4,794	4,696	-2.0%	3,878	4,054	3,986	-1.7%	4	4	4	0.0%
Avg # Members	8,488	8,768	8,627	-1.6%	7,445	7,768	7,666	-1.3%	5	5	5	-6.6%
Ratio	1.8	1.8	1.8	0.5%	1.9	1.9	1.9	0.0%	1.3	1.3	1.2	-6.4%
Financial Summary												
Gross Cost	$45,094,672	$55,523,229	$26,605,674	-52.1%	$35,711,039	$45,961,999	$22,398,978	-51.3%	$45,961	$70,916	$27,972	-60.6%
Client Paid	$40,764,731	$50,293,887	$24,992,892	-50.3%	$32,097,283	$41,579,805	$21,045,129	-49.4%	$40,931	$65,329	$26,079	-60.1%
Employee Paid	$4,329,941	$5,229,342	$1,612,781	-69.2%	$3,613,757	$4,382,194	$1,353,850	-69.1%	$5,030	$5,587	$1,893	-66.1%
Client Paid-PEPY	$8,745	$10,492	$10,644	1.4%	$8,277	$10,256	$10,560	3.0%	$10,233	$16,332	$13,039	-20.2%
Client Paid-PMPY	$4,794	$5,736	$5,794	1.0%	$4,311	$5,352	$5,491	2.6%	$8,186	$13,066	$11,177	-14.5%
Client Paid-PEPM	$729	$874	$887	1.5%	$690	$855	$880	2.9%	$853	$1,361	$1,087	-20.1%
Client Paid-PMPM	$400	$478	$483	1.0%	$359	$446	$458	2.7%	$682	$1,089	$931	-14.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	51	29	-43.1%	27	40	23	-42.5%	0	0	0	0.0%
HCC's / 1,000	4.6	5.8	3.4	-42.3%	3.6	5.2	3.0	-41.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$202,775	$195,921	-3.4%	$246,453	$179,535	$201,553	12.3%	$0	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	20.6%	22.7%	10.2%	20.7%	17.3%	22.0%	27.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,218	$1,169	$1,106	-5.4%	$944	$1,036	$1,108	6.9%	$3,360	$2,928	$0	-100.0%
Facility Outpatient	$1,506	$1,832	$1,929	5.3%	$1,395	$1,693	$1,778	5.0%	$1,369	$4,817	$6,326	31.3%
Physician	$1,923	$2,541	$2,556	0.6%	$1,844	$2,461	$2,442	-0.8%	$3,030	$5,153	$4,050	-21.4%
Other	$148	$194	$203	4.6%	$127	$163	$163	0.0%	$427	$168	$801	376.8%
Total	$4,794	$5,736	$5,794	1.0%	$4,311	$5,352	$5,491	2.6%	$8,186	$13,066	$11,177	-14.5%
			Annualized				Annualized				Annualized	

Financial Summary – Prior Year Comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	599	588	578	-1.7%	181	148	129	-12.8%	
Avg # Members	826	807	791	-1.9%	227	188	165	-11.9%	
Ratio	1.4	1.4	1.4	0.0%	1.3	1.3	1.3	0.8%	1.8
Financial Summary									
Gross Cost	$7,418,807	$8,514,643	$3,710,234	-56.4%	$1,918,864	$975,672	$468,489	-52.0%	
Client Paid	$6,863,148	$7,803,114	$3,499,564	-55.2%	$1,763,370	$845,639	$422,121	-50.1%	
Employee Paid	$555,659	$711,529	$210,670	-70.4%	$155,495	$130,033	$46,368	-64.3%	
Client Paid-PEPY	$11,461	$13,272	$12,113	-8.7%	$9,769	$5,730	$6,561	14.5%	$6,209
Client Paid-PMPY	$8,313	$9,674	$8,848	-8.5%	$7,777	$4,508	$5,106	13.3%	$3,437
Client Paid-PEPM	$955	$1,106	$1,009	-8.8%	$814	$477	$547	14.7%	$517
Client Paid-PMPM	$693	$806	$737	-8.6%	$648	$376	$426	13.3%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	18	7	-61.1%	3	0	1	0.0%	
HCC's / 1,000	10.9	22.3	8.9	-60.3%	13.2	0.0	6.1	0.0%	
Avg HCC Paid	$339,256	$175,561	$131,142	-25.3%	$334,114	$0	$127,984	0.0%	
HCC's % of Plan Paid	44.5%	40.5%	26.2%	-35.3%	56.8%	0.0%	30.3%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,028	$2,529	$1,151	-54.5%	$3,554	$787	$831	5.6%	$1,057
Facility Outpatient	$2,243	$3,276	$3,520	7.4%	$2,477	$1,314	$1,198	-8.8%	$1,145
Physician	$2,713	$3,385	$3,637	7.4%	$1,587	$2,165	$2,633	21.6%	$1,122
Other	$328	$484	$540	11.6%	$158	$242	$444	83.5%	$113
Total	$8,313	$9,674	$8,848	-8.5%	$7,777	$4,508	$5,106	13.3%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,252,388	$ 573,417	$ 167,097	$ 5,992,901	$ 5,240,874	$ 551,033	$ 44,289	$ 5,836,196	-2.6%
Outpatient	$ 15,590,988	$ 1,829,887	$ 429,137	$ 17,850,012	$ 15,804,254	$ 2,616,412	$ 287,830	$ 18,708,497	4.8%
Total - Medical	**$ 20,843,376**	**$ 2,403,304**	**$ 596,234**	**$ 23,842,913**	**$ 21,045,129**	**$ 3,167,445**	**$ 332,119**	**$ 24,544,693**	**2.9%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 853	$ 794	$ 1,144	$ 852	$ 880	$ 1,061	$ 688	$ 896	5.2%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 22,498	$ 36,045	$ 25,860	$ 84,403	$ 1,391	$ 79,523	$ 37,565	$ 118,479	40.4%
Outpatient	$ 13,096	$ 261,312	$ 48,020	$ 322,427	$ 24,688	$ 242,668	$ 62,364	$ 329,720	2.3%
Total - Medical	**$ 35,593**	**$ 297,357**	**$ 73,880**	**$ 406,830**	**$ 26,079**	**$ 322,191**	**$ 99,929**	**$ 448,200**	**10.2%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,483	$ 489	$ 233	$ 429	$ 1,087	$ 731	$ 302	$ 563	31.3%

Paid Claims by Claim Type – Total

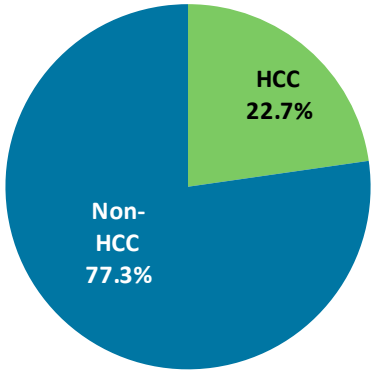
Net Paid Claims - Total Total Participants	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,274,885	$ 609,462	$ 192,957	$ 6,077,305	$ 5,242,265	$ 630,556	$ 81,854	$ 5,954,675	-2.0%
Outpatient	$ 15,604,084	$ 2,091,199	$ 477,156	$ 18,172,439	$ 15,828,943	$ 2,859,080	$ 350,194	$ 19,038,217	4.8%
Total - Medical	**$ 20,878,969**	**$ 2,700,661**	**$ 670,113**	**$ 24,249,744**	**$ 21,071,207**	**$ 3,489,636**	**$ 432,049**	**$ 24,992,892**	**3.1%**

Net Paid Claims - Per Participant per Month	2Q20				2Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 853	$ 743	$ 800	$ 838	$ 880	$ 1,019	$ 531	$ 887	5.9%

Cost Distribution – Medical Claims

2Q20							2Q21					
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
13	0.2%	$2,746,956	11.3%	$45,675	1.7%	$100,000.01 Plus	25	0.3%	$5,681,700	22.7%	($31,257)	-1.9%
36	0.4%	$2,530,493	10.4%	$151,023	5.5%	$50,000.01-$100,000.00	35	0.4%	$2,531,061	10.1%	$42,015	2.6%
105	1.2%	$3,738,843	15.4%	$228,042	8.3%	$25,000.01-$50,000.00	97	1.1%	$3,584,636	14.3%	$118,462	7.3%
344	3.9%	$5,501,828	22.7%	$441,304	16.1%	$10,000.01-$25,000.00	279	3.2%	$4,527,857	18.1%	$228,903	14.2%
402	4.6%	$2,957,706	12.2%	$411,946	15.0%	$5,000.01-$10,000.00	328	3.8%	$2,396,592	9.6%	$238,130	14.8%
690	7.8%	$2,474,881	10.2%	$481,384	17.5%	$2,500.01-$5,000.00	638	7.4%	$2,297,228	9.2%	$320,714	19.9%
5,801	65.8%	$4,299,037	17.7%	$981,193	35.8%	$0.01-$2,500.00	5,632	65.3%	$3,973,818	15.9%	$691,783	43.0%
25	0.3%	$0	0.0%	$8,071	0.3%	$0.00	26	0.3%	$0	0.0%	$4,032	0.2%
1,404	15.9%	$0	0.0%	$0	-0.1%	No Claims	1,567	18.2%	$0	0.0%	$0	0.0%
8,819	**100.0%**	**$24,249,744**	**100.0%**	**$2,748,639**	**100.0%**		**8,627**	**100.0%**	**$24,992,892**	**100.0%**	**$1,612,781**	**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 NEO) Neoplasms	11	$1,250,252	22.0%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	8	$889,787	15.7%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	14	$583,071	10.3%
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	12	$547,324	9.6%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	3	$360,840	6.4%
(CCS GEN) Diseases of the Genitourinary System	11	$344,371	6.1%
(CCS INF) Certain Infectious and Parasitic Diseases	10	$342,985	6.0%
(CCS DIG) Diseases of the Digestive System	12	$314,253	5.5%
(CCS CIR) Diseases of the Circulatory System	15	$310,845	5.5%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	12	$299,933	5.3%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	25	$189,359	3.3%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere	21	$93,277	1.6%
(CCS PRG) Pregnancy, Childbirth and the Puerperium	1	$53,460	0.9%
(CCS RSP) Diseases of the Respiratory System	11	$37,256	0.7%
(CCS NVS) Diseases of the Nervous System	12	$34,851	0.6%
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	8	$16,111	0.3%
(CCS EYE) Diseases of the Eye and Adnexa	6	$8,481	0.1%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	4	$3,590	0.1%
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalities	2	$1,369	0.0%
(CCS EAR) Diseases of the Ear and Mastoid Process	1	$209	0.0%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	2	$87	0.0%
Overall	**----**	**$5,681,709**	**100.0%**

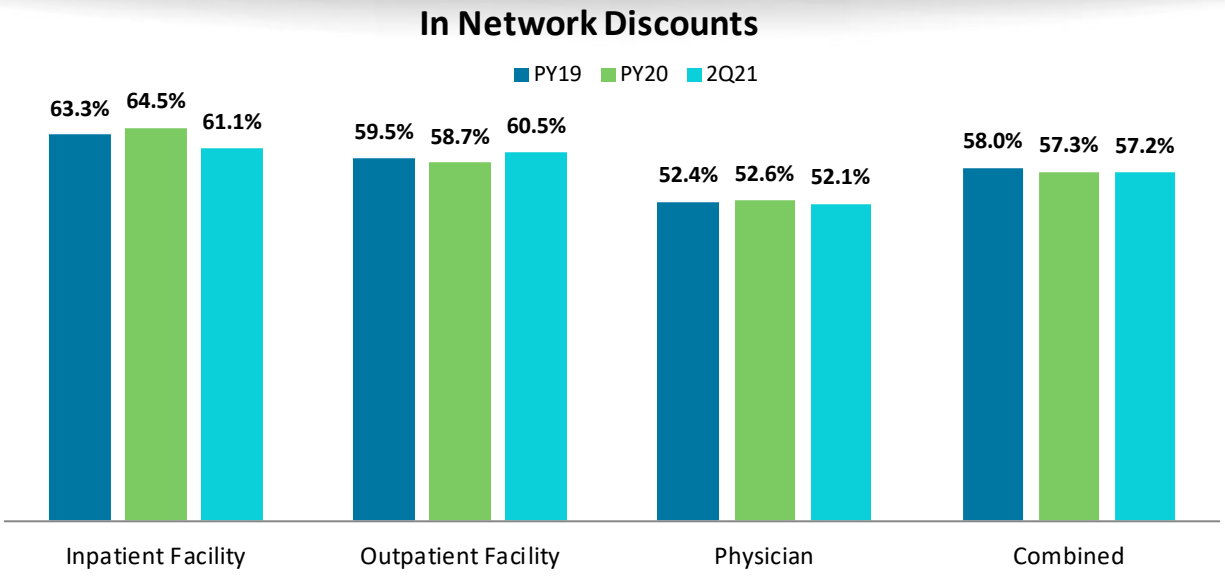
Utilization Summary (p. 1 of 2)

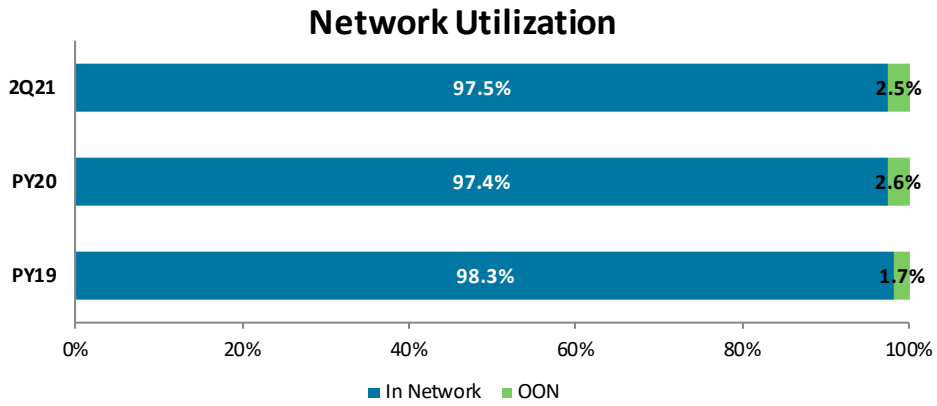
	Total				State Active				Non-State Active		
Summary	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**
Inpatient Facility											
# of Admits	507	372	301	-19.1%	441	319	267	-16.3%	1	1	0
# of Bed Days	2,491	1,722	1,513	-12.1%	2,026	1,492	1,200	-19.6%	2	2	0
Paid Per Admit	$20,394	$12,601	$16,338	29.7%	$15,930	$12,608	$16,252	28.9%	$16,801	$14,640	$0
Paid Per Day	$4,151	$2,722	$3,250	19.4%	$3,468	$2,696	$3,616	34.1%	$8,401	$7,320	$0
Admits Per 1,000	60	84	70	-16.7%	59	82	70	-14.6%	200	400	0
Days Per 1,000	293	391	351	-10.2%	272	382	313	-18.1%	400	800	0
Avg LOS	4.9	4.6	5	8.7%	4.6	4.7	4.5	-4.3%	2.0	2.0	0.0
Physician Office											
OV Utilization per Member	4.4	5.4	4.8	-11.1%	4.2	5.2	4.6	-11.5%	5.6	8.0	6.9
Avg Paid per OV	$94	$101	$102	1.0%	$95	$103	$104	1.0%	$105	$97	$87
Avg OV Paid per Member	$410	$546	$488	-10.6%	$402	$535	$474	-11.4%	$587	$775	$594
DX&L Utilization per Member	8.9	11.1	10.3	-7.2%	8.4	10.5	9.8	-6.7%	14	20	12.9
Avg Paid per DX&L	$78	$71	$78	9.9%	$75	$72	$77	6.9%	$106	$107	$82
Avg DX&L Paid per Member	$690	$784	$805	2.7%	$629	$755	$757	0.3%	$1,491	$2,141	$1,052
Emergency Room											
# of Visits	1,453	993	786	-20.8%	1,261	849	691	-18.6%	0	1	1
# of Admits	192	150	105	-30.0%	154	115	82	-28.7%	0	0	0
Visits Per Member	0.17	0.23	0.18	-21.7%	0.17	0.22	0.18	-18.2%	0.00	0.40	0.43
Visits Per 1,000	171	225	182	-19.1%	169	217	180	-17.1%	0	400	429
Avg Paid per Visit	$2,608	$2,620	$2,576	-1.7%	$2,546	$2,715	$2,522	-7.1%	$0	$3,495	$391
Admits Per Visit	0.13	0.15	0.13	-13.3%	0.12	0.14	0.12	-14.3%	0.00	0.00	0.00
Urgent Care											
# of Visits	2,450	1,565	1,091	-30.3%	2,232	1,437	985	-31.5%	0	0	0
Visits Per Member	0.29	0.35	0.25	-28.6%	0.30	0.37	0.26	-29.7%	0.00	0.00	0.00
Visits Per 1,000	288	355	253	-28.7%	300	368	257	-30.2%	0	0	0
Avg Paid per Visit	$140	$160	$180	12.5%	$140	$162	$181	11.7%	$0	$0	$0
		Annualized	Annualized			Annualized	Annualized			Annualized	Annualized

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**PY19**	**2Q20**	**2Q21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	52	47	29	-38.3%	13	5	5	0.0%	
# of Bed Days	361	215	192	-10.7%	102	13	121	830.8%	
Paid Per Admit	$47,923	$12,883	$15,473	20.1%	$61,977	$9,066	$25,926	186.0%	$16,173
Paid Per Day	$6,903	$2,816	$2,337	-17.0%	$7,899	$3,487	$1,071	-69.3%	$3,708
Admits Per 1,000	63	116	73	-37.1%	57	51	60	17.6%	61
Days Per 1,000	437	530	485	-8.5%	450	133	1,464	1000.8%	264
Avg LOS	6.9	4.6	6.6	43.5%	7.8	2.6	24.2	830.8%	4.3
Physician Office									
OV Utilization per Member	5.6	7.3	6.7	-8.2%	5.0	6.8	6.4	-5.9%	3.3
Avg Paid per OV	$85	$89	$92	3.4%	$86	$78	$81	3.8%	$50
Avg OV Paid per Member	$473	$650	$618	-4.9%	$431	$533	$515	-3.4%	$167
DX&L Utilization per Member	12.1	15.9	14.8	-6.9%	12.2	14.7	11.6	-21.1%	8.3
Avg Paid per DX&L	$88	$64	$86	34.4%	$104	$64	$68	6.3%	$67
Avg DX&L Paid per Member	$1,069	$1,017	$1,271	25.0%	$1,274	$938	$791	-15.7%	$554
Emergency Room									
# of Visits	158	128	83	-35.2%	94	15	11	-26.7%	
# of Admits	30	32	20	-37.5%	8	3	3	0.0%	
Visits Per Member	0.19	0.32	0.21	-34.4%	0.41	0.15	0.13	-13.3%	0.17
Visits Per 1,000	191	316	210	-33.5%	415	154	133	-13.6%	174
Avg Paid per Visit	$2,991	$2,119	$3,157	49.0%	$1,195	$1,415	$1,799	27.1%	$1,684
Admits Per Visit	0.19	0.25	0.24	-4.0%	0.09	0.20	0.27	35.0%	0.14
Urgent Care									
# of Visits	158	88	88	0.0%	60	40	18	-55.0%	
Visits Per Member	0.19	0.22	0.22	0.0%	0.26	0.41	0.22	-46.3%	0.24
Visits Per 1,000	191	217	223	2.8%	265	410	218	-46.8%	242
Avg Paid per Visit	$154	$169	$179	5.9%	$96	$103	$157	52.4%	$74
		Annualized	Annualized			Annualized	Annualized		

Provider Network Summary



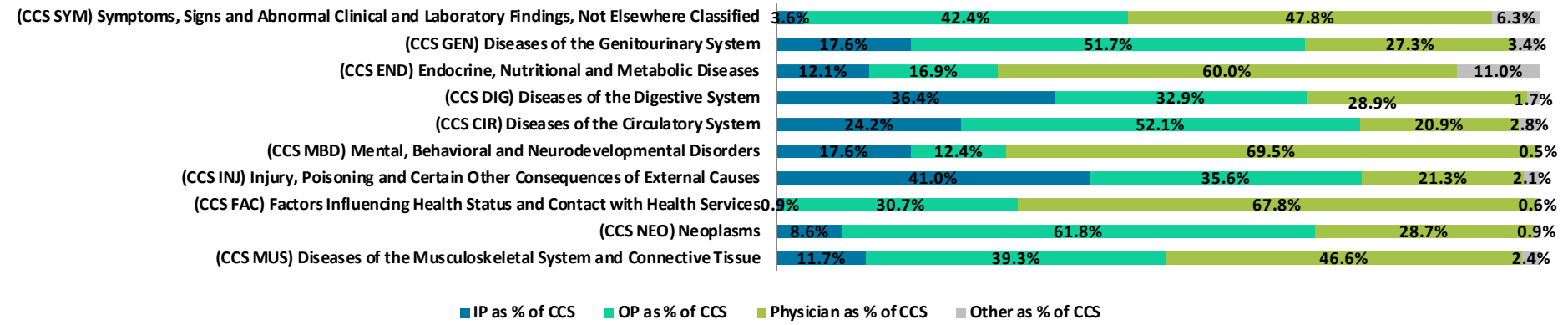


AHRQ* Clinical Classifications Summary

*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.

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$3,493,090	14.0%	$2,574,898	$724,472	$193,720	$1,306,741	$2,186,349
(CCS NEO) Neoplasms	$2,558,070	10.2%	$2,061,043	$469,152	$27,875	$936,066	$1,622,004
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$2,129,455	8.5%	$1,281,432	$211,586	$636,438	$729,917	$1,399,538
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$1,712,949	6.9%	$1,134,299	$308,172	$270,478	$689,754	$1,023,195
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$1,704,903	6.8%	$880,458	$181,272	$643,173	$530,055	$1,174,848
(CCS CIR) Diseases of the Circulatory System	$1,639,362	6.6%	$1,259,596	$350,497	$29,269	$781,050	$858,312
(CCS DIG) Diseases of the Digestive System	$1,459,624	5.8%	$1,113,036	$219,038	$127,551	$840,319	$619,306
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$1,441,592	5.8%	$1,127,706	$221,559	$92,327	$461,958	$979,634
(CCS GEN) Diseases of the Genitourinary System	$1,364,066	5.5%	$835,510	$185,424	$343,131	$561,468	$802,598
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$1,311,013	5.2%	$817,060	$237,031	$256,922	$531,935	$779,078
(CCS NVS) Diseases of the Nervous System	$1,006,826	4.0%	$702,271	$209,594	$94,961	$463,700	$543,127
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$971,283	3.9%	$491,227	$477,104	$2,953	$429,051	$542,232
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$899,502	3.6%	$665,900	$158,232	$75,370	$0	$899,502
(CCS INF) Certain Infectious and Parasitic Diseases	$845,243	3.4%	$633,221	$150,912	$61,110	$301,917	$543,326
(CCS RSP) Diseases of the Respiratory System	$731,591	2.9%	$451,262	$63,211	$217,118	$305,194	$426,397
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$568,749	2.3%	$4,185	$791	$563,773	$73,359	$495,390
(CCS EYE) Diseases of the Eye and Adnexa	$507,981	2.0%	$372,916	$58,836	$76,228	$166,928	$341,052
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$345,297	1.4%	$198,893	$66,700	$79,704	$154,598	$190,699
(CCS EAR) Diseases of the Ear and Mastoid Process	$156,156	0.6%	$107,022	$13,034	$36,100	$60,709	$95,447
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormaliti	$114,668	0.5%	$14,868	$7,482	$92,318	$75,801	$38,866
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$31,351	0.1%	$20,045	$3,107	$8,199	$8,120	$23,232
(CCS EXT) External Causes of Morbidity	$122	0.0%	$0	$122	$0	$122	$0
Total	**$24,992,892**	**100.0%**	**$16,746,847**	**$4,317,328**	**$3,928,717**	**$9,408,760**	**$15,584,132**

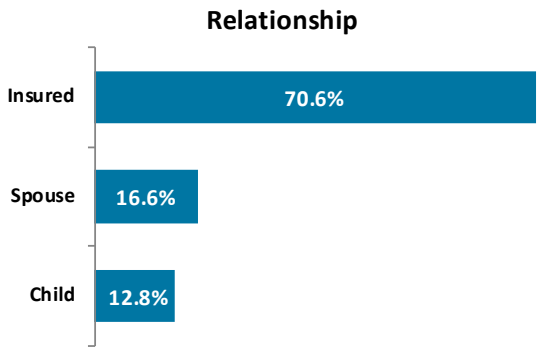
Top 10 Categories by Claim Type

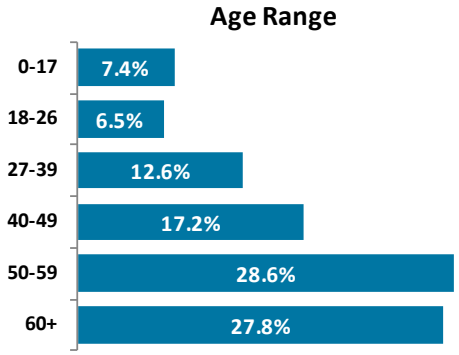


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylopathies/Spondyloarthropathy (Including Infective)	645	3,147	$1,255,252	35.9%
Osteoarthritis	273	806	$509,700	14.6%
Musculoskeletal Pain, Not Low Back Pain	1,038	3,657	$478,749	13.7%
Tendon And Synovial Disorders	175	546	$169,074	4.8%
Other Specified Connective Tissue Disease	293	750	$129,185	3.7%
Acquired Foot Deformities	52	169	$127,747	3.7%
Infective Arthritis	3	40	$115,234	3.3%
Scoliosis And Other Postural Dorsopathic Deformities	27	79	$106,044	3.0%
Other Specified Joint Disorders	119	300	$96,259	2.8%
Low Back Pain	295	1,287	$95,616	2.7%
Systemic Lupus Erythematosus And Connective Tissue Disorders	45	176	$67,619	1.9%
Osteomyelitis	7	46	$59,313	1.7%
Postprocedural Or Postoperative Musculoskeletal System Complication	29	168	$56,496	1.6%
Osteoporosis	35	59	$49,337	1.4%
Disorders Of Jaw	17	62	$47,109	1.3%
Rheumatoid Arthritis And Related Disease	69	183	$43,284	1.2%
Biomechanical Lesions	258	989	$25,349	0.7%
Other Specified Bone Disease And Musculoskeletal Deformities	55	106	$24,008	0.7%
Muscle Disorders	27	44	$20,620	0.6%
Gout	35	56	$6,077	0.2%
Acquired Deformities (Excluding Foot)	12	23	$5,022	0.1%
Neurogenic/Neuropathic Arthropathy	2	24	$3,231	0.1%
Stress Fracture, Initial Encounter	8	13	$772	0.0%
Aseptic Necrosis And Osteonecrosis	1	1	$719	0.0%
Pathological Fracture, Initial Encounter	1	1	$538	0.0%
Pathological, Stress And Atypical Fractures, Sequela	1	3	$349	0.0%
Pathological Fracture, Subsequent Encounter	1	1	$140	0.0%
Immune-Mediated/Reactive Arthropathies	1	1	$105	0.0%
Juvenile Arthritis	1	7	$63	0.0%
Stress Fracture, Subsequent Encounter	1	1	$62	0.0%
Traumatic Arthropathy	1	1	$19	0.0%
	----	----	$3,493,090	100.0%

*Patient and claim counts are unique only within the category

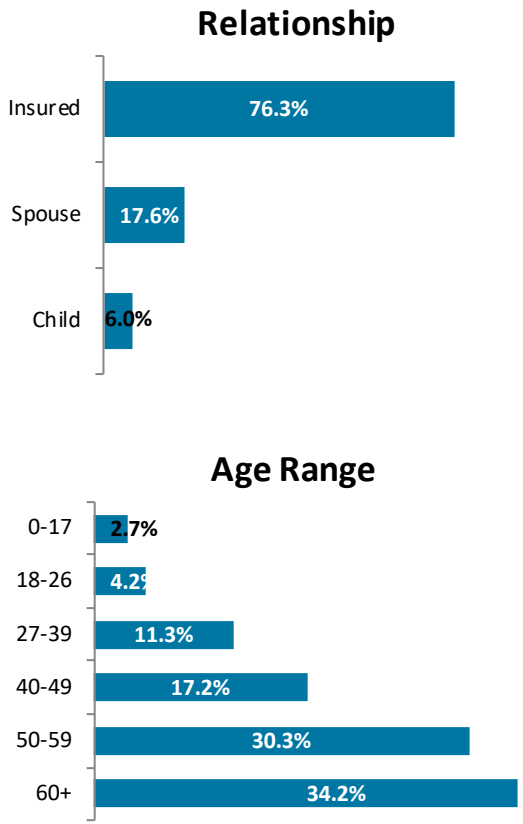




AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Breast Cancer - All Other Types	41	376	$821,164	32.1%
Benign Neoplasms	358	614	$408,719	16.0%
Respiratory Cancers	3	78	$175,484	6.9%
Skin Cancers - All Other Types	16	39	$157,820	6.2%
Nervous System Cancers - Brain	2	38	$126,556	4.9%
Myelodysplastic Syndrome (Mds)	4	76	$119,056	4.7%
Secondary Malignancies	7	15	$112,496	4.4%
Male Reproductive System Cancers - Prostate	23	166	$95,948	3.8%
Sarcoma	3	21	$91,251	3.6%
Female Reproductive System Cancers - Endometrium	2	20	$77,116	3.0%
Leukemia - Acute Myeloid Leukemia (Aml)	1	157	$53,727	2.1%
Neoplasms Of Unspecified Nature Or Uncertain Behavior	306	416	$51,897	2.0%
Multiple Myeloma	4	45	$46,031	1.8%
Head And Neck Cancers - Lip And Oral Cavity	1	14	$34,170	1.3%
Skin Cancers - Basal Cell Carcinoma	48	103	$34,126	1.3%
Female Reproductive System Cancers - Cervix	8	24	$24,569	1.0%
Gastrointestinal Cancers - Colorectal	10	60	$16,313	0.6%
Male Reproductive System Cancers - Testis	2	13	$13,795	0.5%
Leukemia - Chronic Lymphocytic Leukemia (Cll)	7	41	$13,654	0.5%
Gastrointestinal Cancers - Peritoneum	1	15	$11,745	0.5%
Leukemia - All Other Types	3	13	$10,811	0.4%
Head And Neck Cancers - Throat	1	22	$10,405	0.4%
Non-Hodgkin Lymphoma	7	32	$9,941	0.4%
Female Reproductive System Cancers - Vulva	1	5	$8,084	0.3%
Skin Cancers - Squamous Cell Carcinoma	15	27	$7,058	0.3%
Skin Cancers - Melanoma	9	35	$6,170	0.2%
Endocrine System Cancers - Thyroid	13	41	$6,131	0.2%
Gastrointestinal Cancers - Bile Duct	1	17	$4,448	0.2%
Head And Neck Cancers - Tonsils	1	2	$1,868	0.1%
Hodgkin Lymphoma	4	13	$1,787	0.1%
All Others	21	48	$5,728	0.2%
Overall	**----**	**----**	**$2,558,070**	**100.0%**

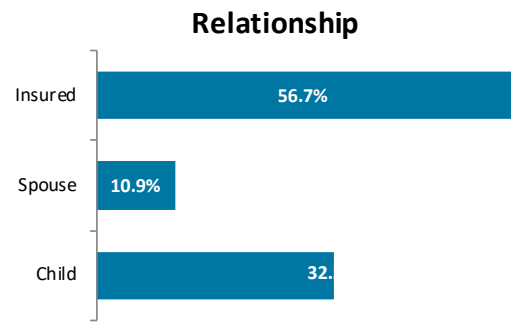
*Patient and claim counts are unique only within the category

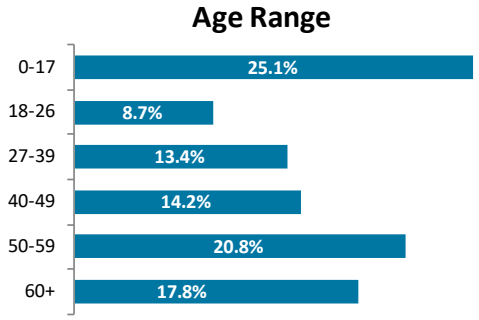


AHRQ Category – Factors Inf Health Status & Contact with Health Services

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Medical Examination/Evaluation	2,527	4,307	$574,090	27.0%
Exposure, Encounters, Screening Or Contact With Infectious Disease	3,137	5,029	$525,411	24.7%
Neoplasm-Related Encounters	963	2,046	$339,992	16.0%
Encounter For Antineoplastic Therapies	11	51	$155,414	7.3%
Contraceptive And Procreative Management	233	369	$118,952	5.6%
Other Aftercare Encounter	168	404	$102,874	4.8%
Implant, Device Or Graft Related Encounter	126	226	$98,717	4.6%
Personal/Family History Of Disease	174	302	$64,868	3.0%
Other Specified Status	298	549	$45,848	2.2%
Encounter For Prophylactic Or Other Procedures	35	55	$43,135	2.0%
Encounter For Observation And Examination For Conditions Ruled Out (Excl	373	486	$22,229	1.0%
Other Specified Encounters And Counseling	80	223	$16,917	0.8%
Acquired Absence Of Limb Or Organ	13	18	$9,333	0.4%
Organ Transplant Status	13	55	$4,243	0.2%
Lifestyle/Life Management Factors	17	33	$2,539	0.1%
Encounter For Administrative Purposes	16	19	$1,457	0.1%
Socioeconomic/Psychosocial Factors	6	23	$1,410	0.1%
Encounter For Prophylactic Measures (Excludes Immunization)	7	11	$1,057	0.0%
Encounter For Mental Health Conditions	7	10	$603	0.0%
Screening For Neurocognitive Or Neurodevelopmental Condition	4	4	$266	0.0%
Carrier Status	2	2	$75	0.0%
No Immunization Or Underimmunization	1	1	$27	0.0%
Overall	**----**	**----**	**$2,129,455**	**100.0%**

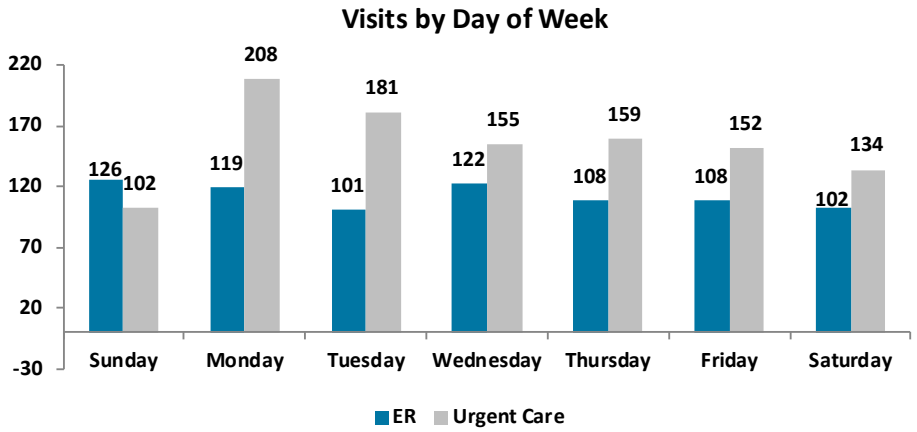
*Patient and claim counts are unique only within the category

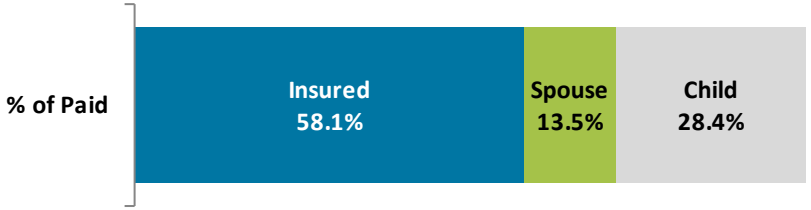




Emergency Room / Urgent Care Summary

	2Q20		2Q21		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	993	1,565	756	1,091		
Number of Admits	150	----	105	----		
Visits Per Member	0.23	0.35	0.18	0.25	0.17	0.24
Visits/1000 Members	225	355	182	253	174	242
Avg Paid Per Visit	$2,620	$160	$2,575	$180	$1,684	$74
Admits per Visit	0.15	----	0.13	----	0.14	
% of Visits with HSB ER Dx	79.2%	----	81.4%	----		
% of Visits with a Physician OV*	83.6%	81.7%	87.0%	83.0%		
Total Plan Paid	**$2,568,193**	**$251,114**	**$2,023,850**	**$196,489**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



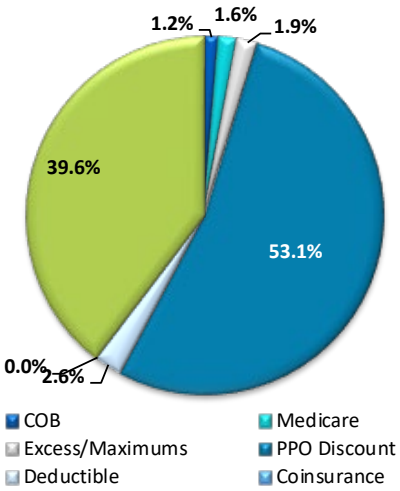


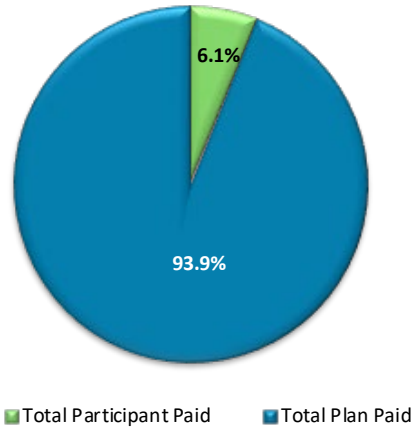
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	452	96	639	136	1,091	232
Spouse	121	130	132	142	253	271
Child	213	71	320	107	533	178
Total	**786**	**91**	**1,091**	**126**	**1,877**	**218**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$63,105,010	$2,240	100.0%
COB	$739,710	$26	1.2%
Medicare	$1,039,640	$37	1.6%
Excess/Maximums	$1,198,792	$43	1.9%
PPO Discount	$33,521,195	$1,190	53.1%
Deductible	$1,612,781	$57	2.6%
Coinsurance	$0	$0	0.0%
Total Participant Paid	**$1,612,781**	**$57**	**2.6%**
Total Plan Paid	**$24,992,892**	**$887**	**39.6%**

Total Participant Paid - PY20	**$91**
Total Plan Paid - PY20	**$874**





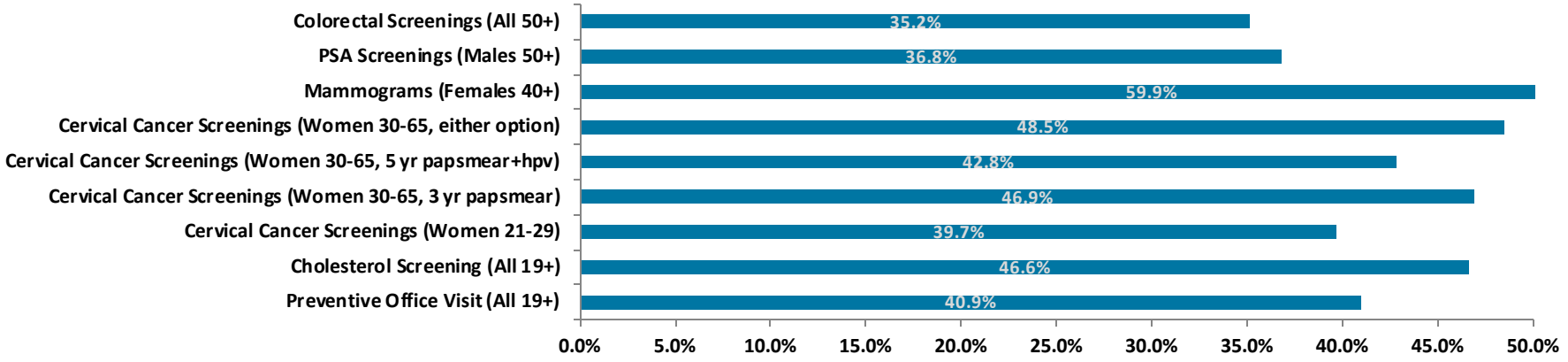
Preventive Services Compliance

*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+)	3,699	1,816	49.1%	2,767	830	30.0%	6,466	2,646	40.9%
Cholesterol Screening (All 19+)	3,699	1,798	48.6%	2,767	1,217	44.0%	6,466	3,015	46.6%
Cervical Cancer Screenings (Women 21-29)	469	186	39.7%	----	----	----	469	186	39.7%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,909	1,364	46.9%	----	----	----	2,909	1,364	46.9%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,909	1,245	42.8%	----	----	----	2,909	1,245	42.8%
Cervical Cancer Screenings (Women 30-65, either option)	2,909	1,411	48.5%	----	----	----	2,909	1,411	48.5%
Mammograms (Females 40+)	2,445	1,465	59.9%	----	----	----	2,445	1,465	59.9%
PSA Screenings (Males 50+)	----	----	----	1,347	496	36.8%	1,347	496	36.8%
Colorectal Screenings (All 50+)	1,739	643	37.0%	1,347	442	32.8%	3,086	1,085	35.2%

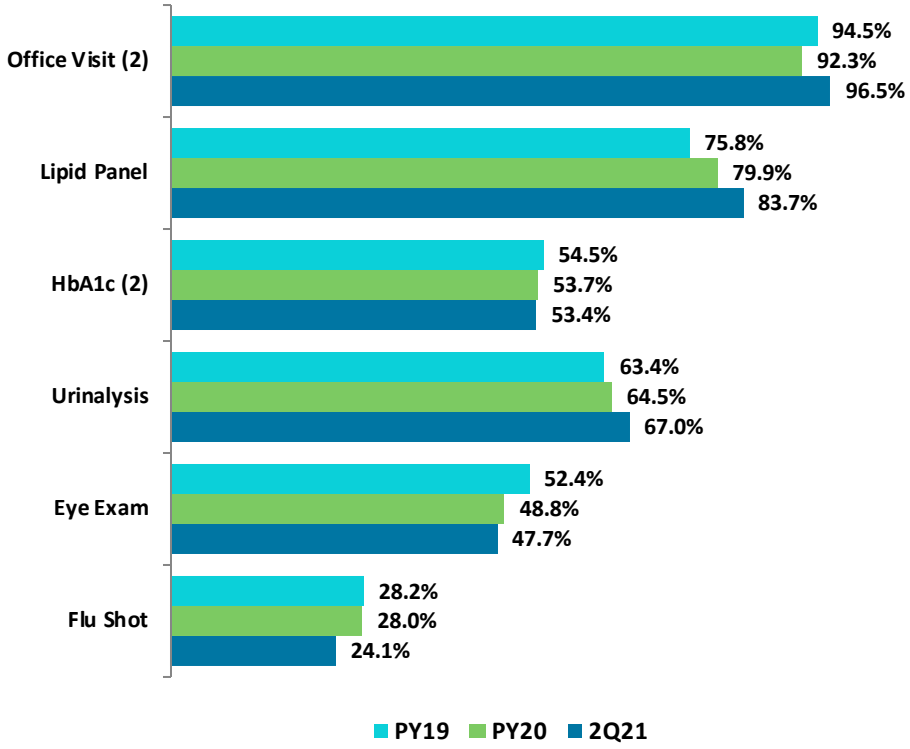
Overall Preventive Services Compliance Rates



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	PY19	PY20	2Q21
Members	525	569	539

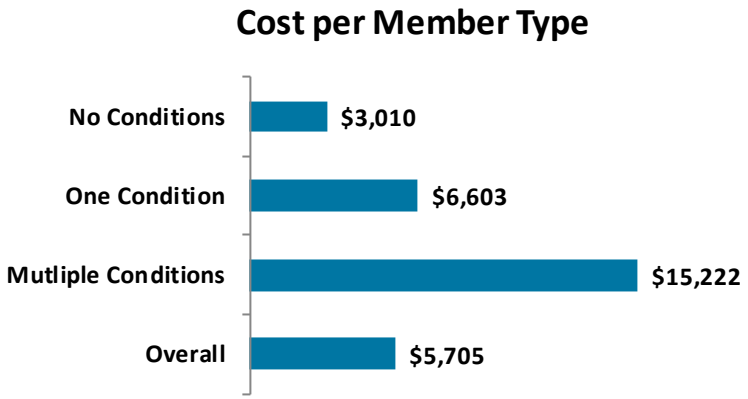


Chronic Conditions Summary

*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	382	367	44	39	$3,438,138	$9,000	99.7%	1 Office Visit
Cancer	260	248	30	57	$6,708,394	$25,802	----	----
Chronic Kidney Disease	67	64	8	58	$1,545,836	$23,072	----	----
Chronic Obstructive Pulmonary Disease (COPD)	69	66	8	59	$1,860,709	$26,967	100.0%	1 Office Visit
Congestive Heart Failure (CHF)	40	38	5	62	$1,383,452	$34,586	15.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	129	122	15	61	$3,501,882	$27,146	22.5%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	617	579	71	40	$6,009,713	$9,740	96.9%	1 Office Visit
Diabetes	539	513	62	55	$6,075,108	$11,271	20.6%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	685	656	79	54	$6,769,042	$9,882	33.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	780	744	90	57	$9,580,523	$12,283	27.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	253	243	29	46	$2,868,601	$11,338	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	5,241	30	41.3%	10.0%	48.7%
One Condition	2,154	46	70.4%	14.2%	15.4%
Multiple Conditions	1,281	54	80.5%	15.4%	4.1%
Overall	**8,676**	**37**	**53.5%**	**11.7%**	**34.8%**



Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending December 31, 2020

Express Scripts

Membership Summary	2Q FY2021 EPO	2Q FY2020 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,629	8,821	(192)	-2.2%
Utilizing Member Count (Patients)	6,094	6,512	(418)	-6.4%
Percent Utilizing (Utilization)	70.6%	73.8%	(0)	-4.3%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	85,478	86,807	(1,329)	-1.5%
Claims per Elig Member per Month (Claims PMPM)	1.65	1.64	0.01	0.6%
Total Claims for Generic (Generic Rx)	72,783	74,516	(1,733.00)	-2.3%
Total Claims for Brand (Brand Rx)	12,695	12,291	404.00	3.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	1,356	1,423	(67.00)	-4.7%
Total Non-Specialty Claims	84,341	85,669	(1,328.00)	-1.6%
Total Specialty Claims	1,137	1,138	(1.00)	-0.1%
Generic % of Total Claims (GFR)	**85.1%**	**85.8%**	(0.01)	-0.8%
Generic Effective Rate (GCR)	**98.2%**	**98.1%**	0.00	0.0%
Mail Order Claims	9,725	8,515	1,210.00	14.2%
Mail Penetration Rate*	12.5%	11.0%	0.02	1.5%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$10,863,329.00	$9,811,925.00	$1,051,404.00	10.7%
Total Generic Gross Cost	$1,693,364.00	$1,730,624.00	($37,260.00)	-2.2%
Total Brand Gross Cost	$9,169,965.00	$8,081,301.00	$1,088,664.00	13.5%
Total MSB Gross Cost	$330,637.00	$317,128.00	$13,509.00	4.3%
Total Ingredient Cost	$10,881,308.00	$9,760,402.00	$1,120,906.00	11.5%
Total Dispensing Fee	$49,353.00	$49,779.00	($426.00)	-0.9%
Total Other (e.g. tax)	$2,668.00	$1,744.00	$924.00	53.0%
Avg Total Cost per Claim (Gross Cost/Rx)	**$127.09**	**$113.03**	$14.06	12.4%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.27	$23.22	$0.05	0.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$722.33	$657.50	$64.83	9.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$243.83	$222.86	$20.97	9.4%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,797,795.00**	**$1,518,660.00**	$279,135.00	18.4%
Total Copay	$1,797,795.00	$1,518,660.00	$279,135.00	18.4%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$21.03	$17.49	$3.54	20.2%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.03**	**$17.49**	**$3.54**	**20.2%**
Avg Copay for Generic (Copay/Generic Rx)	$7.49	$7.33	$0.16	2.2%
Avg Copay for Brand (Copay/Brand Rx)	$98.68	$79.11	$19.57	24.7%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$31.70	$28.49	$3.21	11.3%
Net PMPM (Participant Cost PMPM)	**$34.72**	**$28.69**	$6.03	21.0%
Copay % of Total Prescription Cost (Member Cost Share %)	16.5%	15.5%	1.1%	6.9%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$9,065,534.00**	**$8,293,265.00**	**$772,269.00**	**9.3%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,430,982.00	$3,904,990.00	$525,992.00	13.5%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,634,552.00	$4,388,275.00	$246,277.00	5.6%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$106.06**	**$95.54**	$10.52	11.0%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.78	$15.89	($0.11)	-0.7%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$623.65	$578.39	$45.26	7.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$212.14	$194.37	$17.77	9.1%
Net PMPM (Plan Cost PMPM)	**$175.10**	**$156.70**	**$18.40**	**11.7%**
PMPM for Specialty Only (Specialty PMPM)	$89.52	$82.91	$6.61	8.0%
PMPM without Specialty (Non-Specialty PMPM)	$85.58	$73.78	$11.80	16.0%
Rebates (Q1-Q2 FY2021 actual)	$2,052,634.70	$1,803,627.72	**$249,006.98**	**13.8%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$135.45**	**$122.62**	**$12.83**	**10.5%**
PMPM for Specialty Only (Specialty PMPM)	$76.58	$71.28	$5.30	7.4%
PMPM without Specialty (Non-Specialty PMPM)	$59.40	$48.91	$10.49	21.4%

Appendix C

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2020 – December 31, 2020

KEY PERFORMANCE INDICATORS

PRESCRIPTION DRUG COSTS

Power Of Partnership.

Quarterly Health Plan Performance Review
Prepared for PEBP
Claims Data:
July 1, 2020 – December, 2020 – Current
July 1, 2019 – December, 2019 – Prior
Paid through Jan 2021 **30 day claims run out*

State of Nevada

Key Performance Indicators

Includes Demographics And Financials

39 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

- ✓ 45 OptumCare locations and expanding
- ✓ Over 450 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares with home waiting room option
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 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

- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Launched new HPN App
- ✓ Continued expansion of specialty network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication
- ✓ NV Orthopedic and Spine Center's Fast Track Clinic for patients with acute injuries

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Age	Famiy size	Dependents <18	HHS Risk
Members: 6,816 Employees: 3,919	37.2	1.74	22.5%	1.78
Prior: 6,858 3,949	Prior : 37.3	Prior : 1.73	Prior: 22.3%	Prior: 1.75
	Norm: 36.2	Norm: 1.76	Norm: 20.4	Norm: 1.27
-0.8%	-0.3%	0.2%	1.0%	1.6%

Medical and Rx Spend

5.7%

Medical PMPM
$343.51

Prior $325.12
Norm: $289.33

Utilization

Inpatient: ▼ -21.8%
Outpatient: ▼ -4.8%
Professional: ▼ -5.3%

Spend

Inpatient: ▲ 2.6%
Outpatient: ▲ 3.0%
Professional: ▲ 16.0%

6.1%

Overall PMPM
$475.36

Prior: $448.22
Norm: $380.42

5.7%
Specialty Rx
$66.01

Prior: $62.46
Norm: $43.25

-1.9%
Avg. Scripts PMPY
17.3

Prior: 17.6
Norm: 11.3

7.1%

Rx PMPM
$131.86

Specialty Rx accounts for 50.1% of Rx Spend

Prior: $123.10
Norm: $91.09

Medical and Rx Plan Experience

What Happened

Medical Utilization Summary

UnitedHealthcare

Utilization Metric	Prior	Current	Δ
Physician Office Visits PMPY	2.4	2.3	-4.7%
Specialist Office Visits PMPY	4.7	4.0	-15.3%
ER Visits per K	60.5	43.7	-27.7%
Urgent Care Visits per K	305.9	291.2	-4.8%
OutPatient Surgery			
ASC	66.6	55.3	-17.0%
Facility	18.8	17.0	-9.5%
Inpatient Utilization			
Admissions Per K	34.2	31.0	-9.2%
Bed Days Per K	147.0	153.8	4.6%
Average Length of Stay	4.3	5.0	15.2%
On Demand			
Now Clinic Visits	240	635	164.6%
TAN Calls	252	495	96.4%

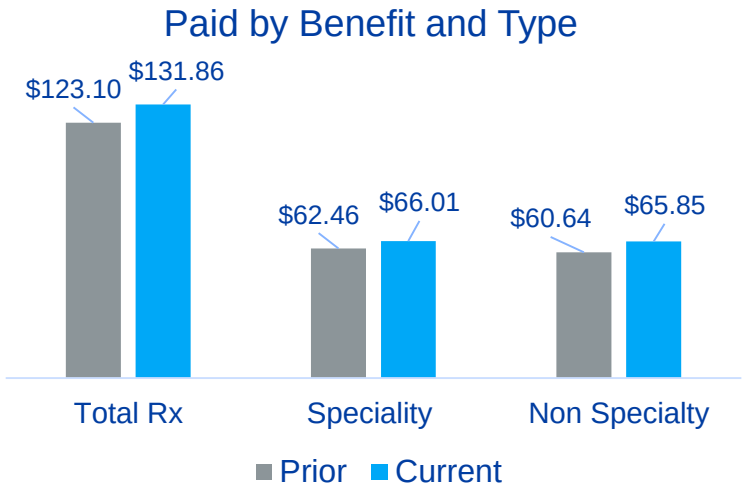
*Not representative of all Utilization

Highlights

- PCP and Specialist visits both decreased from the prior period on a PMPY basis
- ER utilization decreased **-27.7%**,
  - Average Net Paid / Visit increased 22.2% with more complex ER admits
- Urgent Care Utilization decreased **-4.8%**
- Outpatient surgeries decreased at both facility and ASC settings
- Admits Per K decreased -9.2**%** from prior period, but average length of stay increased
- Increased Telehealth Utilization
  - We will continue to see increases in these services as a result of COVID-19
  - *On Demand utilization is understated due to claims lag*

Pharmacy Data

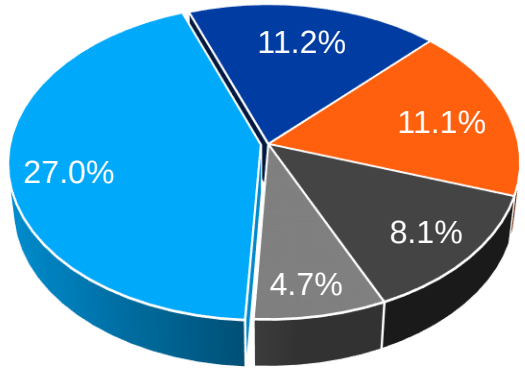
	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,858	6,816	-0.6%		
Average Prescriptions PMPY	17.6	17.3	-1.9%	11.3	52.8%
Formulary Rate	92.5%	91.7%	-0.8%	90.8%	1.1%
Generic Use Rate	86.6%	85.4%	-1.4%	85.4%	0.0%
Generic Substitution Rate	97.4%	97.2%	-0.1%	96.9%	0.4%
Employee Cost Share PMPM	$18.15	$21.68	19.4%	$11.60	86.9%
Avg Net Paid per Prescription	$83.78	$91.51	9.2%	$96.59	-5.3%
Net Paid PMPM	$123.10	$131.86	7.1%	$91.09	44.8%



Pharmacy PMPM trend is 7.1%

- Average net paid per script increased **9.2%**
- Dermatologic utilization increased 4.4%, but spend jumped >100% due to Specialty Rx Stelara
- Antidiabetic spend increased 15.1% YOY, Jardiance, Trulicity and Ozempic are cost drivers in this Therapeutic Class
- Antivirals increased 17.5% in spend on a PMPM basis. Biktarvy (HIV) Rx saw an increase >100% in both spend and utilization

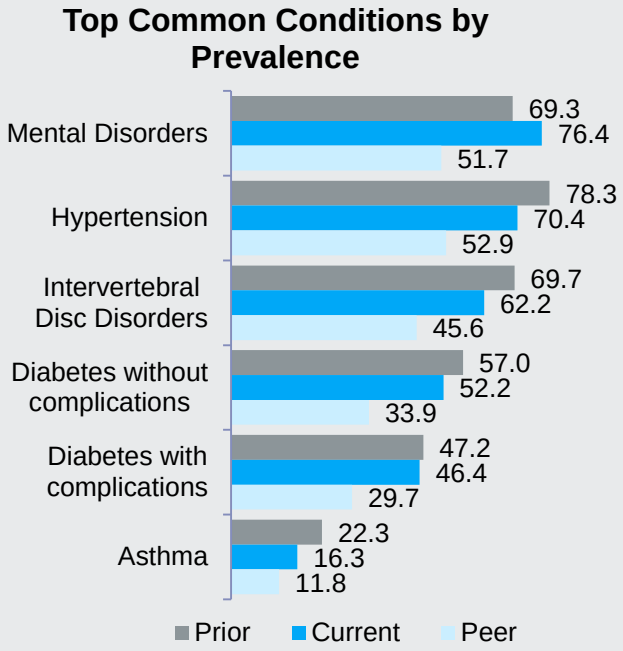
Top 5 Therapuetic Classes by Spend

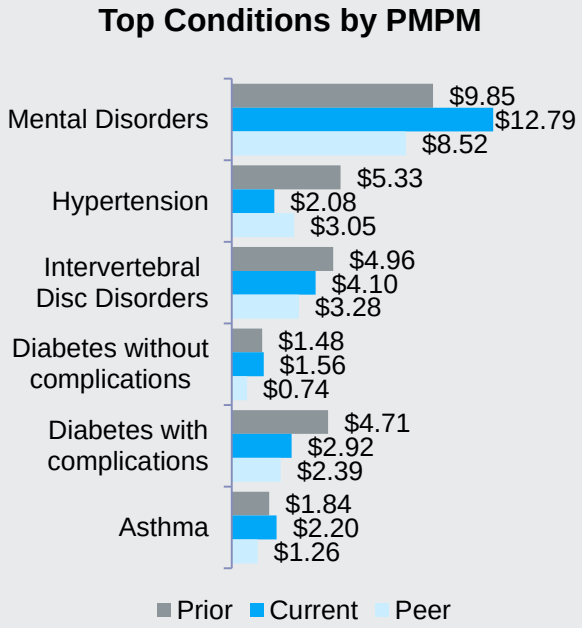


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis



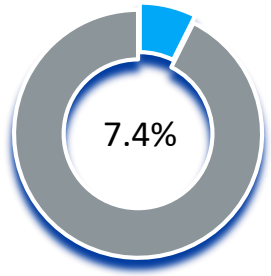
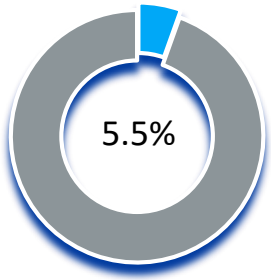
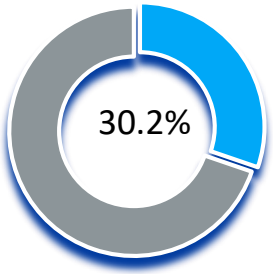
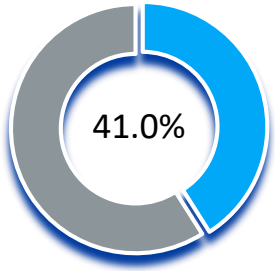


- Mental Disorders, Hypertension and Intervertebral Disc Disorder are the most prevalent clinical conditions within this population
- Prevalence (up 10.4%) and Spend (up 29.9%) for Mental Disorders. Autism and Alcohol related disorders driving spend
- Diabetes with and without complications decreased in prevalence from the prior period

Chronic Condition Cost Drivers

UnitedHealthcare

84% Of Medical spend driven by members with these 4 Chronic Conditions

CAD	COPD	Cancer	Diabetes
1.9% of Members	1.8% of Members	13.3% of Members	21.6% of Members
			
Average paid Per Claimant **$16,358**	Average paid Per Claimant **$12,959**	Average paid Per Claimant **$9,502**	Average paid Per Claimant **$7,950**
Member Engagement **98.4%**	Member Engagement **93.3%**	Member Engagement **99.0%**	Member Engagement **94.5%**

**Data obtained for this slide is for Eval period Feb-2020 thru Jan-2021*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

5.29 Catastrophic Cases Per 1000

Prior: 5.15 ▲ 2.8%

38 Individuals
.53% of the population

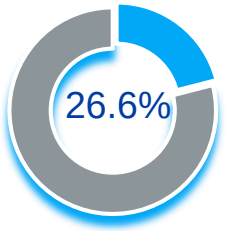
$100,594
Average Paid Per Case

Prior: $88,995 ▲ 13.0%

% of Total Spend as High Cost
19.7%

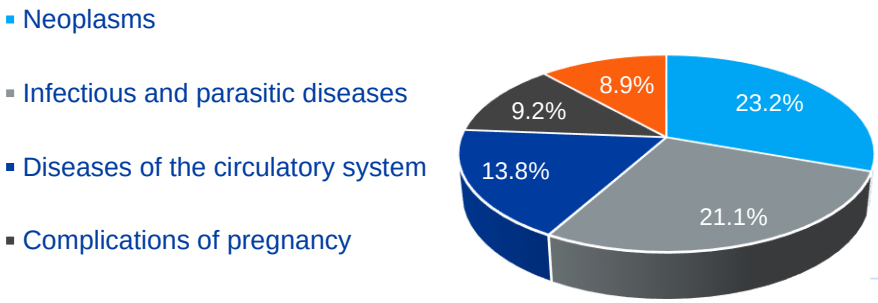
% Paid Attributed to Catastrophic Cases

Medical

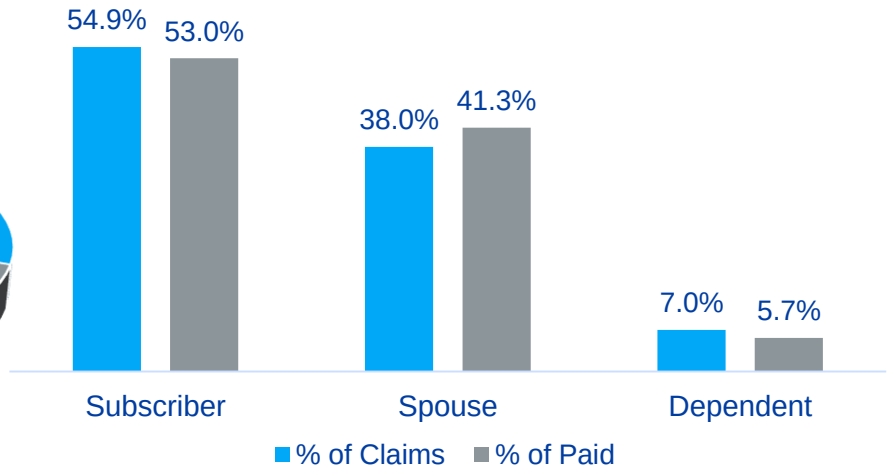


Pharmacy

Top 5 AHRQ Chapter Description by Spend



Claims and Spend by Relationship



4.4

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

4.4.1 HealthSCOPE Benefits – Obesity Care Management

4.4.2 HealthSCOPE Benefits – Diabetes Care Management

4.4.3 American Health Holdings – Utilization and Large Case Management

4.4.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report Q2 2021

4.4.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.4.7 HealthPlan of Nevada, Inc. – Southern HMO

4.4.8 Doctor on Demand Engagement Reports through December, 2020

4.4.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

        4.4.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

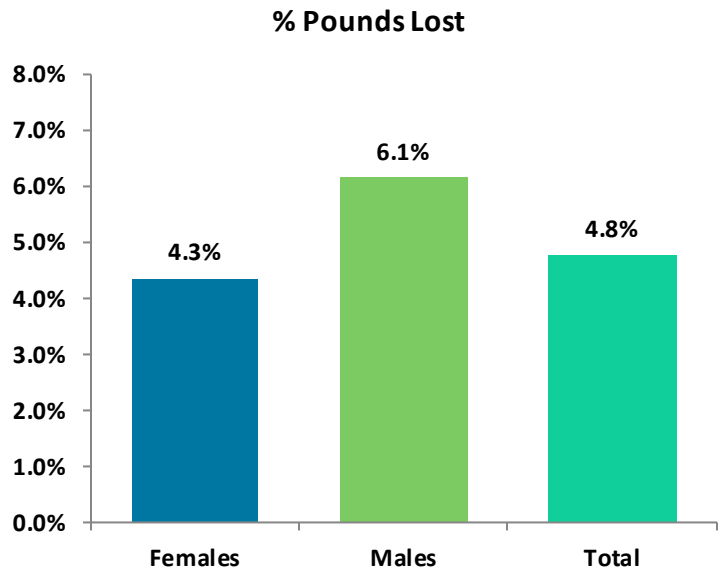
July – December 2020

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

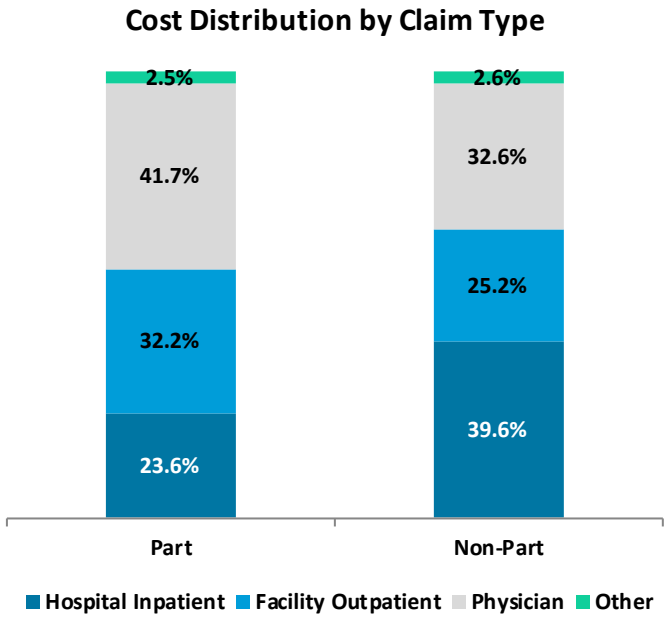
PEBP 2Q21			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	917	236	1,153
Average # Lbs. Lost	9.1	15.8	10.5
Total # Lbs. Lost	8,340.0	3,731.9	12,071.9
% Lbs. Lost	4.3%	6.1%	4.8%
Average Cost/ Member	$5,009	$4,729	$4,952



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	1,002	492	103.6%
Avg # Members	1,115	667	67.3%
Member/Employee Ratio	1.1	1.4	-18.4%
Financial Summary			
Gross Cost	$3,712,267	$3,523,912	
Client Paid	$2,813,857	$2,930,744	
Employee Paid	$898,410	$593,169	
Client Paid-PEPY	$5,619	$11,918	-52.9%
Client Paid-PMPY	$5,046	$8,794	-42.6%
Client Paid-PEPM	$468	$993	-52.9%
Client Paid-PMPM	$420	$733	-42.7%
High Cost Claimants (HCC's) > $100k			
# of HCC's	1	4	
HCC's / 1,000	0.9	6.0	0.0%
Avg HCC Paid	$179,577	$237,722	0.0%
HCC's % of Plan Paid	6.4%	32.4%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,193	$3,485	-65.8%
Facility Outpatient	$1,625	$2,213	-26.6%
Physician	$2,102	$2,864	-26.6%
Other	$126	$233	-45.9%
Total	$5,046	$8,794	-42.6%
	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	45	39	
# of Bed Days	201	313	
Paid Per Admit	$15,032	$30,410	-50.6%
Paid Per Day	$3,365	$3,789	-11.2%
Admits Per 1,000	81	117	-30.8%
Days Per 1,000	360	939	-61.7%
Avg LOS	4.5	8	-43.8%
Physician Office			
OV Utilization per Member	9.2	8.0	15.0%
Avg Paid per OV	$75	$60	25.0%
Avg OV Paid per Member	$689	$479	43.8%
DX&L Utilization per Member	16.2	18.2	-11.0%
Avg Paid per DX&L	$55	$59	-6.8%
Avg DX&L Paid per Member	$897	$1,070	-16.2%
Emergency Room			
# of Visits	130	84	
# of Admits	25	17	
Visits Per Member	0.23	0.25	-8.0%
Visits Per 1,000	233	252	-7.5%
Avg Paid per Visit	$2,222	$2,851	-22.1%
Admits Per Visit	0.19	0.20	-5.0%
Urgent Care			
# of Visits	226	121	
Visits Per Member	0.41	0.36	13.9%
Visits Per 1,000	405	363	11.6%
Avg Paid per Visit	$103	$141	-27.0%
	Annualized	Annualized	

4.4.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

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        4.4.2 HealthSCOPE Benefits – Diabetes Care Management

HSB DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

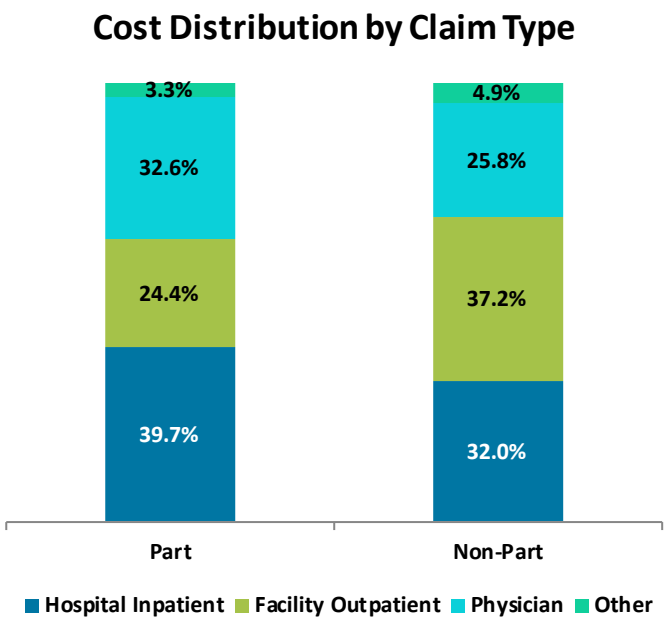
July – December 2020

HealthSCOPE BENEFITS

Diabetes Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	419	1,396	-70.0%
Avg # Members	598	1,765	-66.2%
Member/Employee Ratio	1.4	1.3	13.5%
Financial Summary			
Gross Cost	$2,669,224	$10,599,979	
Client Paid	$2,144,671	$8,973,315	
Employee Paid	$524,552	$1,626,664	
Client Paid-PEPY	$10,245	$12,856	-20.3%
Client Paid-PMPY	$7,179	$10,166	-29.4%
Client Paid-PEPM	$854	$1,071	-20.3%
Client Paid-PMPM	$598	$847	-29.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	3	16	
HCC's / 1,000	5.0	9.1	0.0%
Avg HCC Paid	$260,238	$216,382	0.0%
HCC's % of Plan Paid	36.4%	38.60%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,853	$3,258	-12.4%
Facility Outpatient	$1,753	$3,786	-53.7%
Physician	$2,339	$2,620	-10.7%
Other	$234	$503	-53.5%
Total	$7,179	$10,166	-29.4%
	Annualized	Annualized	



Diabetes Care Management – Utilization Summary

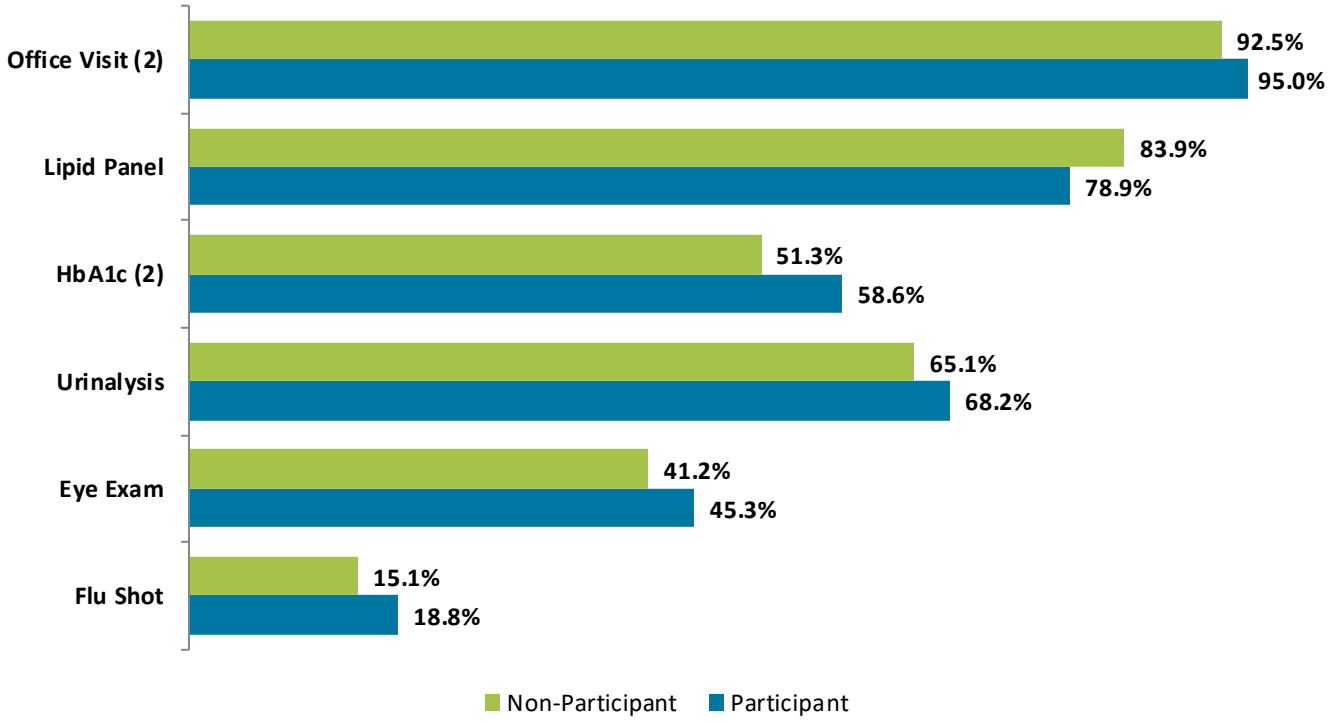
*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	22	138	
# of Bed Days	180	709	
Paid Per Admit	$38,018	$21,174	79.6%
Paid Per Day	$4,647	$4,121	12.8%
Admits Per 1,000	74	156	-52.6%
Days Per 1,000	603	803	-24.9%
Avg LOS	6.4	4.1	56.1%
Physician Office			
OV Utilization per Member	6.4	8.1	-21.0%
Avg Paid per OV	$56	$58	-3.4%
Avg OV Paid per Member	$355	$472	-24.8%
DX&L Utilization per Member	15.9	22.6	-29.6%
Avg Paid per DX&L	$50	$55	-9.1%
Avg DX&L Paid per Member	$804	$1,252	-35.8%
Emergency Room			
# of Visits	53	278	
# of Admits	11	91	
Visits Per Member	0.18	0.31	-41.9%
Visits Per 1,000	177	315	-43.8%
Avg Paid per Visit	$1,629	$2,470	-34.0%
Admits Per Visit	0.21	0.33	-36.4%
Urgent Care			
# of Visits	59	276	
Visits Per Member	0.20	0.31	-35.5%
Visits Per 1,000	197	313	-37.1%
Avg Paid per Visit	$84	$119	-29.4%
	Annualized	Annualized	

Diabetic Compliance

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

Diabetic Population		
Year	Participant	Non-Participant
Members	437	1,837



4.4.3

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

        4.4.1 HealthSCOPE Benefits – Obesity Care Management

        4.4.2 HealthSCOPE Benefits – Diabetes Care Management

        4.4.3 American Health Holdings – Utilization and Large Case Management

Public Employees' Benefits Program – State of Nevada

Medical Management Review

October 1, 2020 – December 31, 2020

AmericanHealth
American Health Holding Inc

Table of Contents

Executive Overview

Overview

This presentation contains information for **Public Employees' Benefits Program** and provides an overview of the **Utilization Management, Case Management,** and **Post-Discharge Counseling**.

All data included is as of **January 31, 2021** and covers the reporting period of **October 1, 2020 – December 31, 2020**; all tables and graphs reflect the reporting period unless expressly noted. When requested, prior period comparison details are provided and indicated on the associated graphs or charts.

Return on Investment – Year Over Year Comparison

- Summary of medical management savings and ROI
  - Utilization Management savings are achieved through medical necessity reviews of inpatient bed days and outpatient services
  - Case Management savings are estimated costs that would have been incurred to the plan, had we not intervened

July 1, 2020 - September 30, 2020			
	Fees	Estimated Savings	ROI
Utilization Management	$196,284	$1,548,817	7.9 to 1
Case Management	$293,587	$860,907	2.9 to 1
Total	$489,871	$2,409,724	4.9 to 1

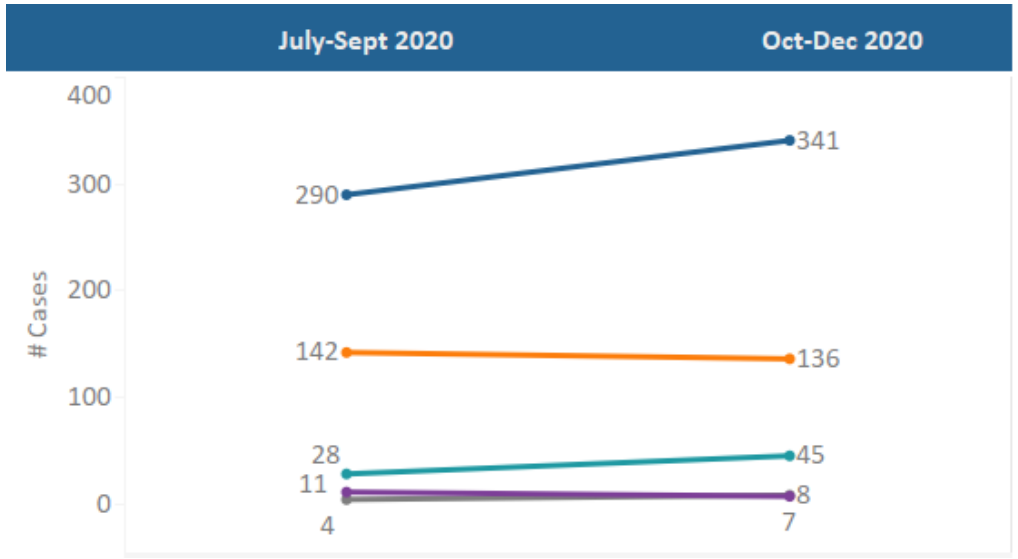
Utilization Management Breakout	
Inpatient Savings	$951,453
Outpatient Savings	$597,364

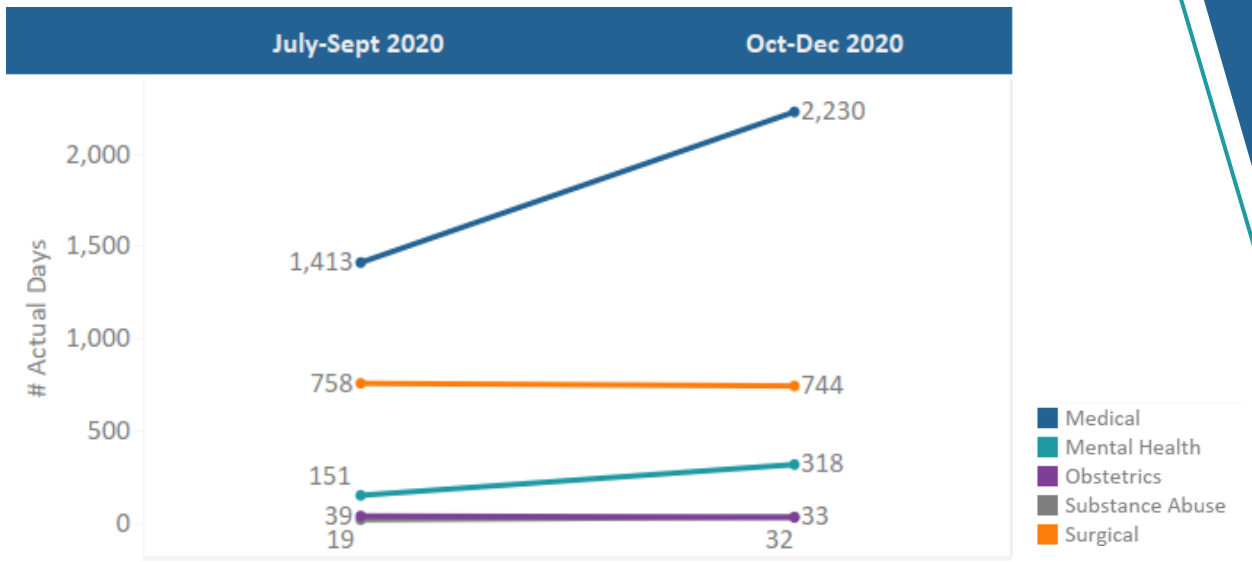
October 1, 2020 - December 31, 2020			
	Fees	Estimated Savings	ROI
Utilization Management	$195,233	$2,116,466	10.8 to 1
Case Management	$292,015	$518,281	1.8 to 1
Total	$487,248	$2,634,747	5.4 to 1

Utilization Management Breakout	
Inpatient Savings	$1,662,913
Outpatient Savings	$453,553

Utilization Management

Acute Inpatient Activity Summary



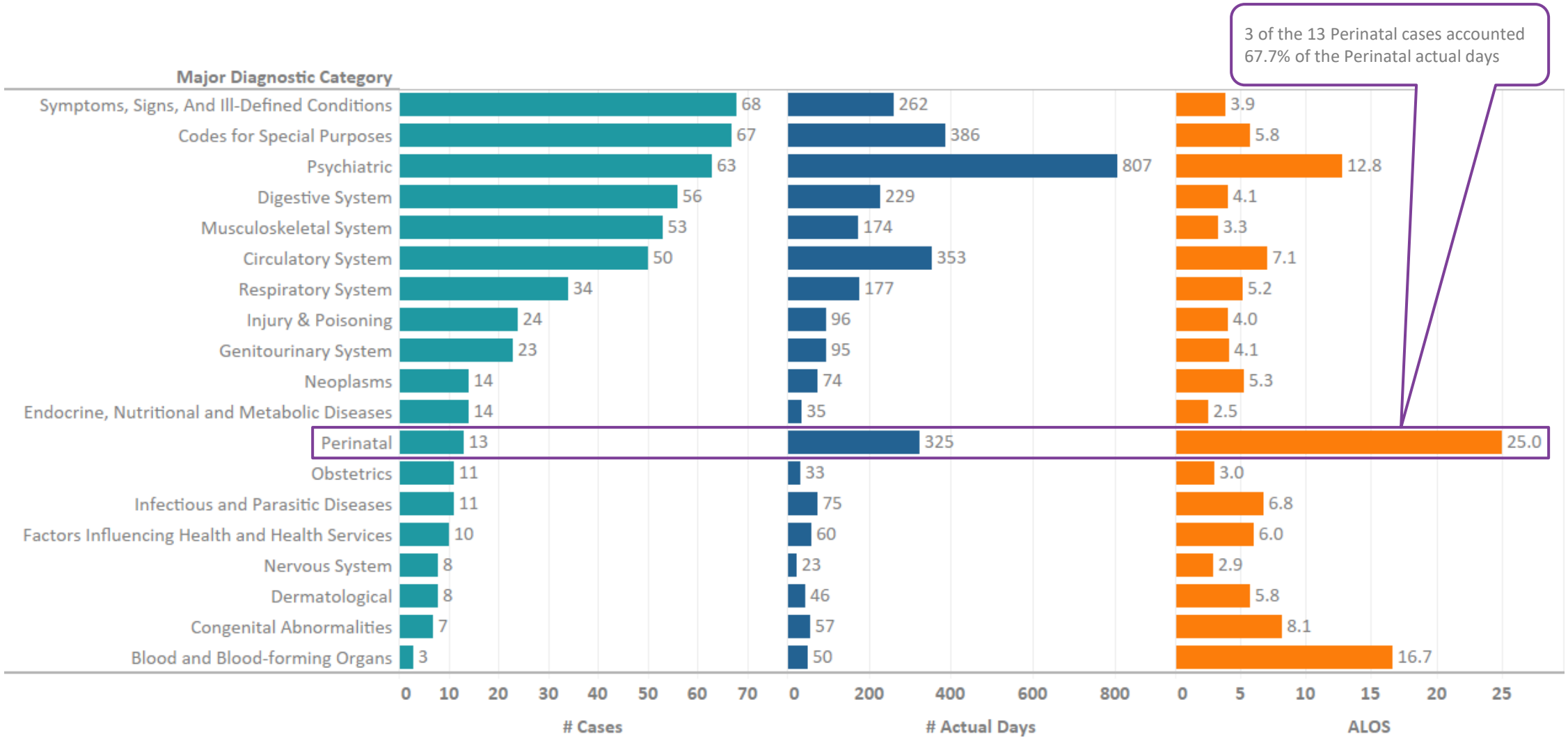


Utilization Review Process

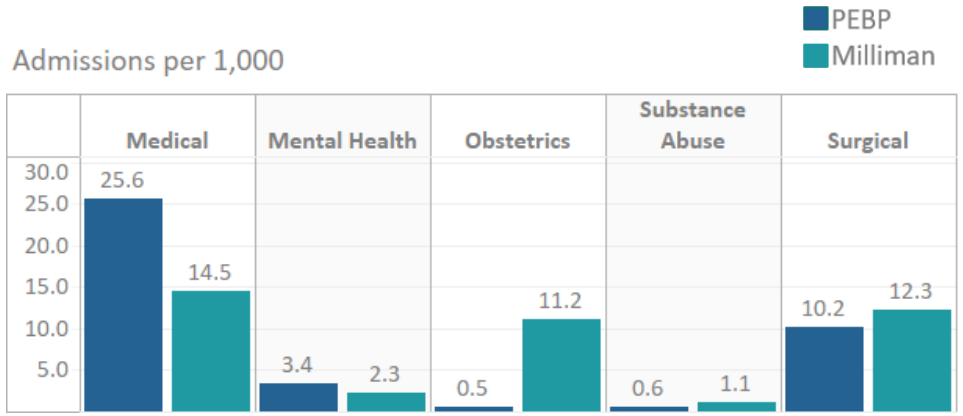
Days Saved: 254
Estimated Savings: $1,644,309

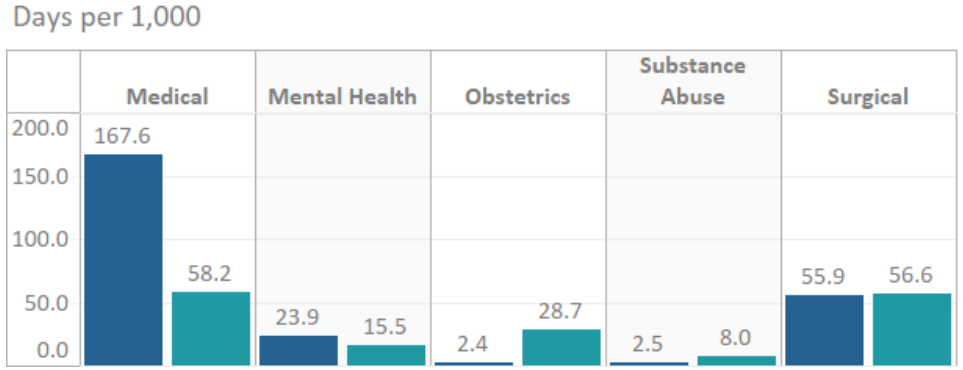
October 1, 2020 - December 31, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	341	2,230	2,245	2,020	225	$1,385,624
Surgical	136	744	532	513	19	$245,689
Mental Health	45	318	318	314	4	$5,547
Substance Abuse	8	33	33	27	6	$7,449
Obstetrics	7	32	32	32	0	$0
Grand Total	**537**	**3,357**	**3,160**	**2,906**	**254**	**$1,644,309**

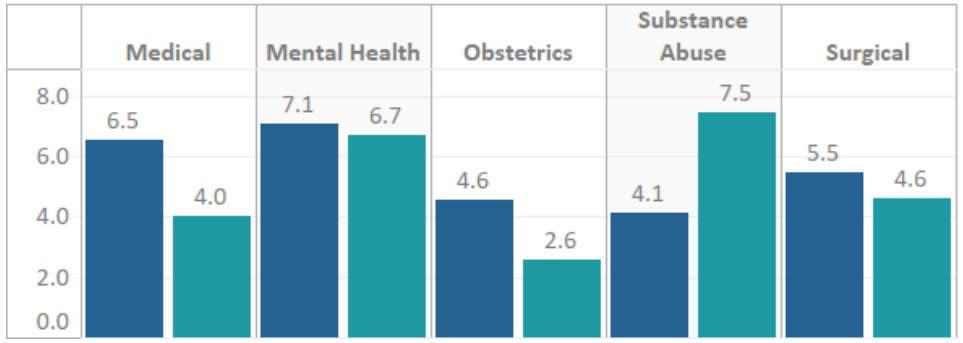
Acute Inpatient – Case and Actual Days by Diagnostic Categories



Acute Inpatient Activity – Utilization Benchmarks







Admissions per 1,000

- Medical: Admissions were 76.6% higher than the Milliman Benchmark.
  - **43** members had **2 or more** inpatient admissions
- Mental Health: Admissions were 47.8% higher than the Milliman Benchmark.
  - **6** members had **2 or more** inpatient admissions

Days per 1,000

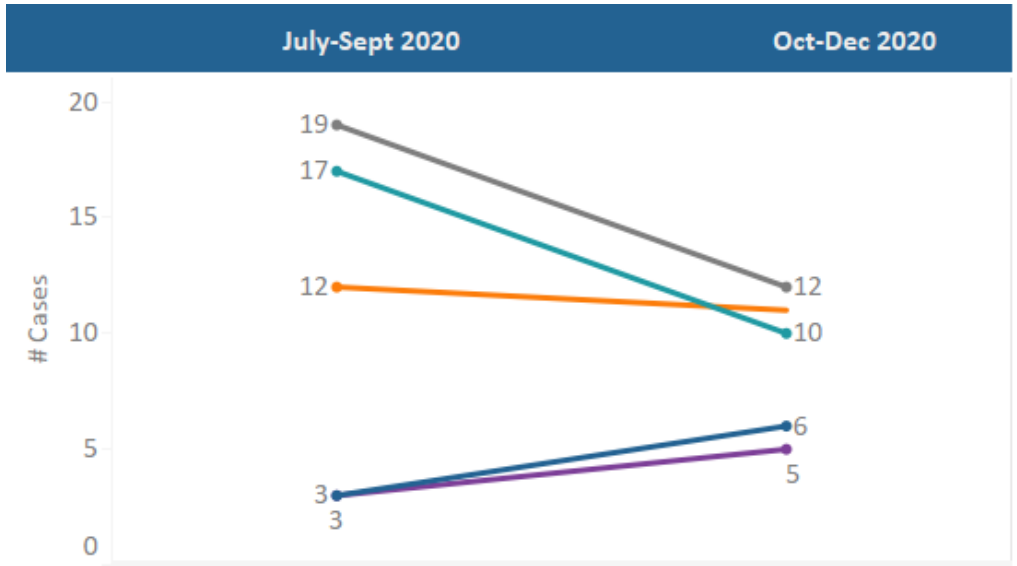
- Medical: Days were 188.0% higher than the Milliman Benchmark.
  - **52** cases utilized **9 or more** days during the report period
- Mental Health: Days were 54.2% higher than the Milliman Benchmark.
  - **3** cases utilized **13 or more** days during the report period

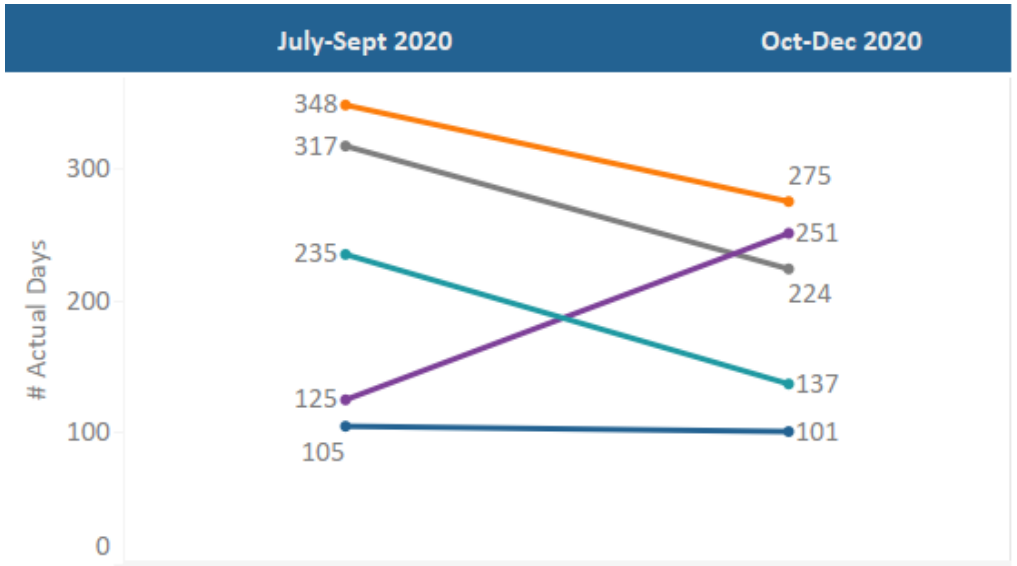
Average Length of Stay

- Medical: ALOS was 2.5 days higher than the Milliman Benchmark.
  - Removal of **19** outlier cases that consumed **21 or more** days each resulted in an ALOS of 4.1
- Mental Health: ALOS was 0.4 days higher than the Milliman Benchmark.
  - Removal of **1** outlier cases that consumed **53** days resulted in an ALOS of 6.0
- Obstetrics: ALOS was 2.0 days higher than Milliman Benchmark.
  - Removal of **3** outlier cases that consumed **5 or more** days each resulted in an ALOS of 3.0
- Surgical: ALOS was 0.9 days higher than Milliman Benchmark.
  - Removal of **1** outlier case that consumed **219** days resulted in an ALOS of 3.9

Due to federal mandate regulations, not all Obstetrics cases require pre-certification; therefore, Obstetrics ALOS should be interpreted with caution.

Non-Acute Inpatient Activity Summary



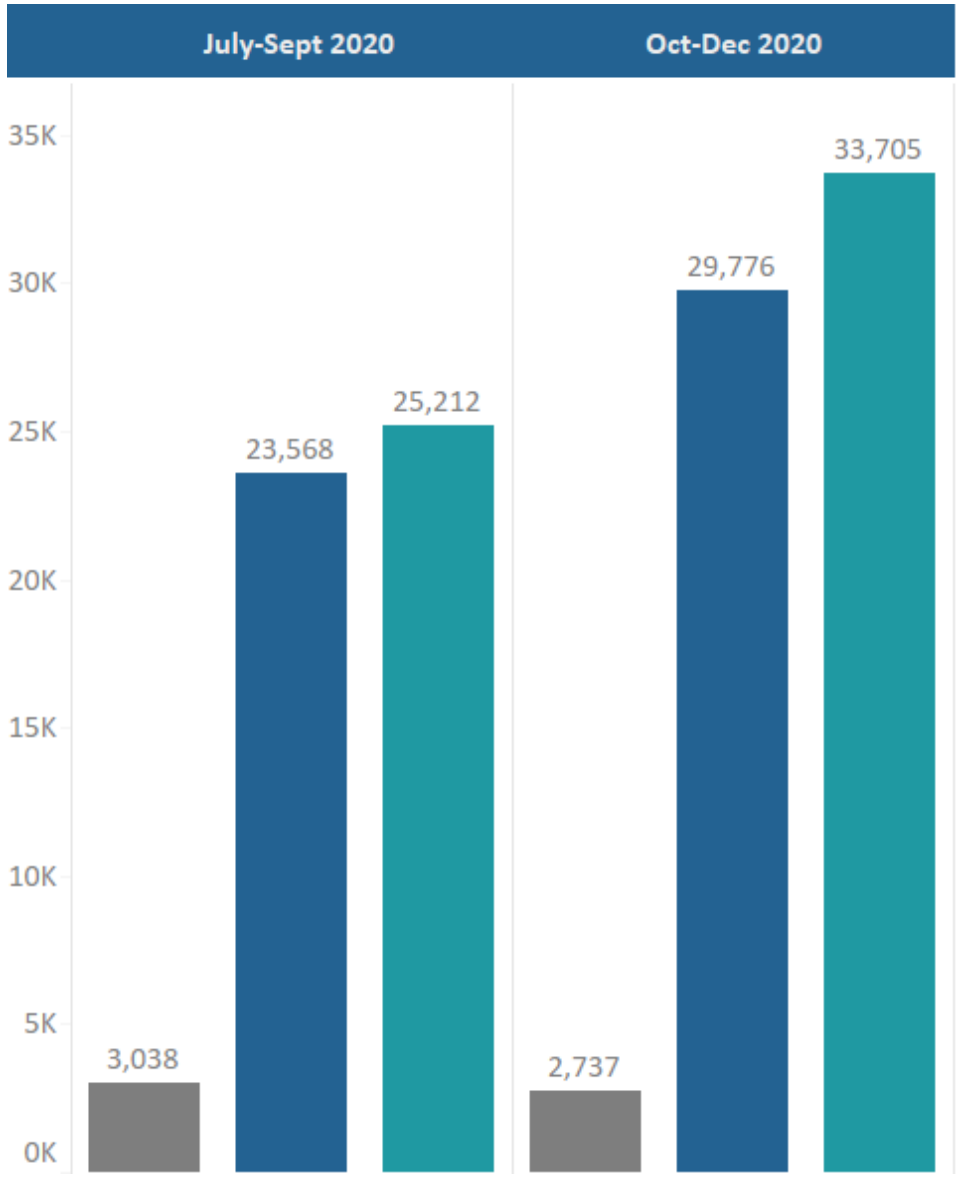


Utilization Review Process

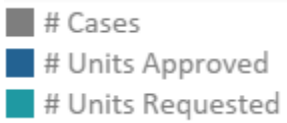
Days Saved: 19
Estimated Savings: $18,604

October 1, 2020 - December 31, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Residential Substance Abuse	12	224	226	225	1	$903
Skilled Nsg Facility	11	275	275	274	1	$681
Medical Rehab	10	137	137	137	0	$0
Long Term Acute	6	101	101	99	2	$7,718
Residential Mental Health	5	251	266	251	15	$9,302
Grand Total	**44**	**988**	**1,005**	**986**	**19**	**$18,604**

Outpatient Activity Summary



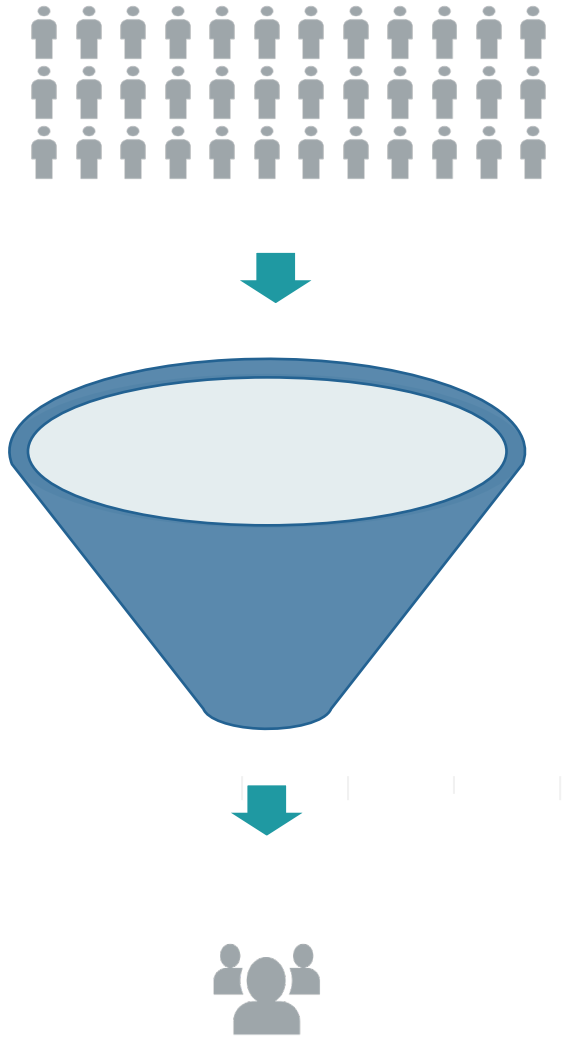
October 1, 2020 - December 31, 2020					
Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,599	1,977	1,901	76	$84,140
Surgery	558	1,002	978	24	$30,568
DME	249	22,301	18,671	3,630	$36,027
Med Treatment	214	4,854	4,777	77	$282,407
Home Health	59	808	752	56	$10,712
MH/SA	28	459	457	2	$0
Home Infusion	21	1,504	1,479	25	$0
Home Enteral Feeding	4	542	542	0	$0
PT/OT/ST	3	169	149	20	$2,987
Hospice Home	2	89	70	19	$6,712
Grand Total	**2,737**	**33,705**	**29,776**	**3,929**	**$453,553**



Utilization Review Process

Units Saved: 3,929
Estimated Savings: $453,553

Case Management Referrals from Utilization Management



- **581** inpatient cases were completed in Utilization Review
- **2,737** outpatient cases were completed in Utilization Review

- **353** inpatient cases **(60.8%)** automatically triggered to Case Management
- **694** outpatient cases **(25.4%)** automatically triggered to Case Management

- **231** inpatient cases **(65.4%)** were deemed appropriate for Case Management
- **22** outpatient cases **(3.2%)** were deemed appropriate for Case Management

Case Management

Case Management Summary

The following tables illustrate overall case activity and total savings achieved for the report period

Total Case Management Savings

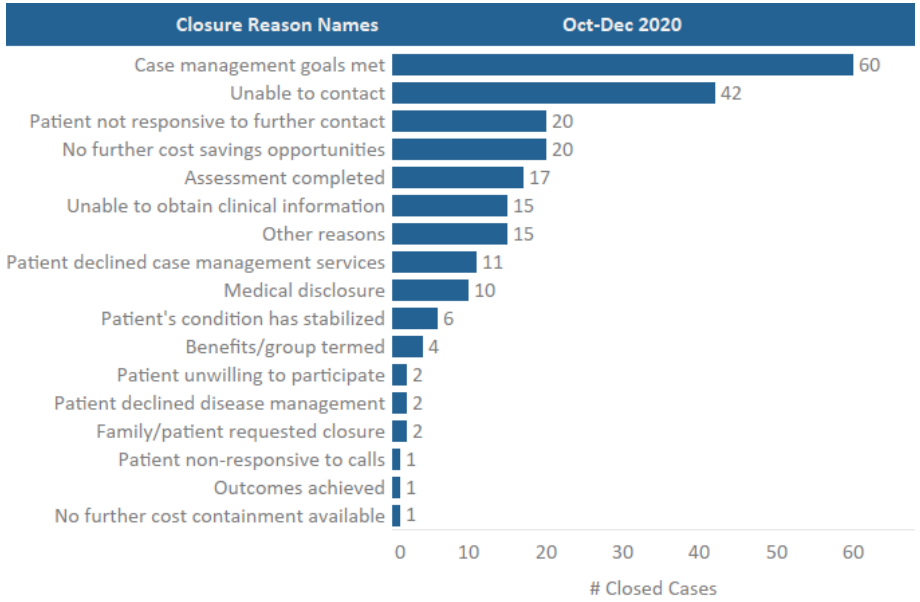
$518,281

Average Savings per Case = $1,336

Based on 388 cases in an open state between 10/1/2020 – 12/31/2020

Number of Cases

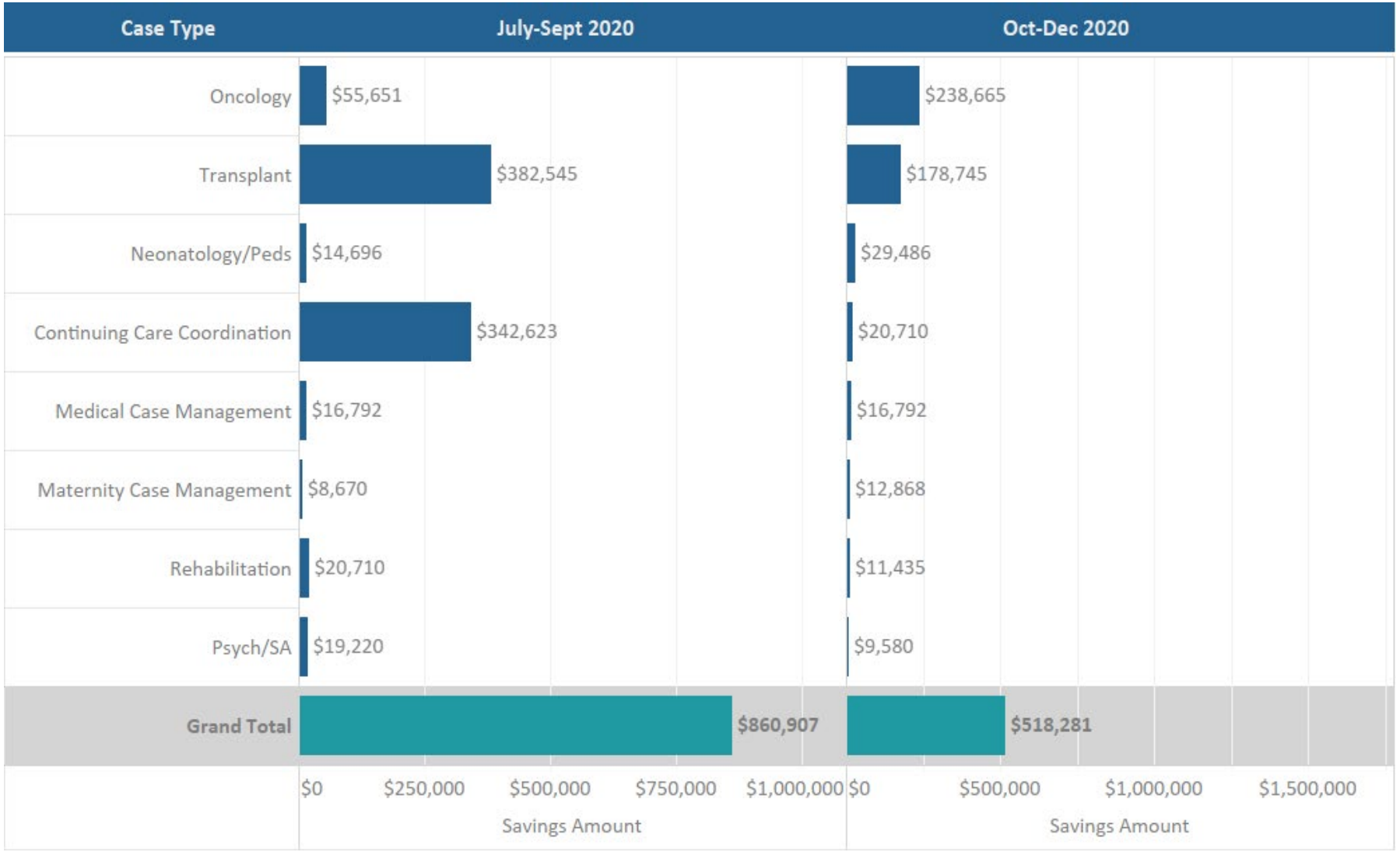
Case Activity	July-Sept 2020	Oct-Dec 2020
# Beginning Cases	203	177
# Opened Cases	187	211
# Closed Cases	213	200
# Ending Cases	177	188



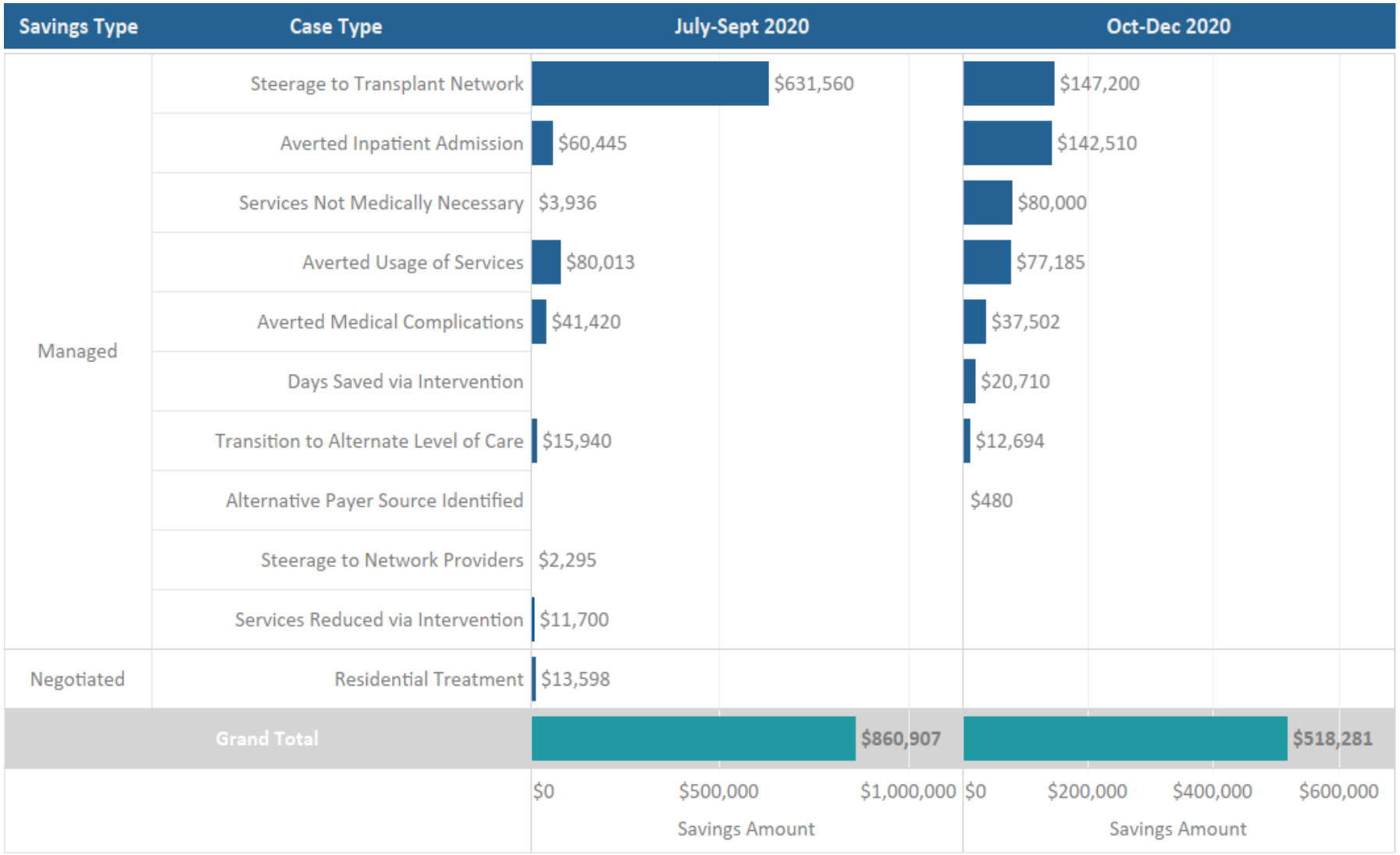
Case Type	Oct-Dec 2020
Continuing Care Coordination	111
Short Term CM	90
Bariatric	44
Advocacy	43
Oncology	37
Medical Case Management	18
Psych/SA	17
Neonatology/Peds	13
Transplant	9
Rehabilitation	2
Maternity Case Management	3
Research and Review	1
Grand Total	**388**

Total number of closure reasons may be greater than the number of cases as cases may have more than one closure reason.

Case Management – Savings by Case Type



Case Management – Savings by Source



Post-Discharge Counseling

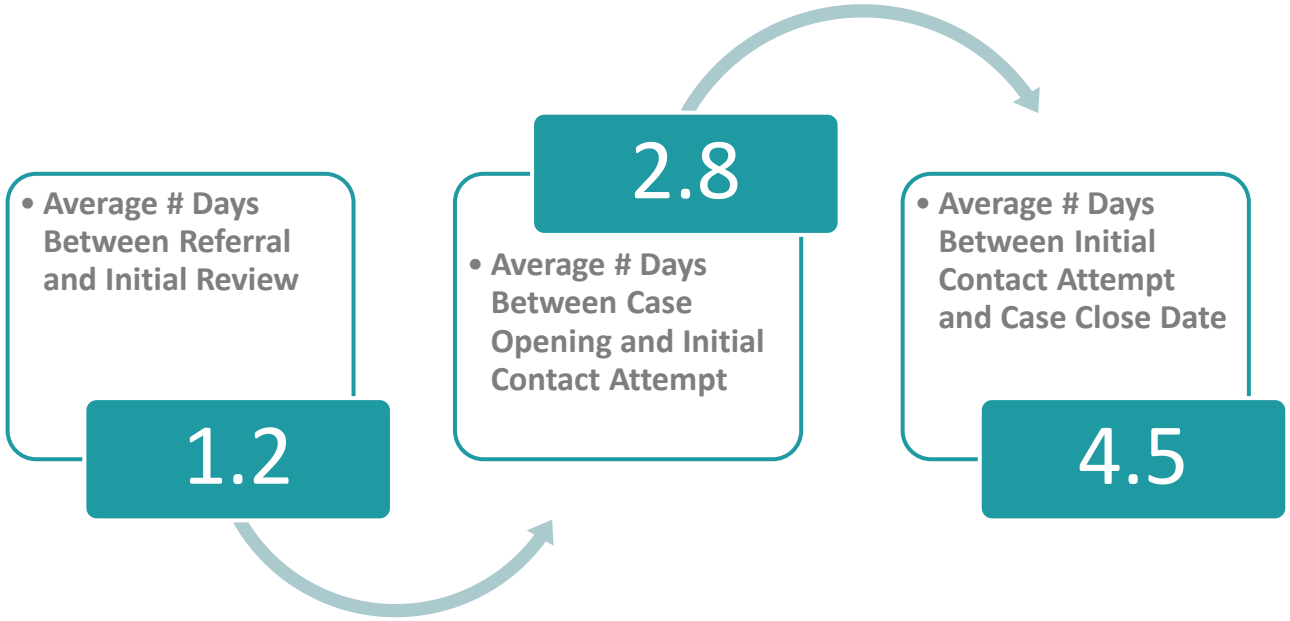
Post-Discharge Counseling – Participation Summary

Program Metric	October 1, 2020 – December 31, 2020
# Cases Identified	250
# Participating Cases	76
% of Cases with Successful Outreach	**30.4%**

AHH BOB
AHH BOB Percent of Cases with Successful Outreach
51.5%

Post-Discharge Counseling – Turnaround Time

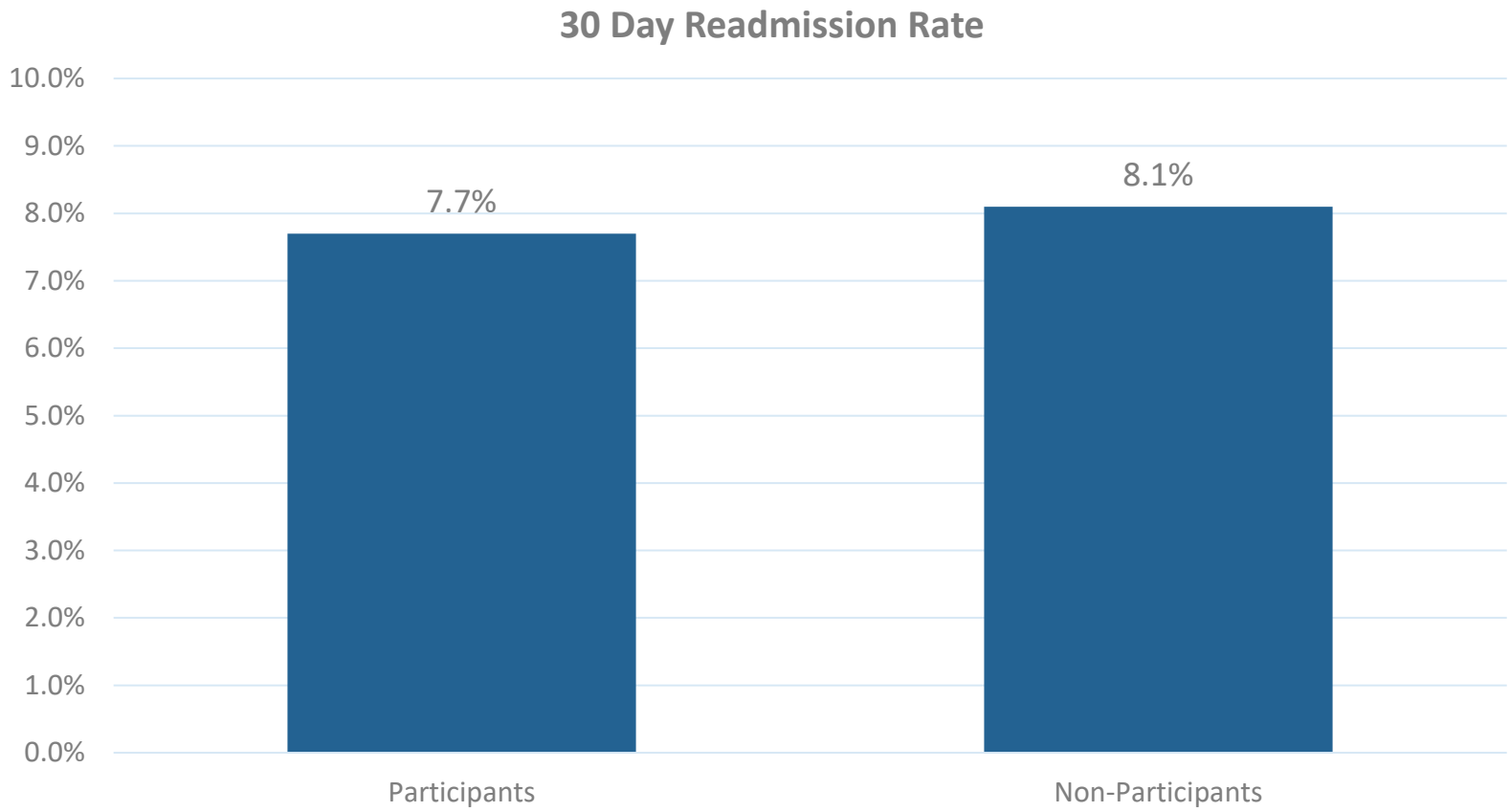
Below is a summary of the average turnaround times for the Post-Discharge Counseling program. Following a referral to the Post-Discharge Counseling program, the CMC will complete an initial review of the case and determine if the case is appropriate for the program. Once the case is reviewed and deemed appropriate, the case will be referred to a case manager who will review the case and subsequently make an initial contact attempt.



*Note that the average number of days between a referral for the Post-Discharge Counseling program and the initial contact attempt was 6.2 days

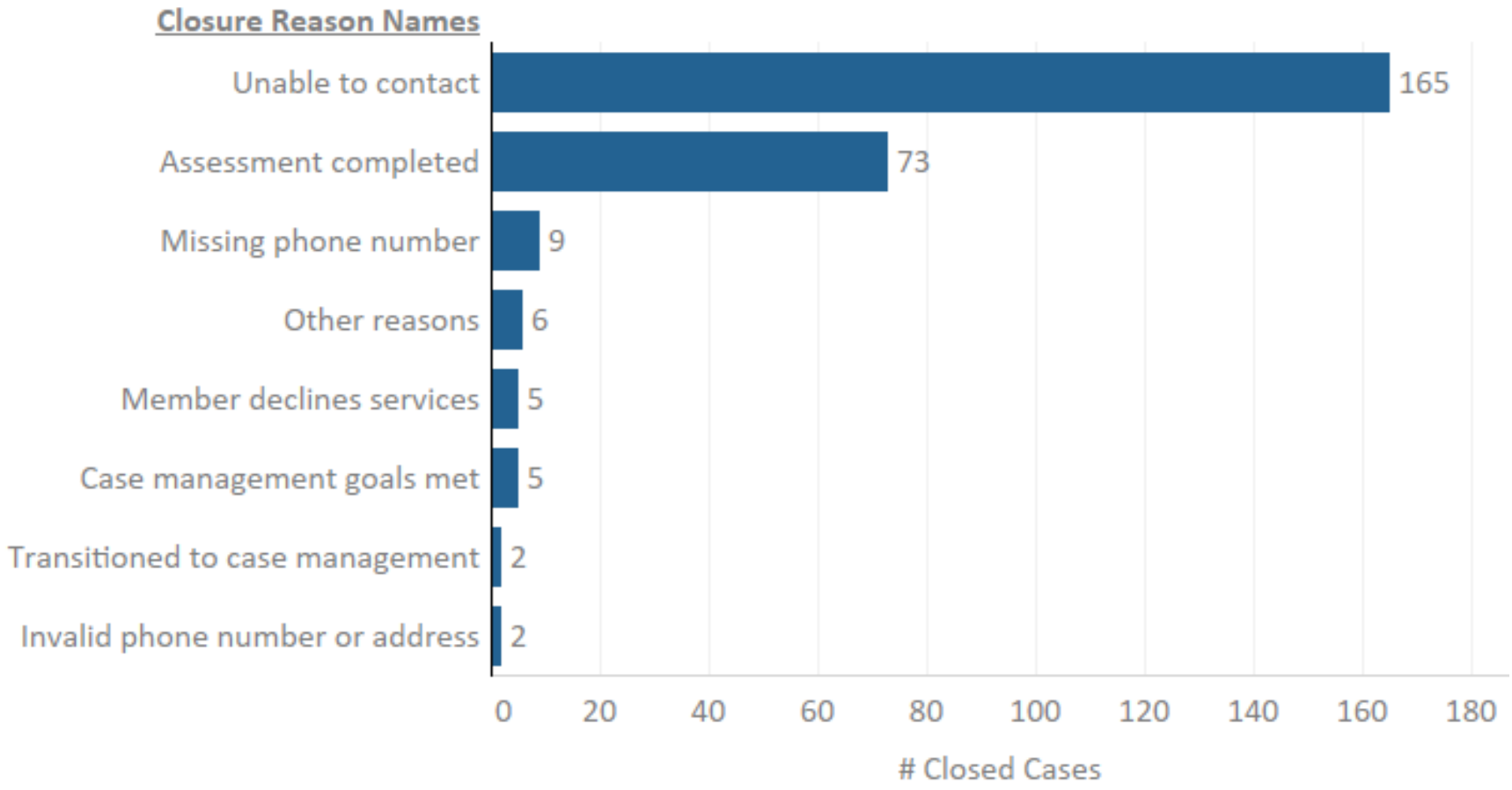
Post-Discharge Counseling – 30-Day Readmission Rate

There were 2 members with 30-day readmissions that participated in the Post-Discharge Counseling program during the report period. The 30-day readmission rates for participants in the program were below the rates for non-participation, illustrating the effectiveness of the Post-Discharge program.



Post-Discharge Counseling – Case Closure Reason

Post-Discharge Counseling cases are closed for a variety of reasons and a case may have more than one closure reason. The following graph presents the number of closed cases by closure reason during the report period.



Observations and Insights

Observations

- Medical experienced a 57.8% increase in actual days in the current time period over the prior quarter
- Medical and Mental Health were higher than the Milliman benchmark for acute inpatient admissions, days, and ALOS
- Outpatient saw a 33.7% increase in units requested and a 26.3% increase in units approved in the current time period over the prior quarter
- Continuing Care Coordination made up 28.6% of case management case types

Insights

- Psychiatric followed by Codes for Special Purposes diagnostic categories represented the largest percentage increase in Medical actual days
- 3 members accounted for 463 of the 2,230 (20.8%) Medical actual days during the current time period
- Outpatient increase in units approved and requested is due to an increase in DME with the majority in the Nervous System diagnostic category
- Psychiatric and Neoplasms major diagnostic categories accounted for 63.1% of open CM Continuing Care Coordination cases

4.4.4

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

        4.4.1 HealthSCOPE Benefits – Obesity Care Management

        4.4.2 HealthSCOPE Benefits – Diabetes Care Management

        4.4.3 American Health Holdings – Utilization and Large Case Management

        4.4.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
December 31, 2020

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2016 to December 31, 2020

This is the second quarter report for the 2020-21 plan year, providing information for the period beginning July 1, 2016 and ending December 31, 2020.

Basic Life

At the half-way point of the current plan year, Basic Life incidence (page 4) is up year-over-year for active members and for retirees. At this time last year, the overall incidence rate was 2.2 claims/1,000 lives; this year, it has increased to 2.5. From a loss ratio perspective (page 5), the loss ratio for active members is down slightly from 26% last year to 25% this year. For retirees, the loss ratio is significantly up, from 241% to 324% compared to last year. Historically, the highest claim activity for PEBP is in the 3rd quarter of the plan year. We'll see how the next quarter 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 remain higher than our block for Circulatory and Respiratory claims and lower for Cancer.

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis, and claims are charged to the plan year in which a disability started. As a result, we typically don't have credible incidence information during the first half of the plan year. At this time last year, there were 8 LTD claims for the 2019-20 plan year, a third of the 25 claims that were incurred during the entire plan year. For the 2020-21 plan year, we've had 5 claims incurred so far. This is a decrease compared to last year for the same time period.

LTD loss ratios (page 8) are reported on a cash basis, without regard for the incurred date. At the halfway point, the loss ratio for the 2020-21 plan year is 5%, which is significantly lower than the loss ratio for the 2019-20 plan year of 31%. The 5% loss ratio is much lower than the five-year average loss ratio of 51%. One of the main drivers of the lower loss ratio is a credit of over $900,000 in Active Claim Reserves for the period. We will keep an eye on the remaining two quarters.

LTD claims by diagnosis (page 7) 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. PEBP continues to have significantly better results for Musculoskeletal claims when compared to our block, by almost 50%.

Basic Life Insurance Claims by Plan Year and Participant Type

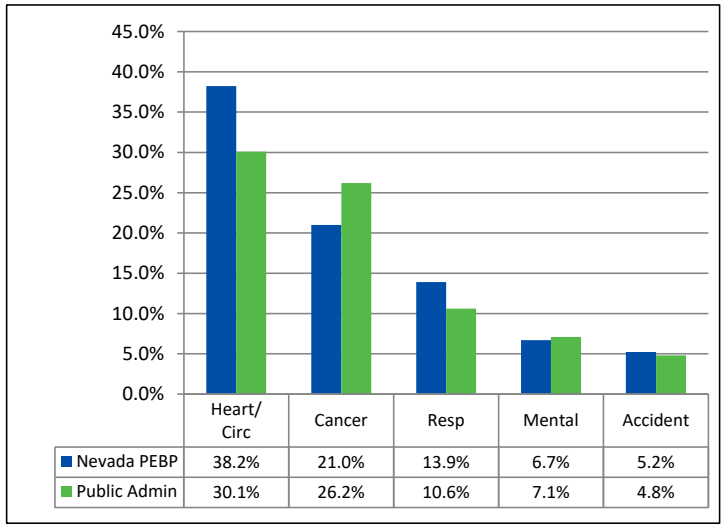
Most Recent Five Plan Years: July 01, 2016 to December 31, 2020

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-20 Through Jun-20		From Jul-20 Through Jun-21	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	51	2.0	41	1.6	47	1.8	47	1.7	17	0.6
Retirees	325	21.8	295	19.5	278	17.7	284	18.0	91	5.7
Totals	**376**	**9.6**	**336**	**8.4**	**325**	**7.9**	**331**	**7.7**	**108**	**2.5**

Basic Life Insurance Claims by Diagnostic Category

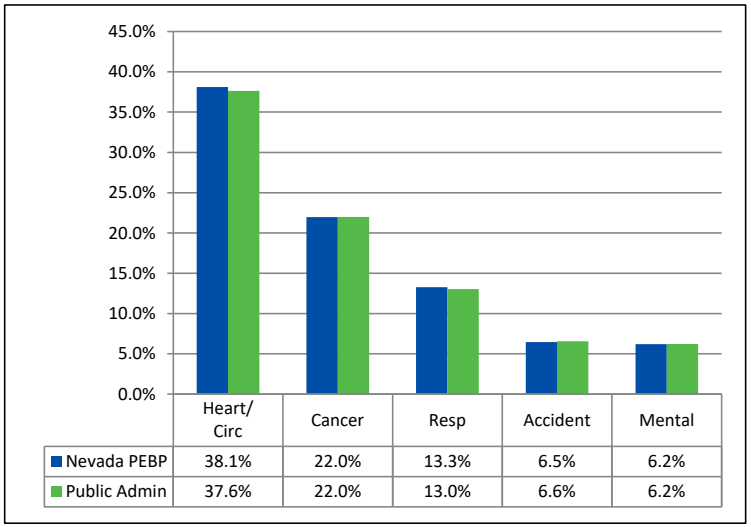
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	38.2%	21.0%	13.9%	6.7%	5.2%
Public Admin	30.1%	26.2%	10.6%	7.1%	4.8%

Top Five Diagnostic Categories by Liability

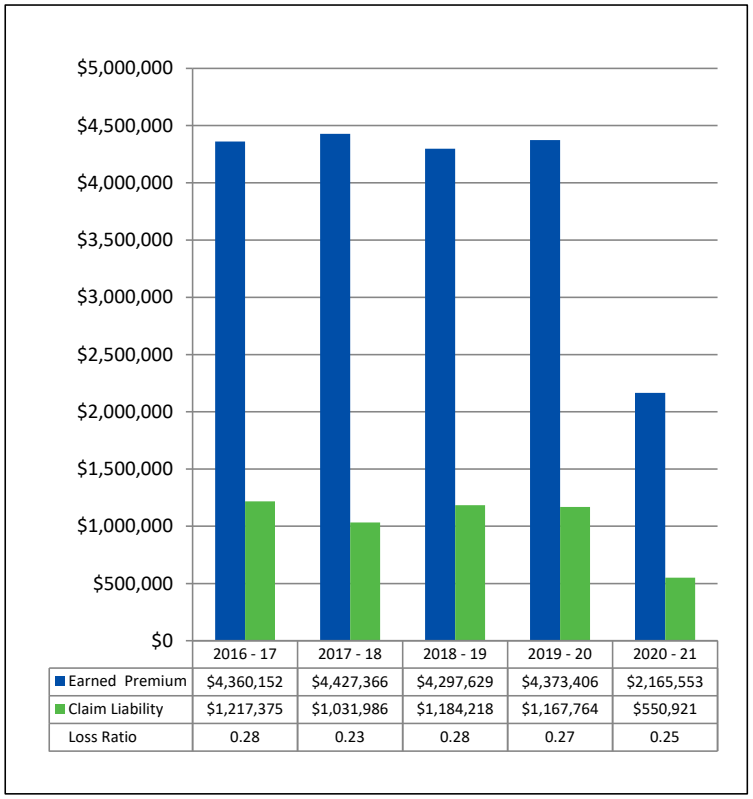


	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	38.1%	22.0%	13.3%	6.5%	6.2%
Public Admin	37.6%	22.0%	13.0%	6.6%	6.2%

Basic Life Insurance Earned Premiums & Liability by Participant Type

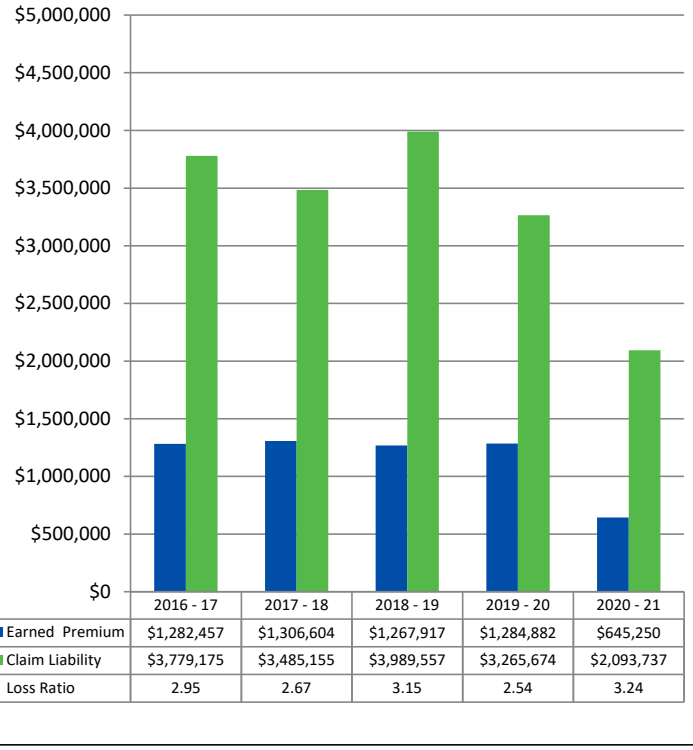
Most Recent Five Plan Years: July 01, 2016 to December 31, 2020

Active Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,360,152	$4,427,366	$4,297,629	$4,373,406	$2,165,553
Claim Liability	$1,217,375	$1,031,986	$1,184,218	$1,167,764	$550,921
Loss Ratio	0.28	0.23	0.28	0.27	0.25

Retired Participants

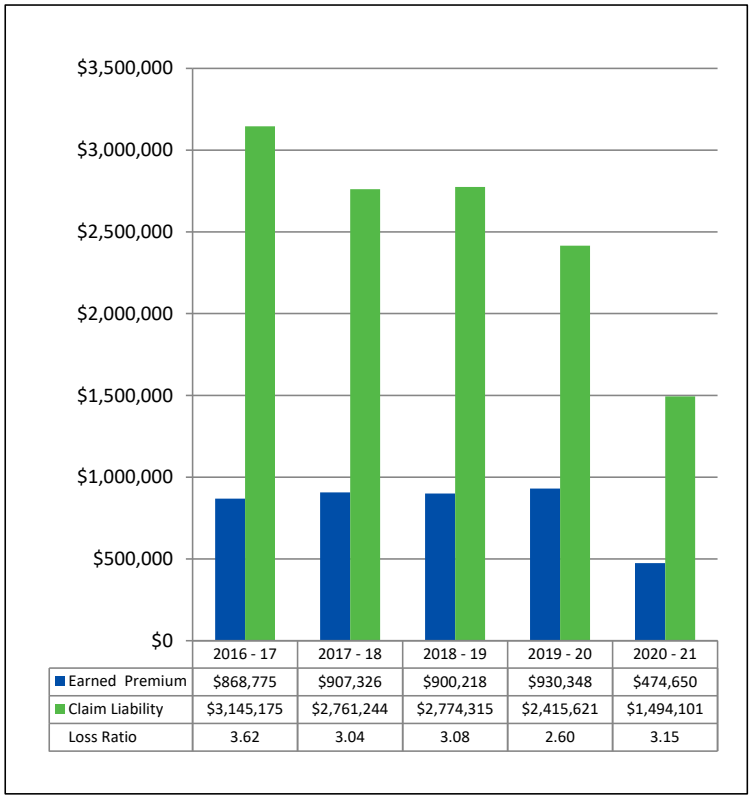


	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$1,282,457	$1,306,604	$1,267,917	$1,284,882	$645,250
Claim Liability	$3,779,175	$3,485,155	$3,989,557	$3,265,674	$2,093,737
Loss Ratio	2.95	2.67	3.15	2.54	3.24

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

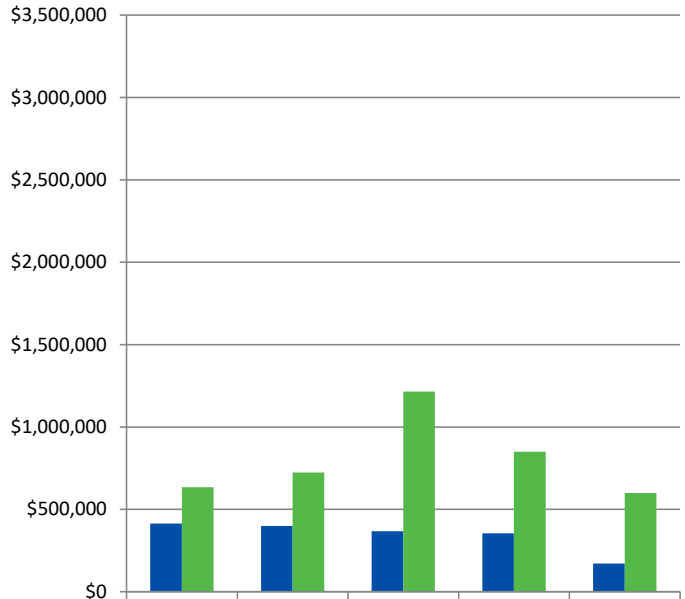
Most Recent Five Plan Years: July 01, 2016 to December 31, 2020

State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$868,775	$907,326	$900,218	$930,348	$474,650
Claim Liability	$3,145,175	$2,761,244	$2,774,315	$2,415,621	$1,494,101
Loss Ratio	3.62	3.04	3.08	2.60	3.15

Non-State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$413,682	$399,278	$367,699	$354,534	$170,600
Claim Liability	$634,000	$723,911	$1,215,242	$850,053	$599,636
Loss Ratio	1.53	1.81	3.30	2.40	3.51

Long Term Disability Claims by Plan Year

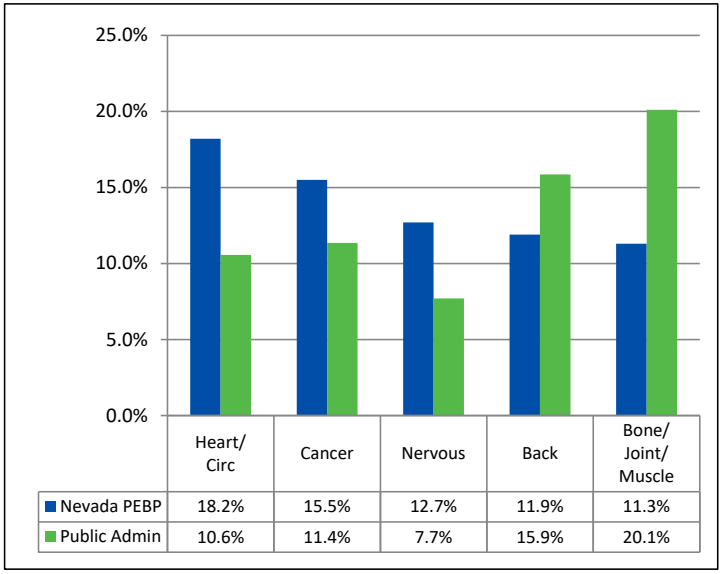
Most Recent Five Plan Years: July 01, 2016 to December 31, 2020

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	36	1.4	29	1.1	25	1.0	25	0.9	5	0.2

Long Term Disability Claims by Diagnostic Category

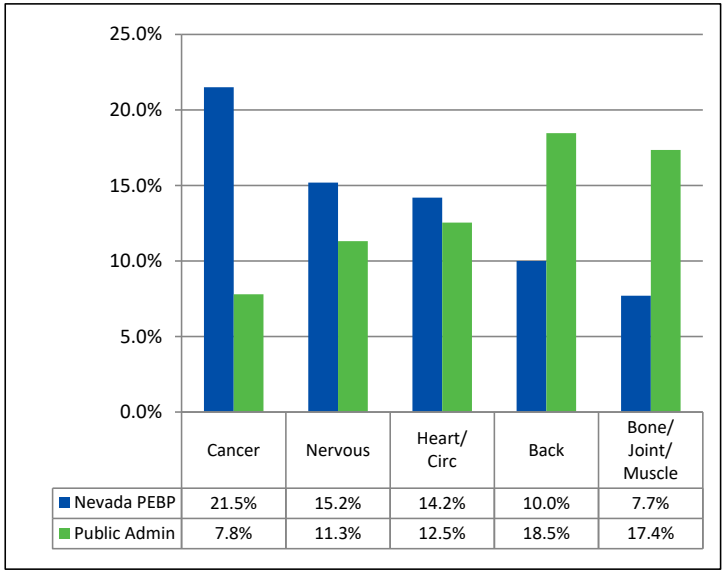
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Nervous	Back	Bone/ Joint/ Muscle
Nevada PEBP	18.2%	15.5%	12.7%	11.9%	11.3%
Public Admin	10.6%	11.4%	7.7%	15.9%	20.1%

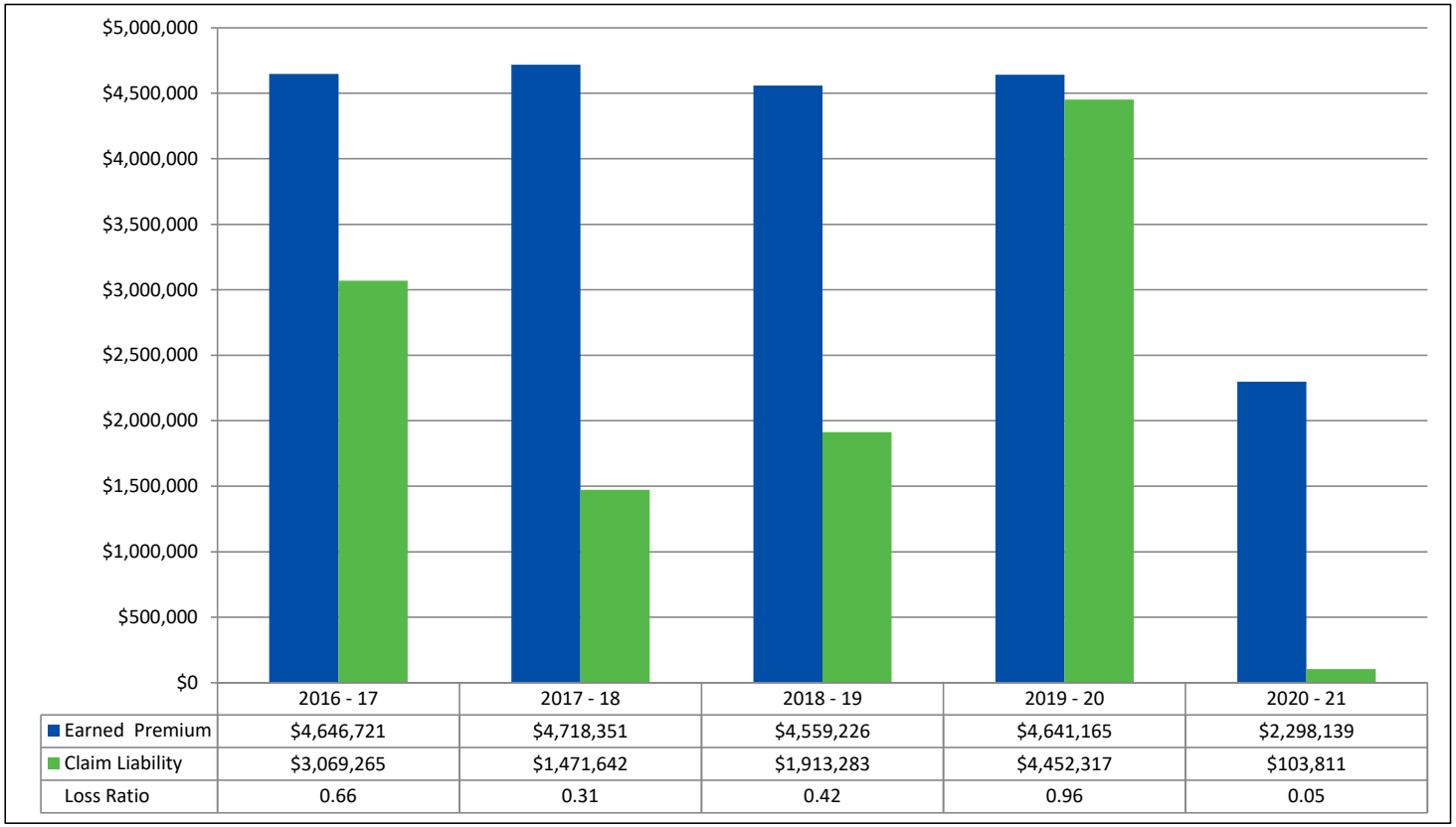
Top Five Diagnostic Categories by Liability



	Cancer	Nervous	Heart/ Circ	Back	Bone/ Joint/ Muscle
Nevada PEBP	21.5%	15.2%	14.2%	10.0%	7.7%
Public Admin	7.8%	11.3%	12.5%	18.5%	17.4%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2016 to December 31, 2020



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,646,721	$4,718,351	$4,559,226	$4,641,165	$2,298,139
Claim Liability	$3,069,265	$1,471,642	$1,913,283	$4,452,317	$103,811
Loss Ratio	0.66	0.31	0.42	0.96	0.05

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2020 to December 31, 2020

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

4.4.5

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

        4.4.1 HealthSCOPE Benefits – Obesity Care Management

        4.4.2 HealthSCOPE Benefits – Diabetes Care Management

        4.4.3 American Health Holdings – Utilization and Large Case Management

        4.4.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

        4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report Q2 2021

Nevada Public Employees Benefit Program

Quarterly Update – 2nd Quarter Plan Year 2021

Willis Towers Watson's Individual Marketplace

March 4, 2021

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2021

Executive Summary

Plan Enrollment:

- At the end of Q2 2021, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 11,912. Since inception, 109 carriers have been selected by PEBP's retirees with current enrollment in 1,504 different plans.
- Medicare Supplement (MS) plan selection increased to 86% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,314 and 2,189 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 to 14%. Top MA carriers include Hometown Health Plan with 725 individual plan selections and Aetna with 392 individual plan selections. The average monthly premium cost to PEBP participants decreased to $17 compared to the prior quarter.

Customer Satisfaction:

- In Q2 2021, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.5 out of 5.0 based on 168 surveys returned.
- For Q2 2021, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 724 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q2 2021.

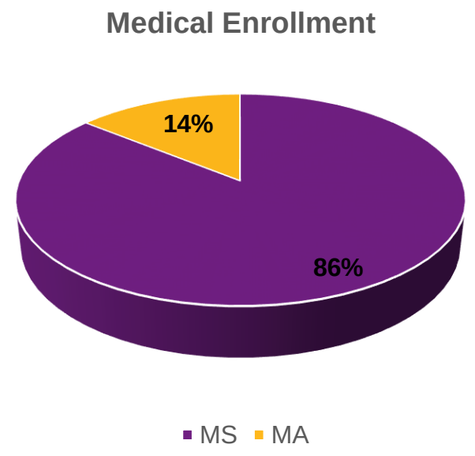
Health Reimbursement Arrangement:

- At the end of Q2 2021 there were 12,994 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 77,130 claims processed in Q2, with 95% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 72,925 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $8,087,705.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2020		Previous Qtr.
Total enrolled through individual marketplace	11,912	12,200
Number of carriers**	109	106
Number of plans**	1,504	1,414

Plan Type Selection Through 12/31/2020		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,687	1,915
Medicare Supplement (MS)	10,225	10,285



"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	10,225	$147
Medicare Advantage (MA,MAPD)	1,687	$0 / $17
Part D drug coverage	7,442	$24
Dental coverage	1,077	$37
Vision coverage	2,030	$12

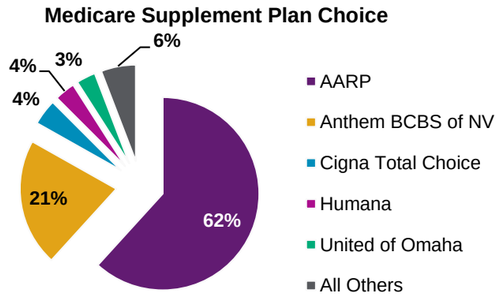
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2021

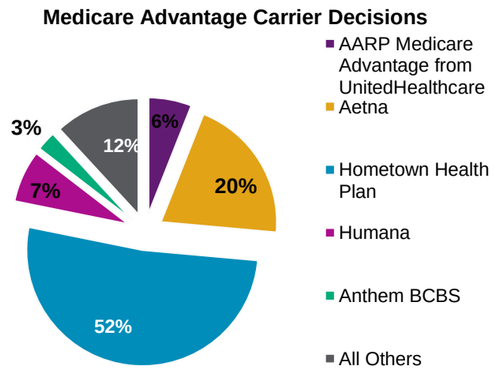
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,314
Anthem BCBS of NV	2,189
Cigna Total Choice	443
Humana	353
United of Omaha	329



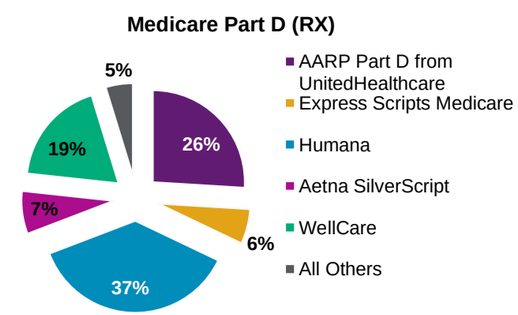
Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$141
Maximum	$481

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	142
Aetna	392
Hometown Health Plan	725
Humana	160
Anthem BCBS	54



Cost Data For MA Plans	Cost
Minimum	$0
Average	$17
Median	$0
Maximum	$188

Top Medicare Part D (RX)	Total
AARP Part D from UnitedHealthcare	1,839
Aetna Medicare Rx (SilverScript)	748
Express Scripts Medicare	492
Humana	2,597
WellCare	1,387



Cost Data For Part D (RX)	Cost
Minimum	$6
Average	$24
Median	$18
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

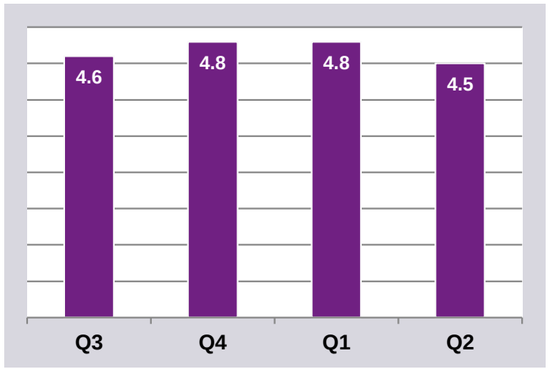
Quarterly Update – 2nd Quarter Plan Year 2021

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

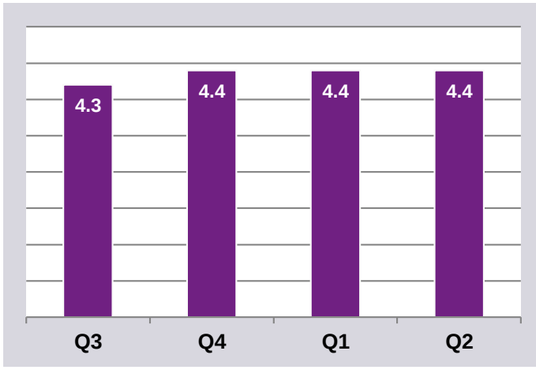
Q2 Enrollment Satisfaction

CSAT score	Count	%
5	118	70%
4	30	18%
3	12	7%
2	4	2%
1	4	2%
	168	**100%**



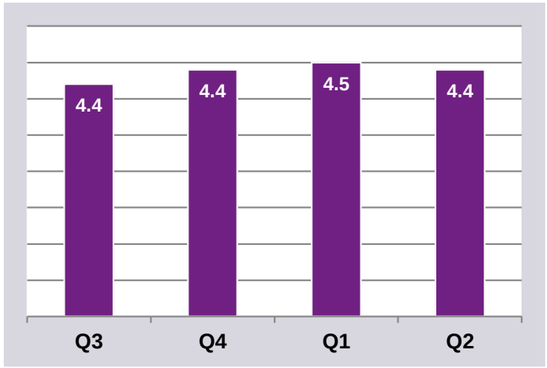
Q2 Service Satisfaction

CSAT score	Count	%
5	492	68%
4	112	15%
3	56	8%
2	23	3%
1	41	6%
	724	**100%**



Q2 Enrollment & Service Combined

CSAT score	Count	%
5	610	68%
4	142	16%
3	68	8%
2	27	3%
1	45	5%
	892	**100%**

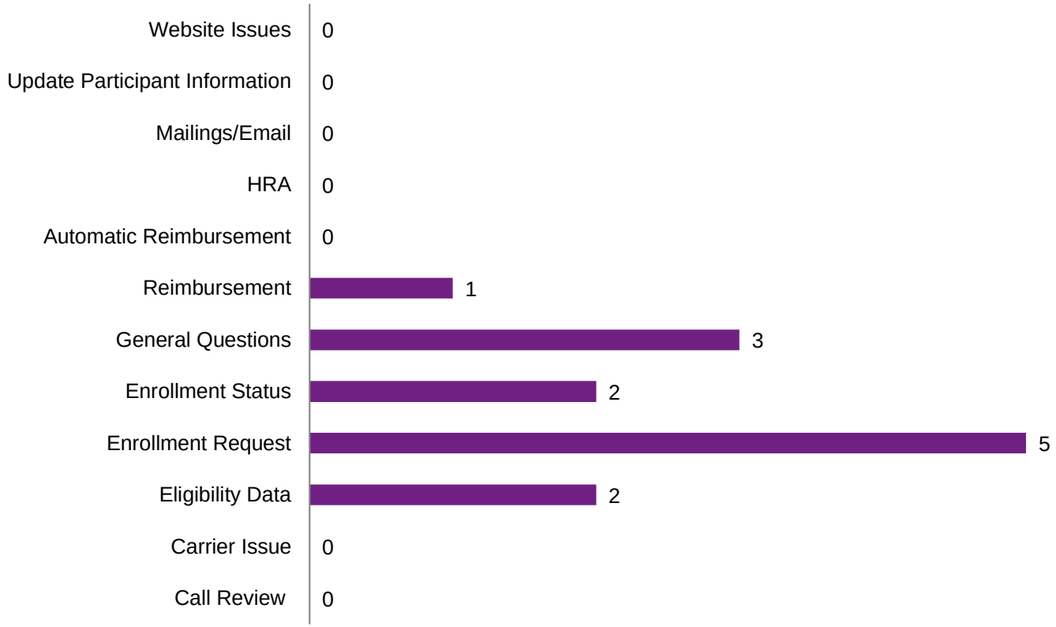


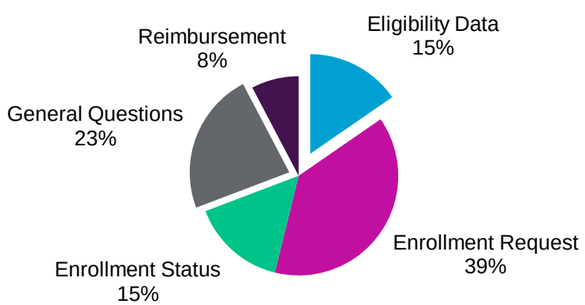
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2021

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-PY21 is 13 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,994
Number of payments	53,781
Accounts with no balance	7,172
Claims paid amount	$8,087,705

Claims By Source	Total 77,130
A/R file	72,925
Mail	2,210
Web	1,908
Mobile App	87

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2021

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.21 Days	Yes
Claim Financial Accuracy	≥ 98%	99.52%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.95%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q2 and Q3 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	8 Minutes 53 Seconds	No
Benefits Administration Customer Service Abandonment Rate	≤ 5%	Annual 8%	No
Customer Satisfaction	≥ 80%	92%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	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 2021

Operations Report

Medicare Open Enrollment Plan Changes for 2021

The Medicare Open Enrollment Season for 2021 occurred from October 15, 2020 – December 7, 2020. The below chart captures information on the number of participants that made changes in their existing Medicare Medical or Prescription Drug Plan. There a significant increase in the number of participants who changed their Medicare Advantage Plan (MAPD). We saw 888 participants change from one MAPD to another MAPD for the 2021 plan year where we only saw 247 participants make a change for plan year 2020. This increase is likely attributed to the participants being more health conscious due to the impacts of COVID-19. In total, we saw 1,819 plan changes for 2021 while we only saw 1,470 changes for 2020.

Original Plan	New Plan	1/1/2021 Changes	1/1/2020 Changes
Medicare Supplement	Medicare Supplement	77	62
Medicare Supplement	Medicare Advantage	75	49
Medicare Advantage	Medicare Advantage	888	247
Medicare Advantage	Medicare Supplement	17	60
Prescription Drug Plan	Prescription Drug Plan	762	1,052

Spring Retiree Meetings

Normally, Willis Towers Watson and Nevada PEBP hold three days of retiree meetings in the Spring focusing on participants ageing into Medicare as well as those already enrolled but who may need help with their HRA. The meetings typically would occur in Las Vegas, Reno, and Carson City with 2 presentations per day. However, due to COVID-19, we are not able to have the live meetings. Instead, we will be holding two days of virtual meetings with two meetings per day. The virtual meetings will be held on March 22 and 23. Links for participants to register for the meetings are available on the main page of our Nevada PEBP specific Website at https://my.viabenefits.com/PEBP

Meeting Date/Time	Meeting Type
March 22 - 9:30 am PT	Pre-Medicare/Ageing into Medicare
March 22 – 12:00 pm PT	HRA/Medicare Open Enrollment
March 23 - 12:00 pm PT	Pre-Medicare/Ageing into Medicare
March 23 - 2:00 pm PT	HRA/Medicare Open Enrollment

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2021

Operations Report

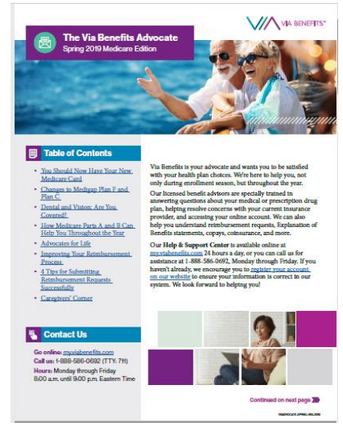
Communications:

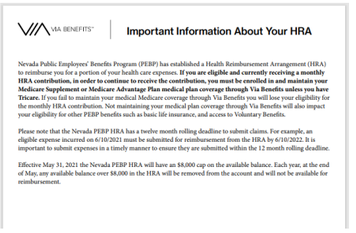
Below is information on communications that were mailed or will be coming up.

- Spring Newsletter
  - This communication is sent to participants via mail or email and is typically sent starting in the February/March. The intent of this communication is to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality. The newsletters are targeted to be sent in mid-April.

- Spring Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days. It is designed to remind them of their HRA balance so they can take action and submit new claims for reimbursement from their account. The Balance Reminder was sent out in late February and early March.

- New HRA Welcome Packet Insert
  - In January, 2021, a new HRA Welcome Packet Insert was created to help communicate three important aspects of Nevada PEBPs HRA plan design to participants:
    - The funding account qualification requirement and the impact to other benefits offered by PEBP if a participant disenrolls from Via Benefits.
    - The twelve month rolling deadline to submit claims from the date they are incurred.
    - The new HRA Available Balance Cap of $8,000 that will go into effective on May 31, 2021.





Outbound Calls Related to $8,000 HRA Available Balance Cap:

Effective May 31, 2021, Nevada PEBP will be implementing an $8,000 HRA Available Balance Cap. Nevada PEBP has sent several communications related to this Cap, and we coordinated with PEBP to have outbound calls place to participant who were sent an email in early February. The recipients of the email were those participants that had a current balance of $7,000 or greater as they are expected to be the ones who will potentially be impacted by the new HRA Balance Cap once it goes live.

Multiple attempts will be made to contact the participant over the phone and help educate them on the new HRA Balance Cap and how they can submit claims for eligible expenses to help decrease their available balance.

4.4.6

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.4 Receipt of quarterly vendor reports for the period ending December 31, 2020:

        4.4.1 HealthSCOPE Benefits – Obesity Care Management

        4.4.2 HealthSCOPE Benefits – Diabetes Care Management

        4.4.3 American Health Holdings – Utilization and Large Case Management

        4.4.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

        4.4.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report Q2 2021

        4.4.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

Hometown Health Providers & Sierra Healthcare Options

Q2 PlanYear 2021

October 1, 2020 – December 31, 2020

Hometown Health

SIERRA HEALTH-CARE OPTIONS, INC.

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

March 25, 2021

Service Performance	Guarantee Measurement	Actual	Pass/Fail	Standard(Metric)
I. EDI claims repricing	**95%**- Turnaround time frame for repricing of medical claims within 3 business days of receipt from PEBP's TPA	92%	Fail	
	97%- Accuracy of claims repriced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA	99%	Pass	
II. A. Hometown Health Provider Data Changes*	**100%**- Data changes must be provided to PEBP's TPA within 30 calendar days following the effective date of the change	100%	Pass	
	100%- Provider fee schedule revisions must be provided to PEBP's TPA within 30 calendar days following the effective date of the change	100%	Pass	
II. B. Sierra Healthcare Options (SHO) Provider Data Changes*	**100%**- Data changes must be provided to PEBP's TPA within 30 calendar days following the effective date of the change	100%	Pass	
	100%- Provider fee schedule revisions must be provided to PEBP's TPA within 30 calendar following the effective date of the change	100%	Pass	
	(100% of the ACT's are rounted to the State of Nevada within 30 days of notification of the add, change or term. Please note: the effective date of add, change or term can be greater than 30 days based on the date SHO receives the notifaction or signed document from the provider)			
III. Data Reporting	A. Standard reports must be delivered within 10 days of end of reporting period or event as determined by PEBP. B. Special reports requested by PEBP and/or PEBP's Consultant/Actuary must be delivered within 10 days of agreed response date. .	100% 100%	Pass Pass	
IV. Subcontractor disclosure	**100%**- of all subcontractors utilized by vendor are disclosed prior to any work being done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	Pass	
V. Website	**100%**- Network website must be updated within 30 calendar days as provider information changes take effect	100%	Pass	

Hometown Health

SIERRA HEALTH-CARE OPTIONS, INC.

4.4.7

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4.4.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

Health Plan of Nevada

Quarterly
Update for
October-December 2020

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

February 12th, 2021

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Quarterly Report for October – December 2020

Service Performance Standard (Metric)	Guarantee Measurement	Actual	Pass/Fail
I. Claims Processing	**97%** - Claims Financial Accuracy	100%	Pass
	95% - Claims Procedural Accuracy	100%	Pass
	95% in 30 working days - Clean claims turnaround for unaffiliated providers	100%	Pass
II. Participant Correspondence	ID Card Turnaround- Mailed within 10 working days of date of eligibility input	3.13 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	5.4 days	Pass
III. Customer Service- Telephone	Speed to queue and answer by live voice- Within 60 seconds	9 sec	Pass
	5% or less - Telephone abandonment rate	1%	Pass
IV. Other Customer Service	**98%** - Resolved resolution within 30 days of receipt of written correspondence (i.e. complaint or appeal)	100%	Pass
	Notification to member regarding PCP disenrollment - within 30 working days	100%	Pass
	Primary Care Physician /Member Ratio - 1 to 2450	1 to 292	Pass

4.4.8

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4.4.8 Doctor on Demand Engagement Reports through December 2020

NVPEB

HealthSCOPE Benefits

2021-01 Engagement Report

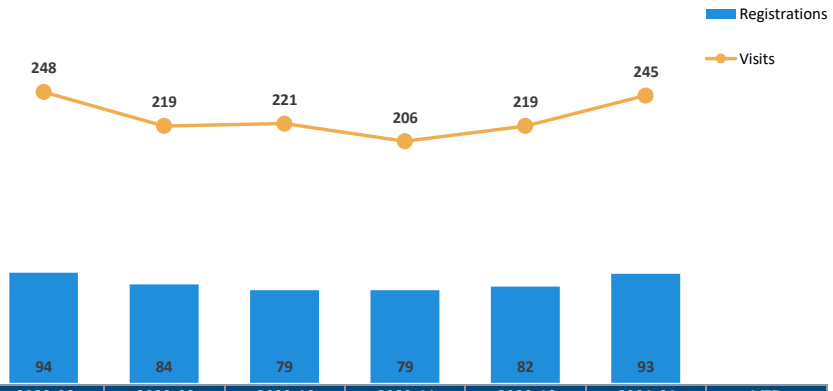
Note: Only Doctor On Demand visits with an associated claim submission to the Payer are included in the Engagement Report -- any free, discounted, uncovered, or other non-claim visits are not included. This is true of all metrics, trends, and aggregations.

Year To Date Activity

Registration Summary	YTD
# Registered	93

Visit Summary	YTD
# Unique Visitors	203
# Visits	245

Monthly Activity



Registration Summary	Prior	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	LTD
# Registered	8,553	94	84	79	79	82	93	9,064

Note: Registration month is captured per the date of Doctor On Demand registration, not the date when the member entered health insurance to his/her profile.

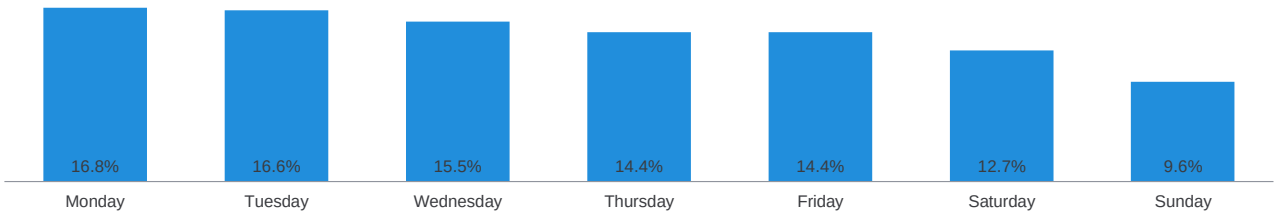
Visit Summary		Prior	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	LTD
# Unique Visitors		3,142	201	185	183	182	191	203	3,602
# Visits		6,560	248	219	221	206	219	245	7,918
Visit Frequency	% 1 Visit	59.4%	84.6%	84.3%	85.2%	89.0%	89.0%	82.8%	57.8%
	% 2 Visits	19.0%	10.9%	13.5%	10.9%	8.8%	7.9%	13.8%	18.4%
	% 3 Visits Or More	21.6%	4.5%	2.2%	3.8%	2.2%	3.1%	3.4%	23.8%

Note: Because a visitor can be unique in multiple months, but only once over history, Prior + Monthly "# Unique Visitors" will not sum to the Total.

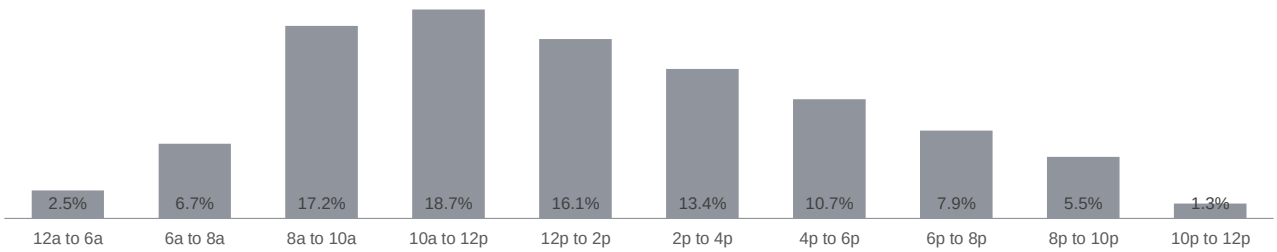
Visit Type Summary		Prior	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	LTD
Medical		5,461	207	176	166	171	184	185	6,550
Mental Health	Therapy	621	21	17	27	16	10	28	740
	Psychiatry	478	20	26	28	19	25	32	628

Six Month Trends: Visit Time And Demographics

Day Of Week



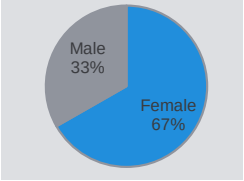
Hour Of Day



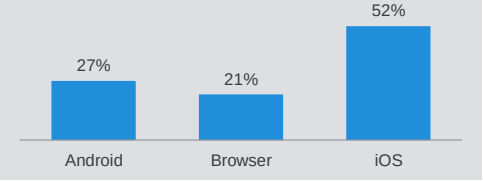
Patient Age

0 to 17 (Custodial)	6%
18 to 29	23%
30 to 49	48%
50 and over	23%

Patient Gender



Visitor App Type



NVPEB

HealthSCOPE Benefits

2021-01 Engagement Report

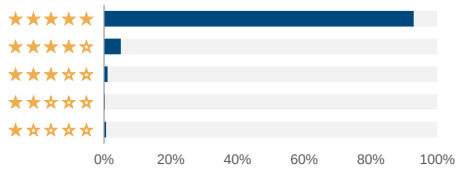
dr. on demand

Historical Visit Experience

5,964 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **8.8 Minutes**

Historical Post Visit Survey Results

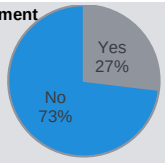
Without Doctor On Demand, where would you have gone to get this issue treated?

Note: Survey presented only when no other post visit action was required

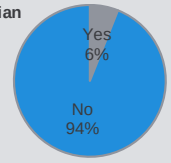
Response	# Responses	% Responses
Emergency Room	81	3%
Urgent Care	1,501	52%
Doctor's Office	828	29%
Stayed Home	373	13%
Other	126	4%

Six Month Trends: Visit Initiation

Initiated By Appointment (Medical Visits Only)

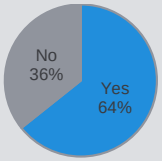


Initiated By Custodian

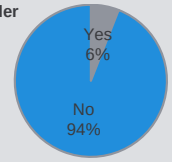


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
Head / Neck: Headache	1,857	6.1%
General Symptoms: Fatigue / weakness	1,838	6.1%
Chest: Cough	1,808	6.0%
Head / Neck: Sore throat	1,673	5.5%
General Symptoms: Difficulty sleeping	1,489	4.9%
Head / Neck: Nasal discharge	1,364	4.5%
Head / Neck: Congestion / sinus problem	1,164	3.8%
General Symptoms: Fever	1,022	3.4%
Head / Neck: Congestion/sinus problem	1,002	3.3%
General Symptoms: Loss of appetite	862	2.8%
Genitourinary: Discomfort / burning with urination	774	2.5%
Genitourinary: Frequent urination	761	2.5%
Gastrointestinal: Sore throat	562	1.9%
Chest: Shortness of breath	550	1.8%
Head / Neck: Difficulty / pain swallowing	519	1.7%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N39.0 - Urinary tract infection, site not specified	715	7.0%
J01.90 - Acute sinusitis, unspecified	521	5.1%
J06.9 - Acute upper respiratory infection, unspecified	521	5.1%
J02.9 - Acute pharyngitis, unspecified	304	3.0%
F41.1 - Generalized anxiety disorder	290	2.8%
R05 - Cough	270	2.6%
J20.9 - Acute bronchitis, unspecified	227	2.2%
Z76.0 - Encounter for issue of repeat prescription	220	2.1%
F43.23 - Adjustment disorder with mixed anxiety and depressed n	187	1.8%
F41.9 - Anxiety disorder, unspecified	159	1.5%
J01.80 - Other acute sinusitis	151	1.5%
Z63.0 - Problems in relationship with spouse or partner	147	1.4%
F33.1 - Major depressive disorder, recurrent, moderate	133	1.3%
J01.00 - Acute maxillary sinusitis, unspecified	118	1.1%
J11.1 - Influenza due to unidentified influenza virus with other resp	113	1.1%

Historical Top 15 Rx

Rx	# Visits	% of All Rx
benzonatate	570	6.9%
amoxicillin-clavulanate	564	6.8%
predniSONE	534	6.4%
nitrofurantoin	517	6.2%
albuterol	507	6.1%
fluticasone nasal	244	2.9%
sulfamethoxazole-trimethoprim	215	2.6%
fluconazole	214	2.6%
azithromycin	212	2.6%
amoxicillin	211	2.5%
methylPREDNISolone	210	2.5%
doxycycline	172	2.1%
ipratropium nasal	170	2.1%
oseltamivir	168	2.0%
sertraline	157	1.9%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	81	10.4%
Comprehensive Metabolic Panel	69	8.9%
Urinalysis, Complete with Reflex	68	8.7%
CBC+diff	58	7.5%
Lipid Panel	49	6.3%
Urine Culture, Routine	45	5.8%
Hemoglobin A1c	40	5.1%
Vitamin D	34	4.4%
Chlamydia/GC, Urine	30	3.9%
B12/Folate	25	3.2%
Urinalysis, Complete	24	3.1%
Basic Metabolic Panel	18	2.3%
RPR w/ Reflex	14	1.8%
SARS-CoV-2 IgG	12	1.5%
T. Vaginalis, Urine MALE	12	1.5%

4.5

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.5 Morneau Shepell/Corestream Voluntary Benefits Report

PEBP Plus Enrollment Data (as of 3/1/2021)

PROVIDER	PRODUCT	ENROLLMENT COUNT
Aflac	Accident Critical Illness Hospital Indemnity	1122 865 944
ASPCA	Pet Insurance	50
ID Watchdog	Identity Theft	619
LegalEASE	Legal	695
Liberty Mutual	Auto/Home	1379
MetLife	Auto/Home	40
The Standard	Employee Life Spouse Life Dependent Child Life Retiree Life	3492 995 1692 1307
Travelers	Auto/Home	28
Unum	Long Term Care	277
Nationwide Pet	Pet Insurance	111
VSP	Vision	4508

4.6

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.6 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2021 for individual coverage and family coverage for PEBP's Consumer Driven Health (CDHP) Plan, Exclusive Provider Organization (EPO) Plan and Low Deductible (LD) Plan

Public Employees' Benefits Program

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

Coverage Period: 07/01/2021 – 06/30/2022
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?	In-network Providers: Individual $1,750	Generally, you pay all costs up to the deductible, except preventive services and certain copayments. In-Network and Out-of-Network Deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services covered if the deductible has not been met; however, a copayment or coinsurance may apply. Example: preventive services and medications on the preventive drug list. For more additional limitations, refer to the CDHP Master Plan Document (MPD).
Are there other deductibles for specific services?	No	The Plan does not include separate deductibles for specific services. Separate deductibles apply to network providers and out-of-network providers.
What is the out-of-pocket limit for this plan?	Network providers: $5,000/Individual out-of-network: $10,600/Individual	The Out-of-pocket limit is the most an individual must pay in a Plan Year for Eligible Medical Expenses. Out-of-pocket limit accumulates separately for In-network and out-of-network
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Penalties you pay for failure to obtain required preauthorization, premiums, non-use of 30-day Express Advantage Network, non-compliance with 90-day retail/mail order, manufacturer-funded copay assistance, non-use of SaveonSP (for non-essential specialty drugs); penalties of balance-billing, and non-covered supplies and services. .
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 network provider You will pay more if use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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 care must be provided in-network. Refer to the CDHP MPD for exceptions for explanations and limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs must be performed at a free-standing lab. 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	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a surcharge. Penalty applies if you do not use a Smart90 retail/home delivery pharmacy for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveonSP for drugs on the Essential Benefit Specialty Drug list. Copay assistance for specialty drugs do not apply to deductible/Out-of-pocket limit.
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
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	Emergency room care paid as in-network; Balance billing applies to out-of-network; out-of-network emergency room, medical transportation, and urgent care subject to the Plan's Maximum Allowable Charge. See the CDHP MPD for information.
	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	Preauthorization required or 50% penalty applies. Balance billing applies to out-of-network
	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	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
	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	Cost sharing does not apply for preventive services. Depending on the type of services coinsurance and Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See CDHP MPD for preventive care
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
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 after 90 combined visits. Balance billing applies to out-of-network claims.
	Habilitation services	20% coinsurance	50% coinsurance	
	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	Preauthorization required after 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

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Acupuncture
- Obesity Care Management Program
- Chiropractic care
- Hearing aids
- Vision exam (limited to one screening exam)
- Bariatric surgery

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

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	$1,750
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	None
Coinsurance	$2,190
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,000**

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

The plan's overall deductible	$1,750
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	None
Coinsurance	$770
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,580**

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

The plan's overall deductible	$1,750
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	None
Coinsurance	$210
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,960**

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 ሊያግዘዎት 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).

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: 07/01/2021 – 06/30/2022
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?	In-network: Family: $3,500, Individual w/in Family: $2,800. Out-of-network: Family: $3,500; Individual w/in Family $2,800	Generally, you pay all costs up to the deductible, except preventive services and certain copayments. Individuals within the family must meet their own individual deductible until the total expenses paid by all family members meets the overall family deductible. In-Network and Out-of-Network Deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services covered if the deductible has not been met; however, a copayment or coinsurance may apply. Example: preventive services and medications on the preventive drug list. For more additional limitations, refer to the CDHP Master Plan Document (MPD).
Are there other deductibles for specific services?	No.	The Plan does not include separate deductibles for specific services. Separate deductibles apply to network providers and out-of-network providers.
What is the out-of-pocket limit for this plan?	Network providers: Family $10,000, individual within Family: $6,850. out-of-network: Family $21,200	The in-network Out-of-pocket limit is the most an Individual or a Family must pay in a Plan Year for Eligible Medical Expenses.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Penalties you pay for failure to obtain required preauthorization, premiums, non-use of 30-day Express Advantage Network, non-compliance with 90-day retail/mail order, manufacturer-funded copay assistance, non-use of SaveonSP (for non-essential specialty drugs); penalties of balance-billing, and non-covered supplies and services.
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 network provider. You will pay more 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).
Do you need specialist referral?	No.	You can see the specialist you choose without a referral.

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

Common	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important

Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
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 care must be provided in-network. Refer to the CDHP MPD for exceptions for explanations and limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs must be performed at a free-standing lab. 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	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a surcharge. Penalty applies if you do not use a Smart90 retail/home delivery pharmacy for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveonSP for drugs on the Essential Benefit Specialty Drug list. Copay assistance for specialty drugs do not apply to deductible/Out-of-pocket limit.
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (i.e., ASC)	20% coinsurance	50% coinsurance	Preauthorization required or 50% penalty applies. Balance billing applies to out-of-network
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Emergency room care paid as in-network; Balance billing applies to out-of-network; out-of-network emergency room, medical transportation, and urgent care subject to the Plan's Maximum Allowable Charge. See the CDHP MPD for information.
	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	Preauthorization required or 50% penalty applies. Balance billing applies to out-of-network
	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	Preauthorization required for certain services.
	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	Cost sharing does not apply for preventive services. Depending on the type of services coinsurance and Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See CDHP MPD for preventive care
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
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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.
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	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required after 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.)

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- Routine foot care
- Orthodontia expenses

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

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

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	$2,800
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0.00
Coinsurance	$1,980
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,840**

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

The plan's overall deductible	$2,800
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0.00
Coinsurance	$560
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,420**

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

The plan's overall deductible	$2,800
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2.800
Copayments	$0.00
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

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

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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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 ሊያግዘዎት 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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ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 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: 07/01/2021 – 06/30/2022

Coverage for: Individual and Family | **Plan Type:** Premier (EPO) 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 **deductible** : Individual: $150/Family: $300, Individual within the Family: $150	Certain services are subject to deductible; for example: specialty drugs, diagnostic tests, and durable medical equipment. You pay out-of-pocket for these services until you meet your deductible.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services are not subject to the deductible, such as office visit copays and pharmacy benefit copays; other services that are not subject to deductible include preventive services.
Are there other deductibles for specific services?	No	The Plan does not include separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual: $5,000/Family $10,000, Individual within Family: $5,000. Out-of-network providers: N/A	The Out-of-pocket limit is the most an Individual or a Family will pay in a Plan Year for Eligible Medical Expenses.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Out-of-pocket limit excludes penalties you pay for failure to obtain required preauthorization, premiums, copay surcharge for not using Express Advantage Network for short-term medications, failure to use 90-day retail/mail order for long-term medications, copay assistance dollars, failure to participate in the SaveonSP (for non-essential specialty drugs); balance billing and non-covered supplies and services.
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 more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important

Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	Not Covered	None.
	Specialist visit	$40 copay	Not Covered	None.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Routine labs covered only when performed at a free-standing lab facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	May require preauthorization depending on the imaging type.
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	30-day/$10 copay 90-day/$20 copay	Not Covered	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a copay surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit Specialty Drug List. Copay assistance for specialty drugs do not apply to deductible or out-of-pocket limit. Must use the Plan's specialty pharmacy.
	Preferred brand	30-day/$40 copay 90-day/$80 copay	Not Covered	
	Non-preferred brand	30-day/$75 copay 90-day/ $150 copay	Not Covered	
	Specialty drugs	30% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center)/physician /surgeon fees	$350 copay	Not Covered	Requires preauthorization. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$750 copay	$750 copay	Out-of-Network emergency room care/emergency medical transportation paid as in-network, subject to the Plan's Maximum Allowable Charge.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit	$50 copay/visit	Out-of-Network urgent care payable up to the Plan's Maximum Allowable Charge
If you have a hospital stay	Facility fee (e.g., hospital room)/physician/surgeon fees	$750 copay/admit	Not Covered	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

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 Visit	$40 copay/visit	Not Covered	None.
	Inpatient services	$750 copay/admit	Not Covered	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$40 copay/visit	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Surgical: No charge Anesthesia: No charge	Not Covered	
	Childbirth/delivery facility services	$750 copay/admit	Not Covered	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	Not Covered	Preauthorization required. 60 visits/plan year.
	Rehabilitation services	$40 copay/visit $750 copay/admit	Not Covered	Preauthorization required for visits exceeding 90 combined (OT, PT, ST) per year.
	Habilitation services	$40 copay/visit $750 copay/admit	Not Covered	Preauthorization required.
	Skilled nursing care	$750 copay/admit	Not Covered	Preauthorization required. 60 visits/plan year.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for equipment over $1,000.
	Hospice services	$750 copay/admit	Not Covered	Preauthorization required after 185 days.
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
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

Refer to the Low Deductible PPO 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

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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	$300
Specialist *[copay]*	$40
Hospital (facility) *[copay]*	$750
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$790
Coinsurance	$230
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

The plan's overall deductible	$300
Specialist *[copay]*	$40
Hospital (facility) *[copay]*	$750
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$89
Copayments	$1,000
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,149**

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

The plan's overall deductible	$300
Specialist *[copay]*	$40
Hospital (facility) *[copay]*	$750
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$975
Coinsurance	$135
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,260**

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.

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

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Public Employees' Benefits Program

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

Coverage Period: 07/01/2021 – 06/30/2022

Coverage for: Individual | **Plan Type:** Low Deductible PPO 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: Individual $500.Out-of-Network $500	Certain services are subject to deductible; for example: specialty drugs, inpatient hospitalization, diagnostic tests, durable medical equipment, etc. You pay out-of-pocket for these services until you meet your deductible. In-Network and Out-of-Network Deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services are not subject to the deductible, such as office visit copays and pharmacy benefit copays; other services that are not subject to deductible include preventive services.
Are there other deductibles for specific services?	No	The Plan does not include separate deductibles for specific services. In-network and an Out-of-Network Deductibles accumulate separately.
What is the out-of-pocket limit for this plan?	In-Network: Individual $5,000 Out-of-network: Individual $10,600	The In-Network Out-of-pocket limit for self-only coverage (individual) is $5,000; the out-of-network Out-of-pocket limit is $10,600. In-Network and out-of-network Out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Out-of-pocket limit excludes penalties you pay for failure to obtain required preauthorization, premiums, copay surcharge for not using Express Advantage Network for short-term medications, failure to use 90-day retail/mail order for long-term medications, copay assistance dollars, failure to participate in the SaveonSP (for non-essential specialty drugs); balance billing and non-covered supplies and services.
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 more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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 illness or injury	$30 copay	50% coinsurance	None.
	Specialist visit	$50 copay/visit	50% coinsurance	None.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered when performed at a free-standing lab facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization required for some imaging tests.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Preferred Generic	30-day/$10 copay 90-day/$20 copay	Not Covered	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a copay surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit Specialty Drug List. Copay assistance for specialty drugs do not apply to deductible or out-of-pocket limit. Must use the Plan's specialty pharmacy.
	Preferred brand	30-day/$40 copay 90-day/$80 copay	Not Covered	
	Non-preferred brand	30-day/$75 copay 90-day/ $150 copay	Not Covered	
	Specialty drugs	30% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center)/physician/surgeon fees	$500 copay	50% coinsurance	Requires preauthorization. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Balance billing applies to out-of-network providers.
If you need immediate medical attention	Emergency room care	$750 copay	$750 copay	Emergency room care, emergency medical transportation paid as in-network; Balance billing applies to out-of-network emergency room and emergency medical transportation, subject to the
	Emergency medical transportation	20% coinsurance	20% coinsurance	

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

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)	
				Plan's Maximum Allowable Charge.
	Urgent care	$80 copay	50% coinsurance	Out-of-network: Balance billing applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	$50 copay/office visit	50% coinsurance	Out-of-network: Balance billing applies.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$50 copay/office visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. 60 visits/plan year.
	Outpatient rehabilitation services	$50 copay per visit	50% coinsurance	Preauthorization required for visits exceeding 90 combined (OT, PT, ST) per year.
	Inpatient rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Maximum 60 visits/plan year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	. Preauthorization required after 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.

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

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
• Infertility treatment	• 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	• 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	$500
Specialist *[copay]*	$50
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,691
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,291**

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

The plan's overall deductible	$500
Specialist *copay]*	$50
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$89
Copayments	$1,040
Coinsurance	
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,149**

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

The plan's overall deductible	$500
Specialist *[copay]*	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,075
Coinsurance	$64
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,639**

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 ሊያግዘዎት 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).

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: 07/01/2021 – 06/30/2022
Coverage for: Family | **Plan Type:** LD PPO

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 **deductible** : Family: $1,000; Individual within the Family: $500	Certain services are subject to deductible; for example: specialty drugs, inpatient hospitalization, diagnostic tests, durable medical equipment, etc. You pay out-of-pocket for these services until you meet your deductible. In-Network and Out-of-Network Deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services are not subject to the deductible, such as office visit copays and pharmacy benefit copays; other services that are not subject to deductible include preventive services.
Are there other deductibles for specific services?	No	The Plan does not include separate deductibles for specific services. In-network and an Out-of-Network Deductibles accumulate separately.
What is the out-of-pocket limit for this plan?	In-Network: Family $10,000; Individual within Family: $5,000. Out-of-network providers: Family $21,200	The In-Network Out-of-pocket limit is the most a Family ($10,000) or an individual w/in a Family ($5,000) must pay in a Plan Year for Eligible Medical Expenses. The out-of-network Out-of-pocket limit for Family is $21,200 (may be satisfied by one member or by a combination of claims for all family members. In-Network and out-of-network Out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Out-of-pocket limit excludes penalties you pay for failure to obtain required preauthorization, premiums, copay surcharge for not using Express Advantage Network for short-term medications, failure to use 90-day retail/mail order for long-term medications, copay assistance dollars, failure to participate in the SaveonSP (for non-essential specialty drugs); balance billing and non-covered supplies and services.
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 more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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	$30 copay	50% coinsurance	None.
	Specialist visit	$50 copay	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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 facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization depending on the imaging type.
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	30-day/$10 copay 90-day/$20 copay	Not Covered	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a copay surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit Specialty Drug List. Copay assistance for specialty drugs do not apply to deductible or out-of-pocket limit. Must use the Plan's specialty pharmacy.
	Preferred brand	30-day/$40 copay 90-day/$80 copay	Not Covered	
	Non-preferred brand	30-day/$75 copay 90-day/ $150 copay	Not Covered	
	Specialty drugs	30% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center); physician /surgeon fees	$500 copay	50% coinsurance	Requires preauthorization. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$750 copay	$750 copay	Emergency room care, emergency medical transportation, paid as in-network; Balance billing applies to out-of-network emergency room and emergency medical transportation, subject to the Plan's Maximum Allowable Charge. See the LD PPO MPD.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$80 copay	50% coinsurance	Balance billing applies to out-of-network urgent care

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	$50 copay/office visit	50% coinsurance	None.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$50 copay/office visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. 60 visits/plan year.
	Outpatient rehabilitation services	$50 copay per visit	50% coinsurance	Preauthorization required for visits exceeding 90 combined (OT, PT, ST) per year.
	Inpatient rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. 60 visits/plan year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required after 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.

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

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
• Infertility treatment	• 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	• 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.

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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	$500
Specialist *[copay]*	$50
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,691
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,291**

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

The plan's overall deductible	$500
Specialist *[copay]*	$50
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$89
Copayments	$1,040
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,149**

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

The plan's overall deductible	$500
Specialist *[copay]*	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,075
Coinsurance	$64
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,639**

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.

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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).

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5.

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: March 25, 2021

Item Number: V

Title: Executive Officer Report

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the overall activities of PEBP.

REPORT

IMPLEMENTATION AND OPEN ENROLLMENT ACTIVITIES

Implementation and transition activities are already underway at PEBP. The enrollment and eligibility system transition has been the focus of much of staff's attention. Since this is the primary tool used internally by all PEBP staff, externally by members and is the source of record for all our vendors there is very significant lift and it is crucial for all staff to be involved, regardless of function. In addition to a new system vendor, PEBP also will be changing networks. We have already begun initial discussions with Aetna to address transition activities and specifically communication. Provider groups will be sent communication blasts through the network and PEBP will be sending out both targeted and blanket member communications several times leading up to July 1.

In addition to the new contracts being implemented in time for the start of PY22, staff are also very busy preparing for the solicitations that will be released throughout the course of the next several months. The development of comprehensive and thorough solicitations is crucial to the success of the program, so it is extremely important for all staff across all functional areas to be heavily involved.

Open Enrollment (OE) work has also started. Staff have been busy updating master plan documents, developing materials and presentations for the OE meetings and working with Morneau Shepell to ensure the eligibility system is properly programmed to allow members to

enroll in the new Low Deductible Plan. Similar to last year, OE meetings will be held virtually with several sessions available throughout the beginning of May, including incorporating a Saturday session.

LEGISLATIVE SESSION

Nevada's 81st Legislative session is in full swing. PEBP staff, with the help of our vendor partners have been performing impact analysis on legislation as bill language has become available. The first major deadline – the deadline for bill introductions sponsored by legislators was set for March 15, but that date was extended an additional week to allow for the backlog of legislation to be presented. It is expected the next deadline to introduce bills sponsored by committees will also be extended. As proposed legislation continues to trickle in, PEBP anticipates future Board updates to include information on several new bills affecting PEBP.

Additionally, PEBP's budget closing is tentatively set for April 6th. PEBP has provided follow up information and data requested by the committee during the initial budget presentations. Furthermore, PEBP staff have been working closely with the Governor's Finance Office and legislative staff to ensure all parties are thoroughly involved and aware of PEBP's unique fiscal situation.

FEDERAL STIMULUS UPDATES

In 2020, PEBP received approximately $5.7M in CARES Act funding to cover expenditures relating to COVID testing and treatment. Those dollars were due to expire at the end of 2020 but were approved in late December to be extended into 2021. Based on conversations with the Governor's Finance Office, PEBP will not be requesting any additional CARES Act relief. The plan has experienced significant claims suppression throughout the last year as a result of lockdowns and stay at home orders, so there is an expectation PEBP will end the fiscal year with a significant surplus. Requesting CARES Act funding at this point would only add to that surplus, while potentially eliminating the opportunity for another agency or program to leverage those dollars today. Conversely, PEBP will be applying for the reimbursement of vaccine related costs (projected to be $1M-$2M through the end of the fiscal year) through FEMA funds. These funds are more restricted and should PEBP be awarded this assistance, it would not reduce the availability of funding to other Nevada state and local governments.

The American Rescue Act, the most recent federal stimulus package passed by congress earlier this month is another potential source of relief. PEBP has already initiated conversations with the Governor's Office and Governor's Finance Office regarding the specifics of the legislation, but a lot remains unknown at the present time. There are ongoing discussions on a state and federal level to address questions and details on how the funding can be appropriated to meet each state's unique needs and there is some optimism that the Governor's Office will be able to provide some more definite guidance by summer. Unfortunately, PEBP does not have the luxury of delaying PY22 decisions as the program is obligated to meet open enrollment deadlines.

6.

6. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

    6.1 Contract Overview

    6.2 New Contracts

        6.2.1 Claim Technologies Inc.

        6.2.2 Clifton Larson Allen LLP

    6.3 Contract Amendments

    6.4 Contract Solicitations

        6.4.1 Actuarial Consultants

        6.4.2 Group Basic Life Insurance and Long-Term Disability

    6.5 Status of Current Solicitations

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 25, 2021

Item Number: VI

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

6.1 Contracts Overview

Below is a listing of the active PEBP contracts as of February 28, 2021.

PEBP Active Contracts Summary							
Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,600,000	$ 55,744,872	$ 6,855,128
Health Claim Auditors Inc.	Health Plan Auditor	12614	10/11/2011	9/30/2022	$ 2,827,910	$ 1,535,497	$ 1,292,413
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000	$ 10,716,315	$ 4,738,685
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 95,000,000	$ 73,784,962	$ 21,215,038
HealthScope Benefits	Voluntary Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000	$ -	$ 125,000
Diversified Dental Services Inc.	Dental Contract	14563	7/9/2013	6/30/2021	$ 3,081,984	$ 2,451,109	$ 630,875
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000	$ 4,887,117	$ 1,212,883
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2021	$ 8,560,090	$ 8,178,082	$ 382,008
Standard Insurance Company	Voluntary Life Insurance	15503	7/1/2014	6/30/2023	$ 22,500,000	$ -	$ 22,500,000
Morneau Shepell LTD	Benefits Management System	15941	1/1/2015	12/31/2023	$ 8,623,789	$ 5,808,523	$ 2,815,266
Extend Health, Inc	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000	$ 1,233,742	$ 312,258
KPS3	Website Redesign	17226	11/1/2015	6/30/2021	$ 80,775	$ 69,117	$ 11,658
Casey,Neilon & Associates	Financial Auditor	17424	3/8/2016	12/31/2021	$ 236,500	$ 225,052	$ 11,448
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$226,500,000	$ 215,766,935	$ 10,733,065
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,376,585	$ 2,525,502	$ 851,083
Health Plan of Nevada Inc	Southern Nevada HMO	18362	7/1/2017	6/30/2021	$231,000,000	$ 136,908,059	$ 94,091,941
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2023	$ 8,000,000	$ 3,387,670	$ 4,612,330
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/8/2020	6/30/2027	$ 6,849,000	$ -	$ 6,849,000
Aetna	PPO Network	23846	7/1/2021	6/30/2026	$ 7,127,250	$ -	$ 7,127,250
Health Plan of Nevada Inc	HMO Provider	23802	7/1/2021	6/30/2025	$192,093,848	$ -	$192,093,848
Diversified Dental Services Inc.	Dental Provider	23810	7/1/2021	06/30/206	$ 1,601,613	$ -	$ 1,601,613

Recommendation

No action necessary

6.2 New Contracts

The PEBP Board approved the solicitation for a Financial Auditor on May 28, 2020 and approved the solicitation for a Health Claims Auditor on September 24, 2020. Request for Proposals were released, and PEBP staff has successfully negotiated a contracts for Health Claims Auditing and Financial Auditing services.

6.2.1 CLAIM TECHNOLOGIES INC.

On November 24, 2020, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1388 for Health Plan Auditing Services. The following were some items important to PEBP in the consideration of the award of this contract:

- Audits are essential to assure that services provided by PEBP and PEBP's contracted vendors are following contract requirements and performance guarantees.
- Provide audit services of PEBP's Third Party Administrator (TPA) that will include audits of the following:
    - Health Savings Accounts (HSA) and Health Reimbursement Accounts (HRA) and managed by PEBP's TPA;
    - Pharmacy Benefits Manager (PBM);

    - PEBP's Preferred Provider Networks;
    - Utilization Management Company; and
    - Health Reimbursement Accounts (HRAs) administered by the IMME.
- Provide an audit of PEBPs internal practices in the management of its Eligibility and Enrollment processes, to include accounting, security, policies and procedures and contract compliance.
- Provide additional focus audits periodically as necessary to confirm contracted guaranteed savings that have been negotiated by PEBP with vendors.

Vendor responses were scored based on the following criteria.

- Experience in Performance of Comparable Engagements
- Demonstrated Competence
- Expertise and Availability of Key Personnel
- Conformance with the Terms of the RFP
- Cost

On December 22, 2020, PEBP received two (2) proposals in response to RFP 95PEBP-S1388. The evaluation period began on December 23, 2020 and ended on January 12, 2021. The four-member evaluation committee included one PEBP Board member and other subject matter experts. Claim Technologies Inc. received the highest score by the evaluation committee and PEBP has successfully negotiated a contract. Some of the reasons given by the individual evaluators for their scores were:

- Overall cost
- References
- 30 Years of Experience

Claim Technologies Inc. will be a new vendor for PEBP for Health Claim Auditing services; however, we don't expect any issues in the transition from our current vendor.

The effective date of the contract is anticipated to be April 13, 2021 (upon BOE approval) through June 30, 2027. The services are expected to begin on May 1, 2021. The contract maximum is $1,407,656.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with Claim Technologies Inc. for Health Plan Auditing Services beginning May 1, 2021.

6.2.2 CLIFTONLARSONALLEN LLP

On January 8, 2021, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1445 for Financial Auditing services. The following were some items important to PEBP in the consideration of the award of this contract:

- Provide financial audits of PEBP's two trust funds, the Self Insurance Trust Fund and the State Retiree's Health and Welfare Benefits Fund.
- Vendor must be licensed in the State of Nevada to perform certified financial audits.
- Vendors must be familiar with all relevant Governmental Accounting Standards Board (GASB) Pronouncements and any other applicable rules, regulations, accounting, or governmental audit standards covering financial, as well as compliance audits for self-insured group benefits programs for a governmental entity

Vendor responses were scored based on the following criteria.

- Experience in Performance of Comparable Engagements
- Demonstrated Competence
- Expertise and Availability of Key Personnel
- Conformance with the Terms of the RFP
- Cost

On February 16, 2021, PEBP received two (2) proposals in response to RFP 95PEBP-S1445. The evaluation period began on February 17, 2021 and ended on March 9, 2021. CliftonLarsonAllen LLP received the highest score by the six-member evaluation committee that included two PEBP Board members and other subject matter experts. Some of the reasons given by the individual evaluators for their scores were:

- Overall cost
- References
- GASB Experience

CliftonLarsonAllen LLP will be a new vendor for PEBP for Financial Auditing services; however, we don't expect any issues in the transition from our current vendor.

The effective date of the contract is anticipated to be May 11, 2021 (upon BOE approval) through December 31, 2024. The services are expected to begin on July 1, 2021. The contract maximum is $212,485.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with CliftonLarsonAllen LLP for Financial Auditing services beginning July 1, 2021.

6.3 Contract Amendment Ratifications

PEBP does not currently have any contract amendments for ratification.

6.4 Contract Solicitation Ratifications

Below are the services that are pending solicitations for a new contract.

6.4.1 Actuarial Consultant

PEBP's current contract for Actuarial Consulting services with AON Consulting (AON) began in 2016. Since then, the contract has been amended four times to correct clerical errors, and most recently to add additional expenditure authority to assist PEBP with the TPA and PBM solicitations. The original 6-year contract has never been extended and is now due to expire on June 30, 2022.

Recommendation

PEBP recommends the Board authorize staff to complete a Request for Proposal for an Actuarial Consultant.

6.4.2 Basic Life Insurance

PEBP's current contract for Basic Life Insurance services with The Standard began in 2013. Since then, the contract has been amended three times (third amendment pending) to increase expenditure authority, extend the term, and update the fee schedule. The original 5-year contract has been extended one time and is now due to expire on June 30, 2022.

Recommendation

PEBP recommends the Board authorize staff to complete a Request for Proposal for a Basic Life Insurance Contract.

6.5 Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	Anticipated RFP release date	Anticipated/Actual NOI	Anticipated Board Approval
Medical TPA	04/26/2021	08/15/2021	Nov 2021
Dental TPA	04/26/2021	08/15/2021	Nov 2021
Medical National Network	04/26/2021	08/15/2021	Nov 2021
Medical Statewide Network	04/26/2021	08/15/2021	Nov 2021
HSA HRA Admin	06/21/2021	10/01/2021	Nov 2021
2nd Opinion	07/05/2021	10/15/2021	Jan 2022
Telemedicine	07/20/2021	11/05/2021	Jan 2022
Transparency	08/09/2021	12/01/2021	Jan 2022
Pharmacy	08/27/2021	12/05/2021	Jan 2022

Recommendation

No action necessary

7.

7. Discussion and possible action regarding (1) PEBP's Voluntary Benefit Platform implementation, and (2) selection of voluntary benefits for implementation on January 1, 2022. (Nik Proper, Operations Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 25, 2021

Item Number: VII

Title: Benefitfocus Voluntary Benefits Selection and Platform Update

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the Benefitfocus voluntary benefits selection and platform.

REPORT

The contract allowing LSI (Labyrinth Solutions, Inc. d/b/a LSI Consulting) to provide an Eligibility & Enrollment Benefits Management System, approved by the PEBP Board in November, was approved by the Board of Examiners on December 8, 2020. PEBP is contracted with LSI, but the actual enrollment and eligibility technology including the voluntary benefits platform is subcontracted to Benefitfocus. BenefitStore, Inc. is the licensed agency of Benefitfocus with licenses being current and held in all 50 states. The new enrollment system is scheduled to go live on or before January 1, 2022, replacing the current Morneau Shepell system.

VOLUNTARY BENEFITS

Implemented in 2019, current voluntary benefit offerings are managed by Corestream, the licensed sub-contracted vendor of the current enrollment and eligibility vendor Morneau Shepell. Due to the mid-year change of the enrollment and eligibility and voluntary benefits' vendors, PEBP is recommending a year end Special Enrollment Period for voluntary benefits for a 1/1/22 effective date to ensure members can continue their voluntary benefits with minimal disruption. All carriers being recommended by Benefitfocus are licensed in all 50 states. Consent agenda item 4.5 shows the current voluntary benefit enrollments and Attachment A provides further details around the recommendations. The table below illustrates carrier recommendations.

Product	PEBP Recommendation	Current Carrier
Accident Plan	Bundle The Standard for Accident, Critical Illness, Hospital Indemnity, Voluntary life insurance, Voluntary Short Term Disability, and Voluntary Long Term Disability plans. *See Attachment A for LTD plan options.	Aflac
Critical Illness Plan		Aflac
Hospital Indemnity Plan		Aflac
Voluntary Life Insurance		The Standard
Voluntary Short-Term Disability		The Standard
Voluntary Long-Term Disability		Not currently offered *See Attachment A for 2 plan options for LTD offered by The Standard
ID Theft Protection	ID watchdog	ID watchdog
Legal Plan Provisions	LegalEASE	LegalEASE
Auto, Home and Renters Insurance	Liberty Mutual	Liberty Mutual, MetLife, Travelers
Pet Insurance	Nationwide	Nationwide, ASPCA
Voluntary Vision	VSP Vision Services	VSP Vision Services
Long Term Care	Revisit for 7/1/22 effective date	UNUM

POTENTIAL FUTURE OFFERINGS

PEBP will continue working with the Division of Insurance (DOI) and Benefitfocus to identify and potentially propose new offerings such as a Dental buy-up option to include orthodontia, whole or universal life insurance, and revisiting Long-Term Care plan options for a 7/1/22 effective date.

TRANSITION ACTIVITIES

PEBP will continue working with the DOI and Benefitfocus to ensure a proper transition, to include communication to members regarding voluntary benefit offerings and changes.
The below outlines the options for members who currently have a voluntary benefit with a carrier that is recommended to be changed.

Aflac Plans (Accident, Critical Illness, and Hospital Indemnity): Members can keep their current policy on a direct billed basis or cancel their policy.

Metlife (Home/Auto): Members can keep their current policy on a direct billed basis or cancel their policy.

Travelers (Home/Auto): Members can keep their current policy on a direct billed basis or cancel their policy.

ASPCA (Pet Insurance): Members can keep their current policy on a direct billed basis or cancel their policy.

UNUM (Long-Term Care): Members can keep their current policy on a direct billed basis or cancel their policy.

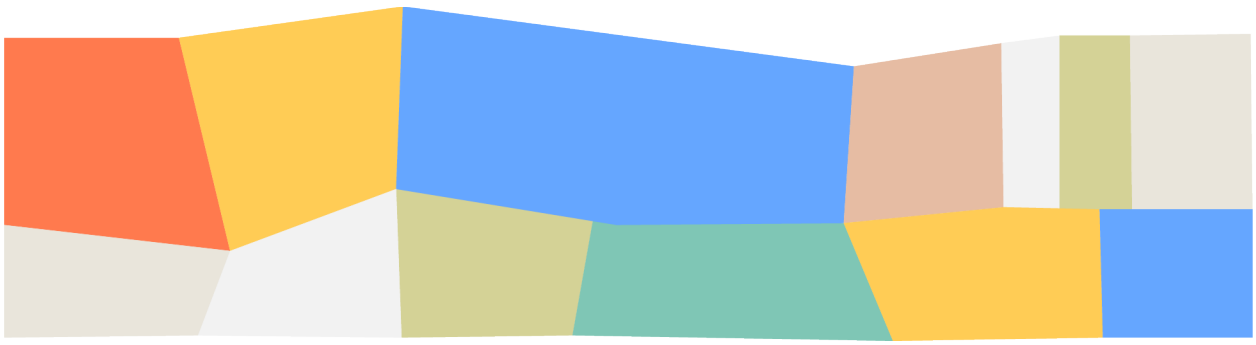
SUMMARY OF RECOMMENDATIONS

1. Approve the Special Enrollment Period for Voluntary Benefits for a 1/1/22 effective date, with the specific time frame to be brought back to the Board and finalized at a later meeting.
2. Approve The Standard for Accident, Critical Illness, Hospital Indemnity, Voluntary Life insurance, Voluntary Short-Term Disability, and either plan option A or B for Voluntary Long-Term Disability plans (as shown in Attachment A).
3. Approve ID Watchdog for ID Theft Protection.
4. Approve LegalEASE for Legal Plan.
5. Approve Liberty Mutual for Auto and Home Insurance.
6. Approve Nationwide for Pet Insurance.
7. Approve VSP Vision Services for Voluntary Vision.
8. Approve the removal of UNUM Long Term Care policy to revisit carrier options for 7/1/22.

Attachment A

PEBP 1/1/22 Voluntary Benefit Recommendations

Benefitfocus for life™



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Overview

BenefitStore, Inc. is the licensed agency of Benefitfocus. Licenses are current and held in all 50 states including Nevada (Attachment B). Each vendor recommended has given BenefitStore, Inc. appointment to sell insurance products in Nevada. All carriers selling insurance products hold current licenses in all 50 states.

Carrier recommendations made are based on a proposal process which required:

- Improving the current in force benefit plan designs
- Offering lower and/or comparable rates
- Offering better options for Retirees
- Providing meaningful plan choices while streamlining vendors
- Minimizing member disruption midyear
- Improving current member enrollment and claims experience

Employee Experience

A dedicated Customer Support number and email will be provided for members with a voluntary benefit(s) question or seeking navigational assistance. A Customer Support representative will assist the member to resolution, including warm transferring members to appropriate vendor for questions (such as those regarding claims assistance). Customer Support representatives are not licensed insurance agents and thus will not give benefit advice.

Benefitfocus platform will be available in Q4 2021 for a special voluntary benefit enrollment for 1/1/22 effective date to align with the Benefitfocus technology go live in advance of PEBP's current vendor contract expiration. A full Annual Enrollment will be held in May 2022 to align with Core benefits 7/1 effective date moving forward.

There are current in force policies and varying member impacts to consider based on each carrier recommendation. The below charts share the key differentiators leading to each recommendation as well as the member new enrollment or continuation of coverage options. Customer Support representatives will be trained how to help members with continuation of coverage questions.

Plan	1/1/22 Recommendation	Key Differentiators	Employee Experience
Accident **Critical Illness** **Hospital Indemnity**	The Standard (*move from AFLAC)*	• Group Retiree Coverage • Comparable/better rates • Additional plan option(s) • Streamlining vendors	Active enrollment for 1/1/22
Voluntary Life **Voluntary STD**	The Standard (incumbent)	• No midyear changes to coverage or additional health statement/EOI for enrolled members	No midyear disruption in carrier

Voluntary LTD	The Standard (new benefit)	• New product enhancing voluntary benefit offering • Pre-ex waived for 1/1/22	Active enrollment for 1/1/22
ID Theft	ID Watchdog (incumbent)	• Industry benchmarking report (Benefits IQ - $60,000 value) • 15% rate reduction	No midyear disruption in carrier
Legal	LegalEase (incumbent)	• Lower cost plan option added • Additional covered services added	No midyear disruption in carrier
Home/Auto	Liberty Mutual (remove MetLife and Travelers)	• Largest population of current enrollees	Enroll anytime
Pet	Nationwide (remove ASPCA)	• Largest population of current enrollees	No midyear disruption in carrier
Voluntary Vision	VSP	• No midyear changes to coverage	No midyear disruption in carrier
Long Term Care	Remove UNUM option for 1/1/22; Revisit for 7/1/22	N/A	Keep current policy on a direct billing arrangement with UNUM, or can cancel. (Approximately 277 members impacted).

Carrier Changes – Enrolled Members' Experience

Plan	Member Option A	Member Option B	Member Experience/Impact
Accident **Critical Illness** **Hospital Indemnity**	Move to The Standard effective 1/1/22	• Keep current policy with payments to be made directly to AFLAC, or cancel	• Members can review their new options and enroll in late Q4 for 1/1/22 effective date • Members will likely receive letter from AFLAC explaining how they can port coverage. This may be a cheaper option for a very small population of employees who bought AFLAC policies and have since crossed an age band

Home/Auto	Move from MetLife and Travelers to Liberty Mutual (or other carrier outside platform)	• Keep current policy with payments to be made directly to MetLife or Travelers, or cancel	No major impact other than direct payment arrangement (Approximately 68 members impacted)
Pet	Move from ASPCA to Nationwide (or other carrier outside platform)	• Keep current policy with payments to be made directly to ASPCA, or cancel	No major impact other than direct payment arrangement (Approximately 50 members impacted)
Long Term Care	Cancel policy or keep current policy with payments to be made directly to UNUM	• Enroll in PEBP plan for 7/1/22 (as approved)	

Future State

PEBP will be considering some additional voluntary offerings for the 7/1/22 plan year to continually expand member options - such as Buy Up Dental with Orthodontia, Permanent Life insurance, and revisiting Long Term Care. These items will be added for discussion at a future Board meeting.

Accident Plan

Plan Benefit or Provision	The Standard *(recommendation)*	Liberty Mutual	AFLAC *(incumbent)*
On and Off Job Coverage	24 Hour	24 Hour	24 Hour
Situs State	NV	NV	NV
Eligibility	All eligible as State of NV considers for other lines	All defined as Active employees	Full time benefit eligible employees working at least 16 hours per week
Spouse/DP	Eligible	Eligible	Eligible
Dependent Children	Up to age 26	Up to age 26	up to age 26

Retirees	Eligible for same Group plan design	Eligible for same Group plan design	Individually rated
HSA Compliant	Yes	Yes	Yes
Waiting Period	None	30 days	None
Pre-Existing Conditions Limitation	Waived	Waived	Waived
Portable	Yes	Yes	Yes
Benefit Age Reduction	None	None	None
Termination of Coverage due to Age	None	Age 80	None
Injuries			
Fractures	Fractures up to $5,250 non-surgical; $10,500 surgical (no limit on multiple fractures)	Up to $7,500	Up to $8,000
Dislocation Schedule	Up to $3,500 non-surgical; $7,000 surgical (no limit on multiple dislocations)	Up to $6,000	Up to $6,000
Burns - (2nd & 3rd degree) varies by type and severity of burn	Up to $12,500	Up to $25,000	up to $20,000
Skin Graft (% of burn)	25-50% of burn benefit ($100 - $6,250)	50% of burn benefit ($50 - $12,500)	up to $1,000
Concussion	Up to $200	Up to $400	$350
Coma	Up to $15,000	Up to $15,000	$10,000
Ruptured Disc	$750 - $1000	$500 - $1500	up to $1000
Torn Knee Cartilage Repair	$750 - $1000	$500 - $1500	up to $1000
Lacerations	Up to $800	Up to $650	$38-$600
Tendons/Ligaments/Rotator Cuff Repair	$750 - $1000	$500 - $1500	up to $1000
Emergency Dental Work	Crown $350 / Extraction $150	Up to $300	$50-$200

Eye Injuries	Up to $300	Up to $500	$300
Accidental Death, Dismemberment			
Accidental Death	$50,000 or $100,000	$50,000 or $75,000	$50,000
Accidental Death - Common Carrier	$50,000 or $100,000	$50,000 or $150,000	$150,000
Dismemberment	$2,000 - $30,000	$500 - $25,000	$8,750 - $17,500
Catastrophic Dismemberment	$100,000	$4,000 - $50,000	$50,000
Paralysis	$15,000 - $30,000	$12,500 - $20,000	$7,500-$12,500
Medical Services and Treatment			
Ambulance	Ground: $300 - $600 Air: $800 - $1,500	Ground: $300 - $400 Air: $1,000 - $1,500	Ground: $300 Air: $1,000
Emergency Care (Physician Office)	$50 - $60	$150 - $200	$100-$150
Emergency Care (Urgent Care)	$50 - $60	$150 - $200	$100-$150
Emergency Room Treatment	$150 - $200	$200 - $300	$200-$250
CT or MRI	$200 (Major Diagnostic)	$300	$200
Accident Follow-Up Visit	$50 - $70	$80 - $100	$75
Therapy Services (per day)	$50	$50	$25
Prosthesis (1 device or 2 or more devices)	One - $1,000 Two+ - $2,000	$1,000 - $2,000	$2,000
Medical Appliances	$100 - $200	$300 - $500	$30-$300
Blood & Plasma	$300 - $600	$400 - $450	$35-$400
Outpatient Surgery	Up to $2,000 based on surgery type	Up to $3,000 based on surgery type	$400
Hospital Coverage			

Rehabilitation (per day)	$100 - $150	Not covered	$200
Hospital Confinement (per day)	$200 - $400	$200 - $300	$200
Intensive Care (per day)	$200	$200 - $600	$400
Hospital Admission Benefit	$1,000 - $1,500	$500 - $1,500	$1,250
Family Lodging (per day)	$175 - $200	$200 - $250	$200
Monthly Premium			
Employee	Low Plan: $10.54 High Plan: $16.01	Low Plan: $5.71 High Plan: $21.67	$11.49
Employee & Spouse	Low Plan: $16.65 High Plan: $24.96	Low Plan: $10.79 High Plan: $41.44	$17.71
Employee & Child(ren)	Low Plan: $18.45 High Plan: $28.08	Low Plan: $12.25 High Plan: $50.98	$18.52
Employee & Family	Low Plan: $24.69 High Plan: $37.49	Low Plan: $17.32 High Plan: $70.76	$24.74

Accident Claims Example

Soccer Injury

- Emily's 15-year-old daughter Katie was playing in a soccer tournament.
- While attempting a slide tackle, Katie's leg became tangled with her opponent, and she was unable to walk.
- Emily took Katie to the ER where scans revealed a torn ACL and meniscus, requiring surgery.
- Emily used part of her Accident Insurance Premier Plan benefit to cover the co-pays she incurred under her medical insurance plan.

Emergency room	$150
X-ray	$50
MRI	$200
Knee surgery	$1000
Surgical facility benefit	$150
Crutches	$100
Physician follow-up (two visits)	$100
Physical therapy (three sessions)	$150
Youth Organized Sport Benefit	$475
Total Benefits Paid	**$2,375.00**

Here's how Emily's share of covered charges would look on this claims example on the 2021-2022 medical plans in-network:

Medical Plans	You Pay On: CDHP Plan	You Pay On: New Low Ded PPO w/ copay	You Pay On: EPO/HMO	The Standard Accident Premier Plan Pays You:
Individual deductible (in-network)	$1,750	$500	$150	$2,375
ER co-pay/ins.	20%	$750	$750	
MRI co-pay/ins.	20%	20%	20%	
Outpatient Facility	20%	20%	20%	
Follow-up visits x 2	20%	$50 x 2	$40 x 2	
Physical Therapy x 3	20%	$50 x 3	$40 x 3	

Critical Illness Plan

Plan Benefit or Provision	The Standard (recommendation)	Liberty Mutual	Aflac (incumbent)
Situs State	NV	NV	NV
Guaranteed Issue Benefit Amount	$30,000 (max benefit)	$30,000 (max benefit)	up to $30,000 (max benefit)
Pre-Existing Conditions Clause	Waived	Waived	Waived
Portable	Yes for Actives	Continuation of coverage available for Employee, Spouse, Child	Yes
Age Reduction	None	None	None
Waiting Period	None	30 days	None
Eligibility	A regular employee working 20+ hours/week	All Active employees as currently definition	Full time benefit eligible employees working at least 16 hours per week
Spouse Coverage	50%	50%	50%
Child(ren) Coverage	50%	50%	50%
Retirees	Eligible for same plan design	Eligible for same plan design	Individually rated
Termination due to Age	Age 80	Age 80	None
Benefits			
Heart Attack	100%	100%	100%
Heart Transplant	100%	100%	100%
Stroke	100%	100%	100%
Coronary Artery By-Pass	25%	50%	50%
Major Organ Transplant	100%	100%	100%

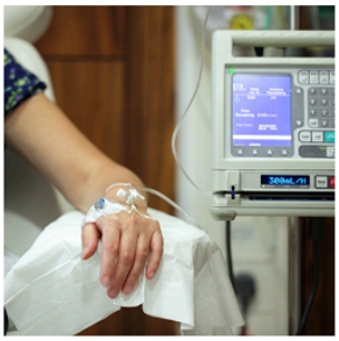
End Stage Renal Failure	100%	100%	100%	
Burns (3rd Degree or 50% coverage)	100%	100%	N/A	
Coma	100%	100%	N/A	
Cancer	100%	100%	100%	
Carcinoma in Situ	100%	25%	100% invasive, 25% non-invasive	
Prostate Cancer	100%	100%	100%	
Skin Cancer	$250	NA	$250	
Advanced Alzheimer's Disease	100%	100%	100%	
Recurrence Benefit	100%	100%	100%	
Additional Standard Offering				
Wellness	$50	$50	$50	
Additional Included Riders/Benefits				
Additional Riders	•21 Childhood Diseases covered •Occupational HIV + Hepatitis covered		Bone Marrow Transplant (Stem Cell Transplant) ; Sudden Cardiac Arrest	
Monthly Premium (Actives)	**Issue Age**	**Issue Age**	**Issue Age / Non-Tobacco**	**Issue Age / Tobacco**
	$10,000	$10,000	$10,000	$10,000
Under 30	$4.60	$6.49	$5.31	$7.24
Age 31	$8.20	$9.01	$8.50	$12.85

Age 41	$16.10	$17.44	$15.70	$24.16
Age 51	$28.20	$57.95	$29.02	$45.99
Age 61	$59.04	$158.31	$54.35	$82.71
Age 71	$122.70	$120.12	$54.35	$82.71
Employee & Spouse	$5,000 Spouse	$5,000 Spouse	$5,000 Spouse	$5,000 Spouse
Under 30	+$2.30	+$4.07	+$3.33	+$4.29
Age 31	+$4.10	+$5.33	+$4.92	+$7.10
Age 41	+$8.05	+$9.54	+$8.52	+$12.76
Age 51	+$14.10	+$29.80	+$15.18	+$23.67
Age 61	+$24.60	+$79.97	+$27.85	+$42.03
Age 71	+$61.35	+$60.47	+$27.85	+$42.03
+ Child(ren)	No additional cost to cover Child(ren)	Additional cost to cover Child(ren)	No additional cost to cover Child(ren)	
Monthly Premium (Retirees)	**Issue Age $10,000**	**Issue Age $10,000**	**Rates unknown, individually rated**	
Under 30	$5.00	$6.49	-	-
Age 31	$9.40	$9.01	-	-
Age 41	$19.30	$17.44	-	-
Age 51	$35.20	$57.95	-	-
Age 61	$63.90	$158.31	-	-
Age 71	$122.70	$120.12	-	-

Critical Illness Claims Example

Cancer Diagnosis

- Shawna beat cancer, but saw many unexpected costs:
  - Co-insurance for chemotherapy, doctors
  - Hair prosthetics
  - Travel to specialists and alternative treatments
  - Husband taking time off work to care for her
- Fortunately, she had $20,000 in benefits to help her with her costs.



Out-of-Pocket Expenses:

Medical insurance deductible	$1,000
Out-of-pocket expenses over 6 mos	$3,500
Alternative treatments not covered by medical plan	$4,500
Transportation to medical appts	$750
Lodging near treatment facility	$1,370
Husband's lost wages	$4,500
Total out-of-pocket expenses	$15,620
Shawna's CI Benefit	**$20,000**

Hospital Indemnity Plan

Plan Benefit or Provision	The Standard (recommendation)	Liberty Mutual	Aflac (incumbent)
Situs State	NV	NV	NV
Eligibility	A regular employee working 20+ hours week in the US	All Active Eligible employees	Full time benefit eligible employees working at least 16 hours per week
Spouse/DP	Eligible	Eligible	Eligible
Dependent Children	Eligible	Eligible	up to age 26
Retirees	Yes	Yes	Individually rated

HSA Compliant	Yes		Yes		Yes
Guaranteed Issue	Yes		Yes		Yes
Waiting Period	None		30 days		None
Pre-Existing Conditions Limitation	Waived		Waived		Waived
Portability	Yes, except for Retirees		Employee, Spouse and Children		Yes
Age Reduction	None		None		None
Termination due to Age	80		80		None
Participation Requirement	10 lives		15%		None
Rate Guarantee	4 years		4 years		5 years
Primary Benefits					
Hospital Confinement	$100 - $200/day		$100 - $200/day		$100
Hospital Admission	$500 - $1000/calendar year		$500 - $1000/calendar year		$500
Hospital Intensive Care - Admission			$500 - $1000		$500
Hospital Intensive Care - Confinement	$100 – 200/day (in addition to regular Hospital Confinement)		$200 - $400/day		$200
Hospital Confinement Max	30 days		$18,000 - $36,000		31 days
ICU Confinement Max	15 days		$36,000 - $72,000		10 days
Pregnancy	Covered		Covered		Covered (Normal & Complications)
COVID-19 Hospitalization	Covered		Covered		Covered
Monthly Premium (Actives)	**Low**	**High**	**Low**	**High**	
Employee	$8.66	$17.32	$9.43	$18.01	$11.78

Employee & Spouse	$14.60	$29.20	$20.42	$39.14	$21.64
Employee & Child(ren)	$12.36	$24.72	$17.17	$31.70	$17.92
Family	$21.95	$43.90	$28.16	$52.82	$27.78
Monthly Premium (Retirees)	Low	High	Low	High	
Employee	$18.62	$37.24	$9.43	$18.01	Individually rated
Employee & Spouse	$56.02	$112.04	$20.42	$39.14	Individually rated
Employee & Child(ren)	$39.90	$79.80	$17.17	$31.70	Individually rated
Family	$71.06	$142.12	$28.16	$52.82	Individually rated

Hospital Indemnity Claims Example

Childbirth

- Brooke delivered via C-section.
- Both she and baby were in good health, but three days in the hospital were needed.
- Her benefits helped meet deductible without cutting into funds for diapers, clothing and childcare.

Medical Plans	**You Pay On: CDHP Plan**	**You Pay On: New Low Ded PPO w/ copay**	**You Pay On: EPO/HMO**	**The Standard Hospital Indemnity Plan 1 Pays You**
Individual deductible (in-network)	$1,750	$500	$150	$500 hospital admission
In-patient hospital	20%	20%	$750	

Physician follow up visits	20%	$50	$40	$100 x 3 days for daily hospital confinement
C-section surgery	20%	20%	20%	
Total				**$800**

ID Theft Protection

Plan Name	ID Watchdog (recommendation, incumbent)	Norton LifeLock	InfoArmor (Allstate)
Participants Input Data via Secure Website Dashboard (SS#, Email Address, Drivers License, Credit Cards, etc.)	Confirmed	Confirmed	Confirmed
Member Alerts	Confirmed	Confirmed	Confirmed
Call Center	24/7/365; US Based (Denver and Las Vegas)	24/7; US & Global	24/7/365; US Based
Program Services			
ID Theft Remediation	Confirmed	Confirmed	Confirmed
Pre-existing ID Theft	Confirmed	Confirmed (previous 12 months)	Confirmed (previous 3 years)
Website Tips, Tools and Resources on Prevention	Confirmed	Confirmed	Confirmed
Credit Score and Report	Confirmed (1 Bureau or 3 Bureau)	Confirmed (1 Bureau or 3 Bureau)	Confirmed (1 Bureau or 3 Bureau)

Sex Offender Registration Reports	Confirmed	Confirmed	Confirmed
National Do Not Call List and No Solicitation Lists	Confirmed	No	Confirmed
Lost Wallet/Care Support	Confirmed	Confirmed	Confirmed
Online Surveillance and Alerts			
Buy, Sell, or Trade of Personal Information on Black Market (Searches for Personal Information Provided by Participant)	Confirmed	Confirmed	Confirmed
Credit Monitoring and Alerts	Confirmed (1 Bureau or 3 Bureau)	Confirmed (1 Bureau or 3 Bureau)	Confirmed (1 Bureau or 3 Bureau)
Credit Lock (adults & minors)	Yes	Yes	Yes
Social Network (Facebook, Twitter, Instagram, Etc.)	Confirmed	Confirmed	Confirmed
Dark Web Monitoring	Confirmed	Confirmed	Confirmed
Court Records (Bankruptcies, Criminal Records, Etc.)	Confirmed	No	Confirmed
Large Scale Data Breach Notifications	Confirmed	Confirmed	Confirmed
New or Added Wireless Accounts	Confirmed	Confirmed	Confirmed
Bank Account Changes	Confirmed	Confirmed	Confirmed
Additional Reporting/Data Availability	Industry Benchmarking Report ($60,000 value)		
Guarantee/Insurance			

Coverage for Victim of ID Theft While in Program (Such as Lawyers, Investigators, Legal Defense)	Confirmed	Confirmed	Confirmed
Reimbursement	Yes, up to the limit of $1M per subscriber	Yes, up to the limit of $1M per subscriber	Yes, up to the limit of $1M per subscriber
HSA + 401K reimbursement	Yes for Platinum; No for Essentials	Yes	Yes
Monthly Premium	ID Watchdog (recommendation, incumbent)	Norton LifeLock	InfoArmor (Allstate)
One Bureau	$4.95/individual, $8.90/family	$5.49/individual, $10.98/family	$9.95 individual & family
Three Bureau	$6.25/individual, $12.25/family	$8.99/individual, $17.98/family	$17.95 individual & family

Legal Plan

General Services for Covered Matters	LegalEASE (incumbent)	U.S. Legal Services
Office & Phone Consultations with Attorney	Covered in Full	Covered in Full (Office)
Document Review	Covered in Full	Covered in Full
DIY Online Access	Confirmed - Portal Access	Confirmed – Portal Access
Services for Non-Covered Matters		
Discount for Non-Covered Items	25% discount	33.3% off Attorney's hourly rates (some exclusions)

Miscellaneous Law Services	15 hours of miscellaneous service covered	None specified
Estate Planning		
Wills & Codicil	Covered in Full	Covered in Full
Living Trusts	Covered in Full	Covered in Full
Powers of Attorney	Covered in Full	Covered in Full
Complex Wills	Covered under 15 hours of miscellaneous	Not specified
Real Estate		
Sale or Purchase of Real Estate	Covered in Full; Landlord benefits Fully Covered up to 10 hours)	Covered in Full (Purchase, Sale, Refi of Primary Residence); Timeshares, Second Home, Vacation Property at 33.3% discount
Refinancing	Covered in Full	Covered in Full
Tenant Negotiations	Covered in Full	Covered in Full
Eviction Defense	Covered in Full	Covered in Full
Property Tax Assessments	Covered under 15 hours of miscellaneous	Not specified
Foreclosure	Covered in Full	Covered in Full
Construction Disputes	Covered in Full	Covered in Full
Neighbor Disputes	Covered in Full	Covered in Full

Family Law		
Adoption	Covered in Full	Covered in Full
Guardianship / Conservatorship	Covered in Full	Covered in Full (uncontested)
Name Change	Covered in Full	Covered in Full
Premarital Agreement	Covered in Full	Covered in Full, 12-20 hours annually. 33 1/3% discount after, if additional time is needed.
Divorce	Covered up to 28.5 hours of Contested, 10 hours Uncontested (LegalGuard Gold Plan only)	Covered up to 12 hours of Contested (afterwards 33.3% discount); Uncontested Paid in Full -Subject to 120 day waiting period
Post Decree Child Custody/Support	Covered up to 28.5 hours	Covered up to 12 hours of Contested (afterwards 33.3% discount); Uncontested Paid in Full -Subject to 120 day waiting period
Domestic Violence	Covered up to 28.5 hours	Covered in Full
Consumer Protection		
Advice & Negotiations	Covered in Full	Covered in Full
Court Representation	Covered in Full	Covered in Full (exclusions)
Small Claims Actions	Covered up to 5 hours	33.3% discount
Financial Matters		

Creditor Negotiations	Covered in Full	Covered in Full
Debt Collection - Defense and Collection for Consumer Debts	Covered in Full	Covered in Full (Foreclosure subject to 120 day wait)
Personal Bankruptcy	Covered in Full – Chapter 7 or Chapter 13	Covered in Full (Subject to 120 day wait)
Personalized Financial Planning	Covered up to 10 hours	Member Portal w/ Financial Education tools
Tax Preparation	Covered in Full as it pertains to Legal items related to Tax Prep	Access to financial calculators, do it yourself preparation, articles and resources
Tax Audits	Covered in Full	Covered in Full
IRS Collection Defense	Covered in Full	Covered in Full
Defense of Civil Lawsuits		
Administrative Hearings	Covered in Full	Covered in Full
Other Civil Litigation	Covered in Full	Covered in Full
Incompetency Defense	Covered in Full	Covered in Full (Incapacity)
Traffic Offenses		
Defense of Tickets	Covered in Full - Includes DUI	Covered in Full (non-criminal moving traffic violations; first offense DUI)
Driving Privilege Protection	Covered in Full	Covered in Full
Other		

Juvenile Court Defense	Covered in Full	Covered in Full
Immigration Assistance	Covered in Full (LegalGuard Gold plan only)	Covered in Full (Visa Extensions, Naturalization & Deportation)
Elder Care Consultation	Covered In Full - for elder matters relating to the participant	Covered in Full
Debt Collection	Covered up to 10 hours	Covered in Full
Debt Consolidation Services	Covered up to 10 hours	Not specified
Budget Analysis Services	Covered up to 10 hours	Financial Planning – Covered in Full
Credit Improvement Services	Covered up to 10 hours	33.3% discount
Monthly Premium	**LegalGuard Gold - $16.85** **Essentials Plan - $8.96**	**$16.90**

Auto, Home and Renters Insurance

Auto Insurance Coverage	Liberty Mutual (recommendation)	MetLife
Automobiles, Boats, Motor Homes, Motorcycles, Snowmobiles, Trailers, Personal Watercraft	Included	Included
Personal Excess Liability	Included	Included
Multi-Car/Multi-Policy Discount	Included	Included
Anti-Theft Device Discount	Included	Included

Home Insurance Coverage		
Home, Condo, Renter's, Rental, Personal Articles, Mobile Home	Included	Included
Protective Devices Discount	Included	Included
Fire Protection	Included	Included
Multi-Home/Multi-Policy Discount	Included	Included
Rates – individually rated		
Group Discount	Yes 5-15% discount (dependencies: State, Payroll deducted, Line of coverage)	Yes 5-15% discount (dependencies: State, Payroll deducted, Line of coverage)

Pet Insurance

Program	Nationwide
Eligible Participants	All Benefit Eligible Employees
Eligible Pets	Cats and Dogs; Avian and Exotic Pet Plans available
Pet Age Limitations	N/A
Medical History Required	N/A
Accidents and Illnesses, Including Hospitalizations and Surgeries	Included

Prescription Medications	Included
Other Included Coverages	My Pet Protection plans include congenital and hereditary conditions with no additional waiting periods, prescribed therapeutic pet foods, prescribed nutritional supplements, prescribed behavioral treatment and therapy, all dental diseases, internal and external parasite treatment, treatment for complications of pregnancy, elective or cosmetic procedures, boarding or kennel fees for employee's hospital stay, advertising and reward coverage, coverage for loss due to theft or straying and a mortality benefit.
Additional Riders (Added Cost)	Wellness
Annual Deductible	$250
Co-Pays	10%
Annual Maximum	$7,500
Maximum Per Incident	N/A
Covered Claims Paid	OPTIONS: • 90% of eligible conditions • 70% of eligible conditions • 50% of eligible conditions
Payroll Deduction	Yes
Group Discount	5%
Multi-Pet Discount	5% additional for 2-3 pets; 10% additional for 4 or more pets

Factors Affecting Rates	State and species
Golden Retriever - Male, 3 years old, 89101 Zip	$35.61 (90% coverage) $21.37 (50% coverage)
Golden Retriever - Male, 7 years old, 89101 Zip	$35.61 (90% coverage) $21.37 (50% coverage)
Domestic Short Hair Cat - Male, 3 years old, 89101 Zip	$21.37 (90% coverage) $12.82 (50% coverage)
Domestic Short Hair Cat - Male, 7 years old, 89101 Zip	$21.37 (90% coverage) $12.82 (50% coverage)

Voluntary Vision Plan

Plan Benefits	**VSP Base**	**VSP Buy-up**
Calendar Year Benefit	Yes	Yes
Wellvision Exam Copay	$10	$10
Prescription Glasses		
Frames Copay	$25	$25
Frame Allowance	$120 / $140 for featured frame brands	$200 / $220 for featured frame brands
Lenses	Single vision, lined bifocal and lined trifocal included	Single vision, lined bifocal and trifocal included

Lens Enhancements	$55-$175	$0-$175
Contacts (Instead of Glasses)		
Copay	Up to $60	Up to $60
Contacts Allowance	$110	$200
Additional Features		
Diabetic Eyecare Plus Program	$20 Copay	$20 Copay
Extra Savings	20% savings on additional glasses, discount on Laser Vision Correction	20% savings on additional glasses, discount on Laser Vision Correction, Retinal Screening enhancement
Monthly Premium		
Employee	$5.86	$9.09
Employee & Spouse	$11.75	$18.16
Employee & Child(ren)	$12.57	$19.43
Family	$20.09	$31.05

NEW Voluntary Long Term Disability Plan

Plan Benefits	Voluntary LTD Plan A	Voluntary LTD Plan B
Benefit Schedule	60%	50%
Insured Predisability Earnings	$12,500	$10,000
Max Monthly Benefit	$7,500	$5,000
Min Monthly Benefit	$100 or 10%	$100 or 10%
Benefit Waiting Period	180 Days	180 Days
Max Benefit Period	To age 65	To age 65
Guaranteed Issue Benefit Amount	Full Benefit	Full Benefit
Employer Contribution	0%	0%
Minimum Participation	*15% This requirement will be waived due to a communication plan between PEBP, The Standard, and Benefitfocus.	*15% This requirement will be waived due to a communication plan between PEBP, The Standard, and Benefitfocus.
Taxability of Benefits	Non-Taxable	Non-Taxable
Own Occupation Period	24 Months	24 Months
Partial/Residual Disability	Included	Included
Preexisting Condition Period	3/12	3/12

Mental & Nervous Limitation	24 months	24 months
Substance Abuse Limitation	24 months	24 months
Other Limited Conditions	24 months	24 months
Return to Work Incentive	24 months	24 months

Voluntary LTD 1/1/22 Rate and Cost Member Examples

Plan A (60% of earnings):

Age	Rate:
0-24	.082
25-29	.122
30-34	.189
35-39	.347
40-44	.436
45-49	.582
50-54	.582
55-59	.582
60-64	.582
65-69	.642
70-999	.661

Example 1:

Member's Age:	33 years old
Member's Annual Salary:	$50,000
Rate based on Member's Age:	$0.189 per $100 of covered payroll
Monthly Cost of Coverage:	Formula: Rate X Salary / $100 / 12 Months
	$0.189 x $50,000 = 9,450
	9,450 / $100 = $94.50 (Annual Cost)
	$94.50 / 12 Months = $7.88 (Monthly Cost)

Example 2:

Member's Age:	51 years old
Member's Annual Salary:	$70,000
Rate based on Member's Age:	$0.582 per $100 of covered payroll
Monthly Cost of Coverage:	Formula: Rate X Salary / $100 / 12 Months
	$0.582 x $70,000 = 40,740
	40,741 / $100 = $407.40 (Annual Cost)
	$407.40 / 12 Months = $33.95 (Monthly Cost)

Plan B (50% of earnings):

Age	Rate:
0-24	.065
25-29	.095
30-34	.149
35-39	.273
40-44	.329
45-49	.435
50-54	.435
55-59	.435
60-64	.435
65-69	.507
70-999	.524

Example 1:

Member's Age:	42 years old
Member's Annual Salary:	$60,000
Rate based on Member's Age:	$0.329 per $100 of covered payroll
Monthly Cost of Coverage:	Formula: Rate X Salary / $100 / 12 Months
	$0.329 x $60,000 = 19,740
	23,030 / $100 = $197.40 (Annual Cost)
	$197.40 / 12 Months = $16.45 (Monthly Cost)

Example 2:

Member's Age:	60 years old
Member's Annual Salary:	$90,000
Rate based on Member's Age:	$0.435 per $100 of covered payroll
Monthly Cost of Coverage:	Formula: Rate X Salary / $100 / 12 Months
	$0.435 x $90,000 = 39,150
	39,150 / $100 = $391.50 (Annual Cost)
	$407.40 / 12 Months = $32.63 (Monthly Cost)

Barbara D. Richardson, Commissioner of Insurance

Non-Resident Producer Firm

Casualty, Health, Life, Property

BENEFITSTORE INC

100 BENEFITFOCUS WAY
DANIEL ISLAND, SC 29492-8378

is authorized to transact business as described above

License No: 985181 Issue Date: 09-29-2014 Expiration Date: 10-01-2023

Generated by Sircon 225260423

Nevada Division of Insurance

THIS IS TO CERTIFY THAT

BENEFITSTORE INC
100 BENEFITFOCUS WAY, DANIEL ISLAND, SC 29492-8378

LICENSE NUMBER: 985181

IS HEREBY AUTHORIZED TO TRANSACT BUSINESS IN ACCORDANCE TO THE LICENSE DESCRIPTION SHOWN BELOW:

Non-Resident Producer Firm
Casualty, Health, Life, Property

Issue Date: 09-29-2014 Expiration Date: 10-01-2023

Generated by Sircon 225260423

8.

8. Discussion and Possible Action to include approving Plan Year 22 (July 1, 2021 – June 30, 2022) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
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

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 25, 2021

Item Number: VIII

Title: Plan Year 22 Rates

SUMMARY

This report outlines options for Plan Year 22 (July 1, 2021 – June 30, 2022) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan.

REPORT

BUDGET CONSIDERATIONS

PEBP's budget since originally submitted last August has undergone many different versions, all while attempting to pivot and adjust to the constantly changing budgetary and healthcare environments. At this point in the process, most of the budgetary decisions now lie with the legislature, however PEBP must set rates to ensure the program is prepared for the May 1 open enrollment date. Although changes made to PEBP's budget during the legislative process (such as deviations to the employer subsidy amounts) would have an effect on rates, the legislature is aware of the implications and is sensitive to this. Because of the evolving situation, PEBP has been in close coordination with LCB fiscal staff and the Governor's Finance Office.

PEBP's budget is somewhat unique because the budget factors in two years of trend, even though it is far too early to project trend two years out. As a result, any trend increases above what was incorporated into the budget is borne entirely on the member premium in the second year of the biennium. In normal years, this is already a challenge, but the pandemic has only intensified this issue. Plan Year 21 claims costs were extraordinarily lower than projected due to shutdowns and stay at home orders, but there are concerns in the industry of potential spikes in future years. The delays in care have not only resulted in pent up demand for scheduled

surgeries, but may also result in more severe health conditions and thus claims costs could rise sharply in the coming years.

In an attempt to adjust for a potential higher than budgeted trend, PEBP and the Governor's Finance Office adjusted employer subsidy amounts in the budget so that the employer subsidy was lower in the first year and raised significantly in the second year. As more claim information became available and actuaries began applying the standard rate methodology, the lower employer subsidy in PY22 has resulted in sizeable increases to participant premiums. Although this standard methodology would normally be recommended, the pandemic has led to some rather unique budget scenarios that cannot be ignored.

The claim suppression in combination with lowered reserve requirements will likely result in substantial excess cash amounts when PEBP closes its books for FY21.

Balancing out the employer subsidy amounts between the two years (as opposed to the lower subsidy in PY22 and higher subsidy in PY23 as was submitted in the budget) would "fix" the situation of higher employee costs in PY22, however GFO indicated that a budget amendment to make this adjustment would be difficult because of the effect on the general fund. Instead, PEBP is proposing that this be accomplished by artificially suppressing rates in PY22. This option will likely reduce the amount of excess that has built up in PY21 (by drawing down on some of the expected year end closing excess cash). However, the size of the excess is difficult to determine and is largely dependent on how long claims suppression continues or how quickly it returns to normal in calendar year 2021 or worst case, how quickly to moves above normal expectations. In addition, this plan would keep rates nearly flat in PY22, as was the desire and goal of the Governor and attempts to keep rates relatively flat in PY23 should the expected spikes in trend not be extraordinarily high.

Option 1:
Application of Standard Rate Methodology/Budgeted Rates:

State Active Employees	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Employee Only	632.57	579.10	53.47	652.21	579.10	73.11	732.12	579.10	153.02
Employee + Spouse	1,254.97	998.95	256.02	1,294.25	998.95	295.30	1,454.07	998.95	455.12
Employee + Child(ren)	865.97	736.54	129.43	892.98	736.54	156.44	1,002.85	736.54	266.31
Employee + Family	1,488.37	1,156.39	331.98	1,535.02	1,156.39	378.63	1,724.81	1,156.39	568.42

State Retirees Non-Medicare	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Retiree only	628.36	386.90	241.46	648.00	386.90	261.10	727.91	386.90	341.01
Retiree + Spouse	1,250.76	667.40	583.36	1,290.04	667.40	622.64	1,449.86	667.40	782.46
Retiree + Child(ren)	861.76	492.09	369.67	888.77	492.09	396.68	998.64	492.09	506.55
Retiree + Family	1,484.16	772.59	711.57	1,530.81	772.59	758.22	1,720.60	772.59	948.01
Surviving/Unsubsidized Dependent	628.36	-	628.36	648.00	-	648.00	727.91	-	727.91
Surviving/Unsubsidized Spouse + Child(ren)	861.76	-	861.76	888.77	-	888.77	998.64	-	998.64

Non-State Active Employees	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Employee Only	986.15	-	986.15	1,031.91	-	1,031.91	931.42	-	931.42
Employee + Spouse/DP	1,962.13	-	1,962.13	2,053.66	-	2,053.66	1,852.68	-	1,852.68
Employee + Child(ren)	1,352.14	-	1,352.14	1,415.07	-	1,415.07	1,276.90	-	1,276.90
Employee + Family	2,328.12	-	2,328.12	2,436.81	-	2,436.81	2,198.15	-	2,198.15

Non-State Retirees Non-Medicare	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Retiree only	981.94	740.48	241.46	1,027.70	766.60	261.10	927.22	586.21	341.01
Retiree + Spouse/DP	1,957.92	1,374.56	583.36	2,049.45	1,426.81	622.64	1,848.48	1,066.02	782.46
Retiree + Child(ren)	1,347.93	978.26	369.67	1,410.86	1,014.18	396.68	1,272.69	766.14	506.55
Retiree + Family	2,323.91	1,612.34	711.57	2,432.61	1,674.39	758.22	2,193.95	1,245.94	948.01
Surviving/Unsubsidized	981.94	-	981.94	1,027.70	-	1,027.70	927.22	-	927.22
Surviving/Unsubsidized	1,347.93	-	1,347.93	1,410.86	-	1,410.86	1,272.69	-	1,272.69

Option 2:
Artificial Suppression to Adjust for Claims Suppression and Excess Cash

State Active Employees	Statewide CDHP				NEW Copay PPO				EPO/HMO			
	Rate	Base Subsidy	Using Excess Cash	Participant Premium	Rate	Base Subsidy	Using Excess Cash	Participant Premium	Rate	Base Subsidy	Using Excess Cash	Participant Premium
Employee Only	632.57	579.10	8.84	44.63	652.21	579.10	8.84	64.27	732.12	579.10	8.84	144.18
Employee + Spouse	1,254.97	998.95	15.25	240.77	1,294.25	998.95	15.25	280.05	1,454.07	998.95	15.25	439.87
Employee + Child(ren)	865.97	736.54	11.25	118.18	892.98	736.54	11.25	145.19	1,002.85	736.54	11.25	255.06
Employee + Family	1,488.37	1,156.39	17.65	314.33	1,535.02	1,156.39	17.65	360.98	1,724.81	1,156.39	17.65	550.77

State Retirees Non-Medicare	Statewide CDHP				NEW Copay PPO				EPO/HMO			
	Rate	Base Subsidy	Using Excess Cash	Participant Premium	Rate	Base Subsidy	Using Excess Cash	Participant Premium	Rate	Base Subsidy	Using Excess Cash	Participant Premium
Retiree only	628.36	386.90	7.18	234.28	648.00	386.90	7.18	253.92	727.91	386.90	7.18	333.83
Retiree + Spouse	1,250.76	667.40	12.39	570.97	1,290.04	667.40	12.39	610.25	1,449.86	667.40	12.39	770.07
Retiree + Child(ren)	861.76	492.09	9.13	360.54	888.77	492.09	9.13	387.55	998.64	492.09	9.13	497.42
Retiree + Family	1,484.16	772.59	14.34	697.23	1,530.81	772.59	14.34	743.88	1,720.60	772.59	14.34	933.67
Surviving/Unsubsidized Dependent	628.36	-	-	628.36	648.00	-	-	648.00	727.91	-	-	727.91
Surviving/Unsubsidized Spouse + Child(ren)	861.76	-	-	861.76	888.77	-	-	888.77	998.64	-	-	998.64

Non-State Active Employees	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Employee Only	986.15	-	986.15	1,031.91	-	1,031.91	931.42	-	931.42
Employee + Spouse/DP	1,962.13	-	1,962.13	2,053.66	-	2,053.66	########	-	1,852.68
Employee + Child(ren)	1,352.14	-	1,352.14	1,415.07	-	1,415.07	########	-	1,276.90
Employee + Family	2,328.12	-	2,328.12	2,436.81	-	2,436.81	########	-	2,198.15

Non-State Retirees Non-Medicare	Statewide CDHP			NEW Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Retiree only	981.94	740.48	241.46	1,027.70	766.60	261.10	927.22	586.21	341.01
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Retiree + Family	2,323.91	1,612.34	711.57	2,432.61	1,674.39	758.22	2,193.95	1,245.94	948.01
Surviving/Unsubsidized	981.94	-	981.94	1,027.70	-	1,027.70	927.22	-	927.22
Surviving/Unsubsidized	1,347.93	-	1,347.93	1,410.86	-	1,410.86	1,272.69	-	1,272.69

Recommendation: Option 2 smooths out volatility of rate fluctuations while ensuring higher rates do not contribute to the excess cash.

9.

9. Public Comment

10.

10. Adjournment