HRA AND HSA Accounts: I am beginning think that getting the mere $600 a year to help with medical bills isn't worth it. Today just today I have spent over two hours going from talking the them at HSA Bank to UMR to my Provider to attempt to figure out what they want. They have a service date but UMR or Provider has no serves date for the date they have but threaten me that I will have to pay it back. Its constant with these people (HSA BANK) that I have to to chase down receipts etc to accommodate them and there records. I don't understand why they arent working with UMR to get the information they seek. I use this card to pay medical bills or prescriptions nothing else, in fact, the card won't let me buy anything else thats in the pharmacy so why do i need to show anything? They see that I'm using it to pay medical expenses so why am i get harass everytime i use it??

The letter below is what I sent to Jennifer Jenkins member service/contact center HSA BANK

Hi Kelly Peterson

I had no date of service on this date 4/8/24. I have contacted both the provider and the insurance company; they can not verify a date of service on this date because there was none. Your people told me that that was the date of service and that it was for $89 and some change and the provider owed me or the card $113 and some change and I paid $202.18 but the provider has no record of me having a credit of this amount. I was told that I would have to repay this amount $113, as if I took it? What probably happened is I had a credit and they applied it to another bill or EOB. This provider does it all the time as do other medical facilities and my next bill being credited without my knowledge. Honestly I don't know. But to tell me I have to repay it is BS when your people can't even give me a correct date of service and my insurance company has no matching dates or amounts to what I was told by your people. I have spent over two hours on the phone in an attempt to help resolve this and am no better off than when I started. Sincerely KellyRA or HSA accounts;

June 12, 2024

To: Nevada Public Employees' Benefits Program Board

Atten: Jack Robb, Chair

From: Jim Jeffress, PEBP member

Re: Petition on PEBP Rule / Termination of PEBP Sponsored Benefits

Dear Mr. Robb,

After turning 65 (ten years ago) I established a supplemental Medicare insurance plan through a contractor with PEBP, Tower Watson who later became Via, to obtain benefits to help offset my Medicare cost or part A and B. I have retained that same policy since that time and had not intented to change until being contacted by a company offering to reassess my Medicare plan for coverage and savings. I recently purchased a new secondary plan to offset costs and improve coverage. The company was vetted with both AARP and Medicare as being an approved insurance company. The termination date and start up dates between the two companies was established as June 1, 2024. I had intended to contact PEBP with the new carrier information, but they beat me to the punch.

My dilemma is being notified by PEBP that my sponsored monthly Via benefits had been terminated effective May 31, 2024. Because there was a lapse in coverage, the termination was put in place. The lapse in coverage is debatable, technically there was not a lapse of my insurance coverage (just coverage with a sanctioned PEBP carrier). After contacting PEBP I learned that "<u>any</u>" new secondary insurance policies <u>must</u> be purchased through Via to maintain continuity with my monthly sponsored HRA benefits (that singular statement is on pg. 19) *"Retirees must enroll in a PEBP sponsored medical plan within 60 days of their retirement date as determined by the Public Employees Benefits program (PEBP) or NSHE."* That statement covers the original sign on plan and is left somewhat open to interpretation with subsequent plans approved by Medicare. Honestly, I did not review or remember that stipulation buried in the manual. I had been on auto pilot with my ten-year-old plan and in hindsight should have not been so anxious to save money and enhance my coverage. PEPB was contacted on Monday June 10th after receiving the termination letter dated June 6th, but not delivered until Saturday June 8th.

Asking guidance from PEBP, they suggested I contact Via to seek a course of action to rectify the situation. Via first recommended I contact the new insurance company to see if they can change the "Agent of Record" to a licensed Via agent. The response was no. Therefore, I circled back to Via to initiate an application process for a secondary insurance plan through a company they recommended. That process was accomplished the next day on June 11th and is moving forward.

Once I have verified coverage (estimated effective date 8/1/2024), I will terminate coverage with the outside company.

With the new insurance plan being processed, PEBP was contacted as to the process required to reinitiate my monthly sponsored PEBP sponsored benefits through Via? PEBP indicated the benefits have been terminated (pg. 32) "*Retirees who acquire a break in medical coverage who terminate medical coverage through the PEBP sponsored medical exchange will terminate this year of service HRA contributions, PEBP dental plan coverage, basic life insurance, and voluntary life insurance if applicable."* In my situation, not suspended until such time I have a new policy through Via but terminated! My intention was not to walk away from PEBP but utilize another secondary insurance to save money and insure there was not a lapse in coverage! My mistake was not picking up on "cancelling medical coverage through PEBP sponsored medial exchange will result in termination of the retirees' sponsored benefits." noted in <u>one area</u> of the document. Despite me having an interim secondary Medicare insurance, my dental plan has been terminated in the middle of some costly implant procedure slated for this summer. PEBP suggested I could try and re-enroll April 2025 and petition for a funding exception or petition the PEBP Quality Control Team with no guarantees either effort will be successful. Therein, my petition to the PEBP Board.

After refreshing myself with the PEBP manual (no easy task), I understand the rationale for cornering the market to pick up secondary insurance through Via, but I cannot rationalize why a retiree has their "earned" PEBP HRA benefits terminated if they make a mistake! If someone purposely walks away from the PEBP program for another plan or secondary insurance, understanding the long-term ramifications, then the ruling makes sense. But not when the retiree is notified of their mistake, takes immediate corrective action to resolve the problem, is covered by an interim Medicare approved provider, and is still hit with a fine, in my case, of $2,727.12 (annual benefits), plus out of pocket dental expenses. If this ruling stand and I am fortunate to live another ten years, I will lose a minimum of $27,700! The retirees of the State of Nevada look to PEBP for help and clarification of the rules, not PEBP taking punitive action against those on a fixed income for making a nonintentional mistake. While still working, I recall being notified by PEBP when my daughter's college credit load fell below the required 12 credits to qualify under my state insurance; PEBP notified me so I could take corrective action to maintain her insurance coverage. That was when PEBP outreached to resolve or avoid a problem. I do not see much dissimilarity between that case and mine today and believe the actions taken by PEBP are "exceptionally excessive." Granted, I made a mistake and should accept the consequences of not receiving my sponsored HRA benefits over the two-month period until my approved Via plan is in place, but not for an entire year.

My petition or request to the PEBP Board is to please review this rule or policy and establish a more fair and equitable procedure to deal with these situations, i.e. *PEBP establishing a "coverage lapse notification process" for the retiree to reestablish or secure a "PEBP sponsored*

medical plan" within XXX number of days, forgoing any interim HRA payments, or termination actions will be implemented.

In the meantime, I petition the Board to authorize my HRA benefits, and dental plan be reinstated once I have validated the new Via policy is in effect and PEBP is notified.

Respectfully,

Jim Jeffress

[redacted]

June 21, 2024

To: Board Nevada Public Employees' Benefits Program

Atten: Jack Robb, Chair

From: Jim Jeffress, PEBP member

Re: Petition on PEBP Rule / Termination of PEBP Sponsored Benefi

Dear Mr. Robb,

In my earlier request for the PEBP Board, dated June 11th, I requested the Board to intervene on my behalf. That is, reinstate my sponsored benefits once I secured a secondary Medicare insurance to rectify my lapse in approved insurance through Via.

With the help of an outside insurance company, a simple and very easy process was put into place to make my request from the Board moot. An industry standard is the client has 30 days to terminate a policy or 30 days to reinstate with the old company. In my case, I simply called Untied Health Care through AARP, clarified my option to reinstate and upon verification of that fact, reinstated. United Health Care indicated with that reinstatement, there was **no** lapse in my policy or coverage.

After multiple phone calls with PEBP on how to rectify my situation, they offered little or no help. As refenced in my earlier letter, they said I could reenroll next spring and apply for my benefits but no guarantees. Where PEBP, on page 32, states all the punitive actions that will be taken if there is a lapse add: If you terminate exchange approved coverage, you have 30 days to reinstate with that company to "not risk losing your sponsored benefits." Or include that statement when they send out the termination notice to the PEBP member!!

A very simple solution to what PEBP has made a very large problem for retirees who stray from the voluminous masterplan document. It is disappointing PEBP is not more proactive in "helping" the retirees.

Respectfully,

Jim Jeffress

[redacted]

PEPB Public Statement for Raven Sumner

I have some concerns and questions regarding the out-of-pocket maximum recorded by UMR for in-network services. I've noticed discrepancies between the amounts listed on my (EOBs) and the information on the UMR webpage. As I tracked my EOBs by their Completed/Notice Dates, I found inconsistencies in the amounts. For example, an EOB processed on 4/5/2024 showed a lower in-network out-of-pocket amount compared to an EOB for the same approved code and copay processed the week before. Despite my inquiries, no one has been able to explain these discrepancies.

Additionally, I reached my in-network out-of-pocket maximum last month, but my healthcare providers cannot verify this. When I called PEBP for clarification, I was informed that PEBP does not notify providers that I have met my in-network out-of-pocket maximum; they only provide information on copays and the 80/20 payment amounts. Consequently, my providers have not been able to verify my out-of-pocket status, resulting in me being charged. Even when they call while I am in the office waiting for my appt. When I contacted both PEBP and a UMR representative, I was told that it is my responsibility to manage my own benefits and inform my providers of my status and that it is up to my providers whether to believe me. If a provider indicates on their bill that I have paid, I should receive reimbursement at some future date. If not, I must wait for the EOB to be processed at 100% payment by UMR and then I need to request a refund from the provider.

Furthermore, I have encountered issues with multiple EOBs being fully denied for all services that are covered under my plan when I have also had a service that is not covered on the same visit. For example, services coded 908 have been approved as a standalone service, but denied specifically when an additional medical service not covered by the plan was performed on the same date. In such cases, all service codes regardless of coverage under the plan was denied, despite my having paid the $50 copay for the 908 service, which was not added to my in-network out-of-pocket maximum. This has happened multiple times, and no one has been able to provide an explanation on this matter.

Managing these various issues feels like a part-time job at times and a significant source of stress. I hope that someone can offer a clear explanation and hopefully a resolution for these issues as well as provide guidance to anyone else facing similar situations.

Thank you

Christopher Young

Please require the pharmacy provider to cover weight loss related drugs (e.g. Zepbound) approved by the FDA for weight loss and prescribed in accordance with the manufacture's requirements for use. These medicines are another valuable tool to ensure a healthy active workforce.

PEBS Board

On July 5, 2024, I participated in a doctor's appointment at the William Bree Ririe Health Care Clinic in Ely, Nevada. While there we discussed that I had not received new cards from my "health care provider". Imagine my surprise today July 11, 2024, when I opened my mail to find that my "health care provider" had finally bothered to send me an updated card. Now what about my July 5th visit? Can UMR be bothered to recognize the bill? When I called the number for members 888-763-8232 what I found was an automated voice with no clue of reality. Since I made the mistake of calling at 8 pm Pacific daylight time instead of a convent time for them on central time I was hung up on.

I want to know if this is what you expect for "customer service" to your members. If you think this is great customer service you are in the wrong business. Afterall the IRS could not successfully run the mustang ranch. And it is obvious to me that you are getting screwed. Perhaps UMR should be running brothels. Maybe they do not like the night hours?

Sincerely

Charles Peartree

Dear Chairman Robb and members of the Board,
For the record my name is Pamela French. I want to inform you of a situation I recently had receiving my retiree premium subsidy.
I turned 65 April 17, 2024. To assure timeliness of my benefit I diligently did all the required paperwork and sent it to PEBP on January 29, 2024. I was active with Social Security on April 1, 2024. I was aware it could take 8 to 12 weeks from my active date for the process to play out.
I have contacted PEBP multiple times over the past few months and told to remain patient for the full 12 weeks.
On June 24,2024 , at exactly 12 weeks I contacted VIA early that morning. They confirmed they had not received anything from PEBP. I then Contacted PEBP via

email and phone. I spoke with Jasmine. She told me they would start the paper process to get things going and that would probably take up to two weeks. So now I was looking at 14 weeks. Of note on this day, I contacted Terri Laird, Executive Director, RPEN to alert her to this delay and request her assistance. I wish to thank her once again for her support. Without her intervention I believe this would have gone far past 14 weeks.

During this time, I paid my three months Social Security payment for April/May/June and in June I sent payment forJuly/Aug./Sept. as you know you must pay in advance. I have now paid $1048.20 for part B coverage. (I don't receive social security at this time). I was counting on my subsidy to be available for this most

recent three month purchase.
Paying my medicare part B premium is not going to break the bank but I was looking to the supplement for that cost, not to mention it is my benefit. Is this delay common practice? I assume PEBP would continue to accrue interest on my benefit funds until they are dropped into my VIA account.
I believe other retirees are also affected by a full 12 week delay. Is it not all electronically sent? I have attended 3 of the pre-Medicare meetings and remember hearing a retiree's specific question about the reasoning for a possible full 12 week delay. The answer was that it depends on when you get your paperwork in, essentially bouncing it back to the retiree. That definitely wasn't my

case.
On Wednesday 7/10/24, 14 weeks since my eligibility date, having heard nothing from PEBP or VIA, I Sent another status request note to PEBP. I Later I received a note from PEBP that they had sent the information to VIA and received confirmation they had received it. Still by Friday 7/12/24 no word from VIA. I checked the website the evening before and my account still wasn't set up. I checked and then called early Friday morning, it was then live. PEBP sent a response that they had notified me the same day of confirmation , but I did not receive anything directly that it was actually live where I could receive my funds. Only that PEBP information had been received. There was a message from Ms Glover to MS Laird on 7/10/24

that it should be set up by Friday. As mentioned above with my am call to VIA we did finally get things set up. Unfortunately a dental reimbursement check had already been sent in the mail to arrive 7/23/24. I have provided a timeline to the best of my memory, my notes and emails.
The bottom line is why did it take over 14 weeks to see my supplement. How long before anyone at PEBP or VIA would have caught that my VIA account was not live and my benefit supplement was not provided? if I had not been able to monitor and bring this to their attention who if anyone would have addressed this. I hope this retiree issue can be explored with some type of quality improvement goal, perhaps a retiree survey. Maybe I am just an outlier. As of yet, I still

have not received my VIA Benefit booklet. At this point It is no longer needed. It should be sent very early on. It now would be old news. I bring all of this to your attention for myself but also as a retired RN of 40 years, I will never stop advocating for others. I actually spent around 18 years in PEBP while CTH was a Public Employer. Twelve hour shifts cut my reportable hour and thus years of service .

Thank you for your time and consideration to my circumstances.

Pamela French, RN
retired